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Maintaining postreproductive health: A care pathway from the European Menopause and Andropause Society (EMAS)

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ABSTRACT

This position statement from the European Menopause and Andropause Society (EMAS) provides a care pathway for the maintenance of women's health during and after the menopause. It is designed for use by all those involved in women's health. It covers assessment, screening for diseases in later life, treatment and follow-up. Strategies need to be optimised to maintain postreproductive health, in part because of increased longevity. They encompass optimising diet and lifestyle, menopausal hormone therapy and non-estrogen-based treatment options for climacteric symptoms and skeletal conservation, personalised to individual needs.

1. Introduction

Life expectancy has increased remarkably in recent years and women live longer than men. Life expectancy at birth in the European Union in 2013 was 83.3 years for women and 77.8 years for men [1]. Between 2002 (the first year for which data are available for all EU Member States) and 2013, life expectancy increased by 2.4 years for women. The UK's Office for National Statistics found that in 2011–2013 women aged 65 years had an average of 20.7 years of life remaining [2]. Worldwide, the number of postmenopausal women is estimated to reach 1.1 billion in 2025 [3].

Ageing populations are naturally more vulnerable to health disorders and their medical care is burdening national economies. Primary care providers should manage the individual needs of most midlife women, with the aim of preventing the development or delaying the progress of menopause-related health disorders. The purpose of this care pathway is to provide guidance to optimise healthcare for midlife women, from assessment to management options. Drugs in development are also detailed.

The care pathway is based mainly on the evidence presented in the following recent documents: EMAS position statements and clinical guides, published in *Maturitas* between 2010 and 2016 [see for example 4], a guideline from the UK National Institute for Health and Care Excellence (NICE) [5], a clinical practice guideline from the Endocrine Society [6], a practitioner's toolkit for managing the menopause [7] and the recommendations for the clinical care of midlife women produced by the North American Menopause Society [8].

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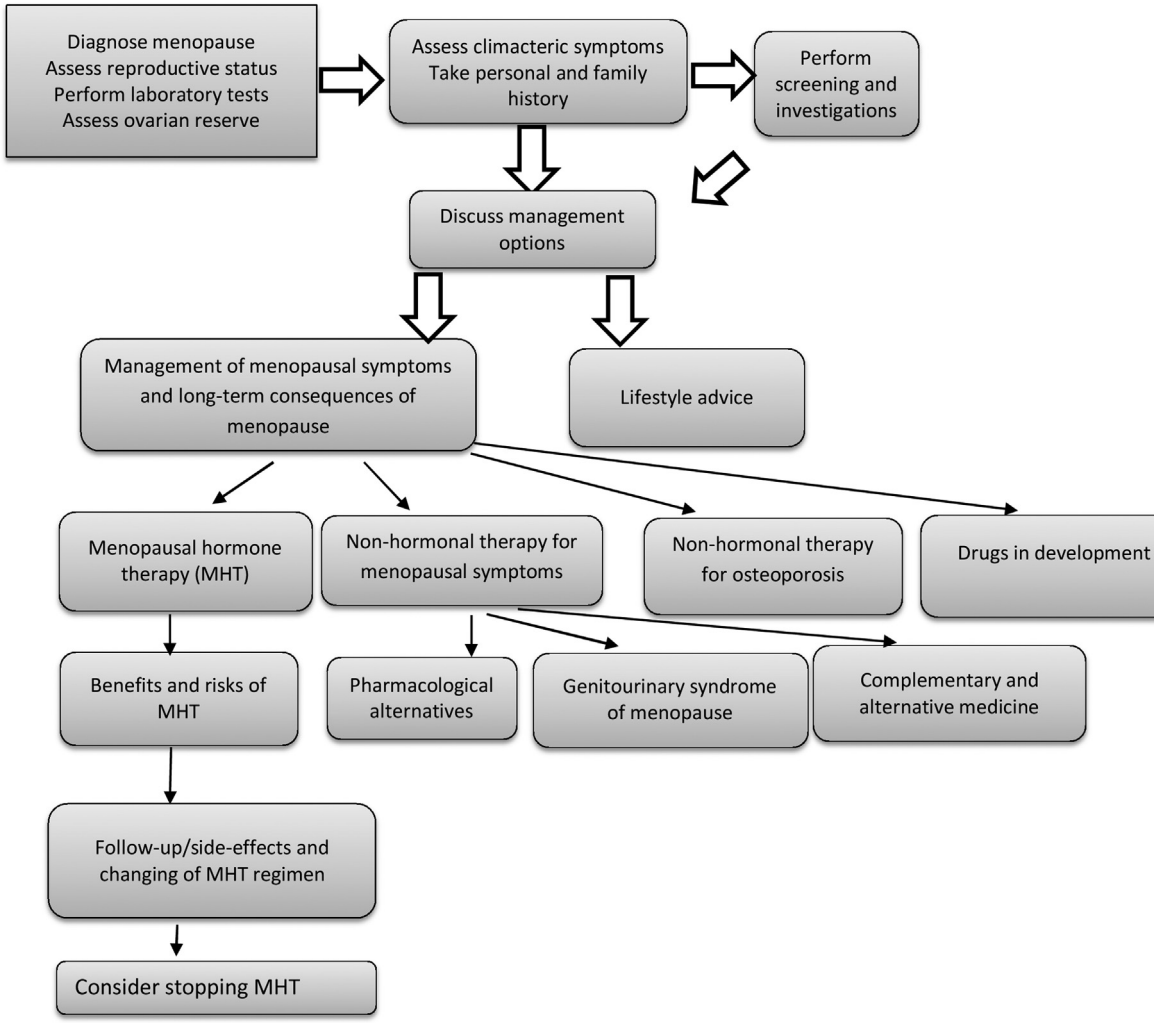

