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- Lowest effective dose available
- Significant long-term improvement in vaginal health
- Precise dose, locally administered, locally effective
- Pre-loaded single-use applicator


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1 Based on patient perception regarding wasting & invasiveness of 1% local 1% estradiol cream
2 Lowest effective dose available
3 Signiﬁcant long-term improvement in vaginal health
4 Precise dose, locally administered, locally effective
5 Pre-loaded single-use applicator

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Vagifem® 10 μg – ultra-low-dose for vaginal atrophy

Editorial
Dr Percy Moodley

SAMS News
Dr Carol Thomas

Genitourinary syndrome of the menopause
Dr Malikah van der Schyff

Clinical assessment in uro-gynaecology
Professor Peter Roos

Medical treatment of osteoporosis
Dr Tobie J de Villiers

Common questions patients ask about menopause and related issues - addressing their fears, concerns and myths
Dr Sumayya Ebrahim

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We are 3 months away from the SAMS conference at the Gateway Hotel in Durban. The conference will concentrate on clinical issues that confront any clinician caring for the mature woman.

The papers presented in this issue of Menopause Focus also carry a strong clinical theme. It aims to assist the clinician in making small changes in management that have a significant impact on the quality of life of patients. The paper on Genitourinary Syndrome of Menopause discusses an under-reported, under-recognised and under-treated condition. Dr Malikah van der Schyff gives an excellent overview from basic science to treatment.

The vast clinical experience and teaching of Professor Peter Roos is reflected in his paper Clinical Assessment in Urogynaecology. He emphasises the time honoured importance of accurate history taking and examination which leads to appropriate investigations and management.

The excellent review prepared by Dr Tobie de Villiers on medical management of osteoporosis guides clinicians on the accessible therapies available in South Africa. The choice is dependent on the age of the patient, risk factors, BMD, cost and an assessment of compliance.

In yet another clinically relevant paper, Dr Sumayya Ebrahim highlights the concerns and needs of patients and the influence of internet and social media on patients’ behaviours and perceptions. Sensational reporting in the media leads to dramatic changes in the behaviour of doctors and patients. Reanalysis that refutes sensational reports seldom reaches the mainstream press, delaying corrective clinical adjustments. Her comments on the approach to patients on alternative therapies has merit.

Increasing comorbidities, morbidity and fear of mortality start impinging on our consciousness and daily lives as we age. The often chanted ‘ageing is not for sissies’ starts to ring true. Athol Kent’s mantras in Menopause Matters about the value of lifestyle management ensure just enough guilt in us to, intermittently, try at least. For most clinicians our emphasis seems to be on what just seems common sense, both to us and the patient, hopefully backed up with evidenced and/or observational based support. In fact, some patients may even feel that they could have accessed that advice from your dated coffee table magazine stash or from their mobile phone while sitting in your waiting room. The main barrier to their search engine efforts is, however, the inability to contextualise and interpret (and treat accordingly) their perceived research to apply to their personal needs.

For patients the list of causes for headache could be a headache, but also a brain tumour. Clinician’s relevance becomes more important in times of overflow of opinion and information, rather than less so. Workflow may be automated and create efficiencies to clinician opinion access, but the 4th industrial revolution can only improve access to considered clinician care, with all its nuances. These thoughts underpin my call to come and join us at our SAMS2018 Congress so that we can help you support you, the clinician, in your quest to add value to your patients and self. We are concentrating on your needs and would like to build more capacity for areas you may identify a need. The congress also represents a unique opportunity to become a member of our SAMS health provider support network by registering on our digital platform, suitable for all health professionals (specialists and doctors in training, pharmacists, physiotherapists, to name but a few). To become part of this emerging community, you’ll have to be a member of SAMS. But, why would one not want to be a member? So, find that form in this edition!

Warm regards, Carol

See SAMS Congress information on page 18.
Genitourinary syndrome of the menopause

Vulvovaginal atrophic symptoms can and will affect all women. It can affect up to 50% of women who are postmenopausal, 15-20% of women on menopausal hormonal therapy (MHT), as well as 15 to 20% of women who are taking combined hormonal contraceptive (CHC). Atrophic symptoms can often be progressive with age, requires treatment and is often under-treated, under-recognised and under-reported.

Background

Many studies and surveys conducted locally and internationally highlight the fact that women consider discussing vaginal discomfort or sexual health a taboo subject. Many women fear broaching this sensitive discussion with their healthcare practitioners (HCPs). It is also shown that many HCPs do not enquire about symptoms related to vulvovaginal atrophy.

The VIVA (Vaginal Health: Insights, Views and Attitudes) study, an international study of 3250 postmenopausal women who were interviewed, expressed that they felt that it was a taboo subject. They often waited too long to talk to the doctors. In the study, 45% of postmenopausal women reported experiencing vaginal symptoms yet only 4% related it to menopause and again expressed that they had waited too long to speak to the doctors. It was also found that up to 40% of HCPs never asked about atrophy, 30% very rarely asked, 20% sometimes asked and only 8% of discussed the subject.1

The REVIVE (REal women’s VIews on treatment options for menopausal vaginal changes) survey found that only 19% of healthcare professionals addressed sexual lives, 13% specifically asked around genitourinary issues and 40% of patients had expected the HCP to broach the subject.2

The CLOSER (CLarifying vaginal atrophy impact On SEx and Relationships) survey was an international, quantitative, internet-based survey that involve many countries such as the USA, Great Britain, Canada, France, Italy, Denmark, Finland and Norway involving 8200 individuals published in 2013.3 These were couples aged 55-65 years who experienced vaginal discomfort and completed a structured questionnaire. South Africa undertook its own CLOSER survey in 2015 and findings reflected international sentiment. Couples completing the survey were open to talk about vaginal discomfort. In fact, 90% of men wanted their partners to talk to them about their experiences of vaginal discomfort.4

The South African results also showed:

- 68% of women avoided being intimate with their partners.
- 29% of women felt uncomfortable talking about the subject to partners.
- 24% of women felt that talking about vaginal discomfort ruined moments of intimacy.
- 52% of women said they were having sex less often and this was mirrored by 51% of men.
- 21% of women felt emotionally distant from their partners.

