

Hormone Therapy for Menopausal Women in the Primary Care Setting

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ABSTRACT

Menopausal hormone therapy (MHT) is the most effective treatment for vasomotor symptoms; however, many women receive inadequate treatment because of a misunderstanding of important MHT research. Reanalysis of findings from the Women's Health Initiative, in conjunction with recent findings from the Study of Women Across the Nation and the Kronos Early Estrogen Prevention Study, support the use of MHT in women who are < 10 years from the onset of menopause and are free of contraindications. Primary care providers are in the ideal position to provide evidence-based counseling to patients and help women make an individualized decision to use MHT safely.

Keywords: genitourinary symptoms, hormone therapy, hot flashes, menopause, perimenopause, primary care, vaginal dryness, vasomotor symptoms

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Menopause is a universal and normal, physiologic progression in a woman's life. By the year 2020, it is estimated that over 50 million women in the United States will be in the perimenopausal/menopausal transition period;^{1,2} approximately 75% of these women will experience vasomotor symptoms (VMSs) affecting their quality of life.^{1,3,4} Although menopausal hormone treatment (MHT) is considered the most effective therapeutic option for the treatment of these symptoms,^{1,4-6} many women with moderate to severe VMSs receive inadequate treatment with nonhormonal methods or no treatment at all because of safety concerns related to MHT.^{1,7} A recent study published in the *New England Journal of Medicine* noted that education for the treatment of menopausal symptoms is lacking in the standard curriculum for both obstetrician-gynecologists and primary care providers.¹ The lack of standardized curriculum, as well as a widespread misunderstanding of important MHT research studies, has contributed to the increased number of untreated women suffering from VMSs.^{1,2,8,9} Nurse practitioners (NPs) in primary care are in the ideal position to close this gap and provide evidence-based counseling and treatment during this phase of life.⁶

DEFINITION AND PATHOPHYSIOLOGY OF MENOPAUSE

Menopause is defined as the natural, systemic decrease of endogenous estrogen production from the ovaries caused by the physiologic depletion of a woman's ovarian reserve.^{3,4} This is a normal process in the aging female and manifests as the cessation of menses and subsequent end in fertility and, in many women, the development of VMSs.³ The average age of menopause in the US is 51 years but can range from the mid-40s to late 50s.^{1,9} Before complete cessation of menstruation, women typically experience a perimenopausal period for approximately 6 months to 2 years.⁴ The perimenopausal period is characterized by VMSs and an irregular menstrual cycle that may include shorter or longer intervals between menses and heavier or lighter menstrual flow. Fluctuating hormone levels and decreasing systemic estrogen are the cause of VMSs, such as hot flashes and vaginal dryness, and an irregular menstrual pattern. When a woman has gone without menses for 12 consecutive months, she has moved from the perimenopausal period into menopause.

The decrease of endogenous estrogen that occurs in menopause is the main cause of physiologic

changes that women experience during this transitional period. A woman's osteoporosis and fracture risk increases as the body's production of estrogen decreases. Bone health is dependent on estrogen's ability to stall bone resorption; therefore, as endogenous estrogen decreases with age, bone breakdown occurs more rapidly.¹⁰ A woman's risk of cardiovascular disease (CVD) and myocardial infarction also increases with menopause and age. In the menopausal transition, the progressive loss of endogenous estrogen is associated with the loss of endothelial function of the vasculature, increasing the risk of atherosclerosis and elevated blood pressure.¹¹ Additionally, the reduction in estrogen affects the central nervous system by influencing temperature regulation, which is controlled by the hypothalamus.^{3,6} The change in temperature regulation results in the characteristic menopausal symptoms of hot flashes, night sweats, and sleep disturbances, known as VMSs.³ Women can also experience vaginal dryness because of the decrease in estrogen in the urogenital mucosa causing an increase in vaginal pH and a decrease in vaginal tissue secretions. This leaves menopausal women susceptible to dyspareunia and atrophic vaginal mucosa and puts them at an increased risk for urinary tract infections.^{4,12}

VMSs, particularly hot flashes, are the most common reasons that women seek care during the perimenopausal and menopausal period, along with urovaginal symptoms.^{3,8} The North American Menopause Society (NAMS) recommends lifestyle changes, such as regular exercise and regulation of body temperature through the layering of clothing and the use of external heating/cooling systems, as the initial step for the management of VMS, whereas suggestions for nonprescription options include the use of vitamin E, soy, and black cohosh.^{3,4,7} Because the exact mechanism of estrogen depletion causing hot flashes and VMSs is unknown,^{3,6,8} there are many nonhormonal prescription and nonprescription medications that can be tried before the initiation of MHT or used as an alternative if MHT is contraindicated (Table 1). These treatment methods come with their own set of contraindications and side effects, which must be

Table 1. Examples of Nonhormonal Medications^{1-3,5-8}

For vasomotor symptoms
Antidepressants
• SSRI: paroxetine
• SNRI: venlafaxine
Gabapentin
Clonidine
SERMs
• Bazedoxifene
• Raloxifene
For genitourinary symptoms
SERM: ospemifene
Replens (Church & Dwight Co., Inc., Ewing, NJ)
Sylk (SYLKUSA, Scottsdale, AZ)
Intrarosa (AMAG Pharmaceuticals, Inc., Waltham, MA)
Soy isoflavones
Red clover isoflavones
Black cohosh
Vitamin E

SERM = selective estrogen receptor modulator; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor.

considered before recommending a therapy to an individual patient.

DEBUNKING THE MYTH BEHIND MHT

If lifestyle changes have been implemented for 3 months with minimal or no relief of symptoms, MHT may be an appropriate next step in a provider's approach to treatment.⁸ MHT should be offered to women who are bothered by moderate to severe VMSs or women who do not experience relief with nonhormonal methods.⁷ MHT is the most effective option in treating menopausal symptoms because through its replacement of estrogen back into a woman's body, the source of the symptoms is physiologically reversed.⁴ However, many providers and patients are resistant to the implementation of MHT because of reports of adverse outcomes revealed in research studies, most significantly in the Women's Health Initiative (WHI).²

Before the year 2000, the majority of research and information on MHT was based on observational studies for the treatment of menopausal symptoms. The WHI, supported by the Department of Health and Human Services, the National Institutes of Health, and the National Heart Lung and Blood Institute, conducted a randomized

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