Fig. 1. A care pathway for the maintenance of women's postreproductive health.

The first step is to assess climacteric symptoms and diagnose menopause (Fig. 1). The consultation can also be an opportunity to assess the risk of disorders in later life such as cardiovascular disease and osteoporosis and to encourage women to take part in national screening programmes for cervical, breast and colon cancer. If the woman is troubled by menopausal symptoms, the management options should be discussed. These will include lifestyle advice as well as pharmacological interventions (hormonal and non-hormonal).

2. Diagnose menopause

For most women the menopause is a natural and inevitable process due to ovarian ageing and which usually occurs in their late 40s or early 50s [9,10]. Spontaneous menopause is recognised retrospectively after 12 months of amenorrhoea and occurs at an average age of 52. However, it can be induced earlier by medical intervention, such as bilateral oophorectomy or iatrogenic ablation of ovarian function by chemotherapy, radiotherapy or treatment with gonadotrophin-releasing hormone analogues. In the absence of surgery, induced premature ovarian failure may be permanent or temporary. The following terms are used:

* **Early menopause** describes menopause in women aged 40–45 years.
* **Premature menopause** denotes definitive loss of ovarian function (e.g. through bilateral oophorectomy) before the age of 40.
* **Premature ovarian insufficiency (POI)** describes transient or permanent loss of ovarian function in women before the age of 40. A substantial proportion of these women have spontaneous resumption of ovulation, menstruation and successful spontaneous pregnancy.
* **Menopause transition** is the time when there are changes to the menstrual cycle and endocrine levels. According to STRAW + 10 the transition begins with variation in the length of the menstrual cycle and ends with the final menstrual period [10].

3. Investigations and assessment of ovarian reserve

3.1. Endocrine investigations

Where it is deemed helpful, the following blood investigations may be used.

3.1.1. Follicle stimulating hormone (FSH)

There is no need to measure FSH levels to diagnose menopause in otherwise healthy women (who are not using hormonal contraception) over the age of 45 who have not had a period for at least 12 months or in perimenopausal women with vasomotor symptoms and irregular periods. Nor should FSH levels be used to diagnose menopause in hysterectomised women with menopausal symp-