Menopausal Symptoms and Their Management

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KEYWORDS

• Menopause • Perimenopause • Vasomotor symptoms • Vaginal dryness
• Dyspareunia • Depression • Cognitive impairment • Insomnia

KEY POINTS

- The late menopause transition (when women begin to experience 60 or more days of amenorrhea) is the point in time when hot flashes, adverse mood, vaginal dryness, and sleep complaints accelerate in prevalence.
- The duration of hot flashes (vasomotor symptoms) maybe longer than previously thought, with newer studies indicating durations of as long as 10 or more years.
- There are nonestrogenic alternatives that are now approved by the US Food and Drug Administration (FDA) for the treatment of menopause-related vulvovaginal atrophy.
- Both depression and anxiety increase in prevalence as women traverse the menopause, and the most vulnerable women are those without any prior episodes.
- Cognitive changes related to estrogen withdrawal include deficits in verbal and working memory, with almost three-fourths of women having a subjective sense of memory loss.

INTRODUCTION

The menopause transition is experienced by 1.5 million women each year and often involves troublesome symptoms, including vasomotor symptoms, vaginal dryness, decreased libido, insomnia, fatigue, and joint pain.[1–3]

In one population-based assessment of 386 Australian women, 86% consulted a clinician at least once to discuss menopausal symptoms.[4] Several symptoms bear an obvious relationship to the changing hormonal milieu associated with menopause, and most women make direct linkages between menopause and the common symptoms of hot flashes, vaginal dryness, and disrupted sleep (with or without associated

N. Santoro has investigator-initiated grant support from Bayer and stock options in Menogenix. C.N. Epperson and S.B. Matthews have nothing to disclose.

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Endocrinol Metab Clin N Am 44 (2015) 497–515
http://dx.doi.org/10.1016/j.ecl.2015.05.001 **endo.theclinics.com**
0889-8529/15/$ – see front matter

night sweats). In addition, during menopause, women may develop depressive symptoms and cognitive difficulties, which are more subtly and inconsistently linked to hormones. Depression and cognitive impairment can be burdensome for women and also compound the burden of medical illness for the aging female population. As postmenopausal women are already at risk for osteoporosis and cardiovascular disease, it is important to address potentially changeable psychiatric issues that may make medical issues more difficult to treat. An understanding of the risk factors, clinical presentation, and management of these common menopausal symptoms allows for improved patient care and health outcomes for older female patients.

THE CORE 4 SYMPTOMS: VASOMOTOR, VAGINAL, INSOMNIA, AND MOOD

Epidemiology

Population-based, epidemiologic studies of menopausal women have recently been conducted and are yielding reliable and consistent information about the incidence, prevalence, and severity of several menopausal symptoms. However, the field is relatively new, and it is likely that there are subsets of women who are more or less vulnerable to particular symptoms or sets of symptoms. In 2005, a state-of-the-science conference on menopausal symptoms was convened, with a worldwide panel of expert evaluators who were tasked with determining which among the large set of midlife symptoms are most likely to be due to menopause. Symptoms were evaluated for their proximity to menopause, apart from the aging process, and the likelihood that estrogen is effective in relieving symptoms.[2] Based on this evidence review, 3 symptoms emerged as having good evidence for linkage to menopause: vasomotor symptoms, vaginal dryness/dyspareunia, and difficulty sleeping/insomnia. After this conference and based on 3 seminal studies,[3,5,6] adverse mood/depression was added to the list. Adequate longitudinal studies on cognitive function during the menopause were not yet available but have also become subsequently widely reported.[2,3,5,7,8]

It is clear that there are many other symptoms that are reported by menopausal women. These include joint and muscle aches, changes in body contour, and increased skin wrinkling.[1] Several studies have examined the associations between these symptoms and menopause. Given the methods of ascertainment, the subjective nature of the complaints, the likelihood that there is publication bias (wherein positive studies demonstrating linkage to menopause are more likely to be published than negative studies), and their variation over time, it has been difficult to establish a true relationship between these symptoms and menopause. Other symptoms, such as urinary incontinence (UI) and sexual function, have mixed data for efficacy of estrogen treatment and linkage to menopause, apart from the aging process. For these reasons, this article addresses the core 4 symptoms and includes cognitive issues because they are of great importance and concern to aging women.

Vasomotor symptoms

Vasomotor symptoms afflict most women during the menopausal transition, although their severity, frequency, and duration vary widely between women. Hot flashes are reported by up to 85% of menopausal women.[7] Hot flashes are present in as many as 55% of women even before the onset of the menstrual irregularity that defines entry into the menopausal transition[9] and their incidence and severity increases as women traverse the menopause, peaking in the late transition and tapering off within the next several years.[10–12] The average duration of hot flashes is about 5.2 years, based on an analysis of the Melbourne Women's Health Project, a longitudinal study that included 438 women.[11] However, symptoms of lesser intensity may be present for a longer