Barriers and bridges in menopause hormonal therapy

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Abstract

In this communication, we attempt to simplify the barriers to menopause hormone therapy (MHT) by suggesting bridges over them. We also create an alliterative rubric to assist in clinical assessment of menopause and the rational prescription of menopausal hormonal therapy (MHT). This will ensure comprehensive management of menopause.

Keywords: Menopause, hormonal therapy, barriers.

Introduction

Menopausal care is a rarely discussed aspect of women's health. The multiple biomedical and psychosocial domains of menopause are well-known. A wide variety of non-pharmacological nutraceutical endocrine and non-endocrine interventions are also available to manage menopause.

Menopausal hormonal therapy can be a boon for the severe vasomotor symptoms in a woman if chosen with care and consideration. In spite of this, menopausal care remains suboptimal. This is especially true in South Asia, where a complex interplay of barriers hamper access and adherence to menopausal care. An understanding of these barriers help plan bridges to overcome them.

Barriers to MHT

Menopausal hormonal therapy (MHT) is not utilized as often as it should be. Lack of adequate knowledge at the level of heath care providers (HCP) (gynaecologists, physicians, family medicine specialists, endocrinologists) is one of the key reasons for underutilization of MHT.The Women's health Initiative (WHI) study, in which MHT was initiated in late menopause (up to 10 years after onset of menopause), showed an increase risk of adverse cardiovascular events.[1] This study had an impact not only in reduction of utilization of MHT but funding for MHT research was also affected.

Since then this study has been revisited and in women without a uterus (those in the 50- to 59-year-old group) there was a generally favourable balance of benefits and risks while receiving conjugated oestrogens alone, and a trend toward reduced mortality.[2] The Endocrine Society have introduced clinical practice guidelines which deem MHT safe in appropriate settings.[3] Fear of side effects with MHT is often the main reason for avoidance of MHT from the patients' perspective. Awareness and education of all stakeholders is the key to improving quality of care for menopausal women.

Bridges over barriers: (Table-1)

1) Clinical assessment:

Menopause is an inevitable part of a woman's life, provided she lives long enough. The endocrine changes that precipitate this can be marked by suboptimal function of other organ-systems. This, in turn, can lead to a myriad of clinical presentations. The treating health care professional may not always recognize these manifestations as being part of the menopausal syndrome. Table-2 presents an

Table-1: Barriers and bridges to menopause hormone therapy.

Domain	Barriers	Bridges
Physician	✦ Suboptimal Interest in subject ✦ Suboptimal Knowledge of therapy	✦ CMEs for generalists and specialists ✦ Inclusion in academic curricula
Public	✦ Suboptimal status of postmenopausal women in society ✦ Suboptimal awareness of benefits/risks of MHT	✦ Social engineering/growth ✦ Social media marketing
Policymakers	✦ Perceived cost of therapy and monitoring ✦ Possibility of litigation	✦ Woman midlife/elder-friendly policies ✦ User-friendly policy protocols
Patient	✦ Perceived side effects ✦ Presentation to variety of specialists	✦ Patient education ✦ Prevention of misinformation
Pharmacology	✦ Availability of multiple therapies ✦ Lack of clarity regarding regulation	✦ Clarity of therapeutic landscape ✦ Classification of menopausal ill health and its treatment

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Table-2: The M's of menopausal dysfunction.

Domain	Symptoms	Relation with estropenia	Role of menopause hormone therapy
Mood and cognitive	Mood disturbance	+ -	-
	Loss of libido	+	+
Motor(vasomotor)	Hot flashes	+	+
Micturition and genital (genitourinary)	Genital atrophy, dyspareunia	+	+
Musculoskeletal	Osteoporosis	-	+ -
Metabolic (cardiovasculo-metabolic)	Metabolic syndrome	-	-
Malignancy	Varied	+ -	-

Table-3: Caveats and contraindications for MHT.

Mood: personal preferences
Medical care: access to regular medical professional help
Monitoring: access to regular investigations
Metabolic: uncontrolled hypertension
Malignancy: CA endometrium

alliterative 6 point list which summarizes the potential health challenges seen in menopause. It serves as a checklist for history taking, as a basis for person-centred investigations, and as a framework for risk benefit assessment of MHT. All these attributes facilitate its use as a clinical decision making aid in menopause management.

2) Caveats to care

Table 3 lists the caveats and contraindications that must be respected while prescribing MHT. This ensures adequate safety and tolerability of prescribed treatment. In general, MHT is stopped after a finite period, once a predecided clinical end point or relief is obtained from the symptoms which necessitated initiation of the therapy.

Summary

MHT is an important pillar of menopause management. The user-friendly format of clinical features of menopause, indications and caveats for MHT allows for easy management of a menopausal woman in a busy clinic. To ensure adequate uptake and acceptance of menopause care, the subject has to be simplified and demystified. This communication attempts to do this and engender confidence in the treating HCP whose prime objective is Primum non nocere (Do no harm).

References

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