In summary, vaginal discomfort was found to be an obstacle for intimacy. which affected physical and emotional relationship.

The survey also found that vaginal discomfort had a negative impact on women’s self-esteem and emotional well-being:

- More than 50% felt they had lost their youth due to vaginal discomfort.
- Almost 50% of women felt their body was not working.
- 33% of women did not feel sexually attractive any more.
- 27% of lost confidence as a sexual partner.
- 26% felt less of a woman.
- 24% felt depressed about their sex life and
- 20% felt the condition left them lonely.

The survey highlighted that there was a lack of discussion with regards to the vaginal discomfort. It reflected that vulvar, sexual and urinary symptoms associated with menopause was under-diagnosed and under-treated.4

New terminology: Genitourinary syndrome of the menopause

Globally, there was a need for new terminology to be designed in order to replace the archaic term of vulvovaginal atrophy or atrophic vaginitis. It was felt that these terms were inadequate, inexact, non-inclusive and did not promote a good dialogue between the healthcare professional and the public.5

Genitourinary syndrome of menopause (GSM) is considered an accurate and comprehensive description of a common postmenopausal problem. This new terminology was thought and aimed to improve and increase communication, research, education and treatment related to the genitourinary and sexual health of post-menopausal women. GSM is found to be an acceptable term to use by primary health care providers.
clinical specialist, researchers, educators, affected women, the media and the public.

The definition of “genitourinary syndrome of the menopause” is a collection of symptoms and signs associated with the decrease in oestrogen and other sex steroids involving the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra and bladder. It may include (but is not limited to):

- genital symptoms of dryness, burning, and irritation;
- sexual symptoms of lack of lubrication, discomfort or pain, and impaired function; and
- urinary symptoms of urgency, dysuria and recurrent UTIs.

Women may present with some or all of the signs and symptoms, which must be bothersome and should not be better accounted for by another diagnosis. These symptoms are often apparent 2-4 years after menopause. However, as previously noted, it can occur in 15-20% of women who are on menopausal hormonal treatment or 15-20% of patients on combined hormonal contraception.

### Physiology

As menopause progresses, the decline of oestrogens in the vagina is closely correlated with decreased vaginal lactobacillus; increased pH; altered epithelial morphology; fragmentation of elastin; hyalinisation of collagen fibres; reduced vascular flow and reduced fluid secretion within the vagina.

Vaginal health plays crucial role for sexual health. Therefore - vaginal dryness, dyspareunia, decrease in genital sensation, vasocongestion and lubrication can lead to reduced sexual desire, poor arousal and orgasm, impaired sexual satisfaction. Urinary symptoms including frequency, urgency, nocturia, dysuria, incontinence and postcoital infection.

The premenopausal vaginal milieu is well oestrogenised with multilayered squamous epithelium, good blood supply. The vagina is often moist and rich in glycogen with a pH of approximately 3.5. The postmenopausal vagina which is oestrogen deficient displays atrophy, dryness, reduced blood supply, loss of glycogen and an altered pH 5.0-5.4.

### Manifestation

Vulval and vaginal atrophy occurring in postmenopausal women result in loss of labial and vulvar fullness, pallor of urethral and vaginal epithelium and decreased vaginal moisture. Untreated, it often results in the increased likelihood that vaginal epithelium will be friable, petechiae, ulceration, tears and prone to bleeding with minimal trauma (speculum insertion, pap, sex).

<table>
<thead>
<tr>
<th>Table 1: Commonest GSM signs and symptoms</th>
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<tbody>
<tr>
<td><strong>Genital dryness</strong></td>
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<tr>
<td><strong>Decreased lubrication</strong></td>
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<tr>
<td><strong>Discomfort or pain with sexual activity</strong></td>
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<tr>
<td><strong>Post-coital bleeding</strong></td>
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<tr>
<td><strong>Decreased arousal, orgasm, desire</strong></td>
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<tr>
<td><strong>Irritation/Burning/Itching</strong></td>
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<tr>
<td><strong>Dysuria</strong></td>
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<tr>
<td><strong>Urinary frequency/urgency</strong></td>
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<tr>
<td><strong>Table 2. Signs and symptoms (regionally)</strong></td>
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<tr>
<td><strong>Perineal area</strong></td>
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<tr>
<td><strong>GSM manifestations</strong></td>
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<tr>
<td><strong>VULVA</strong></td>
</tr>
<tr>
<td>Shrinkage of labial fat pad, labia minora and majora</td>
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<tr>
<td>Shortening of prepuce and excessive exposure of clitoris</td>
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<tr>
<td>Pubic hair loss</td>
</tr>
<tr>
<td>Itching, Soreness</td>
</tr>
<tr>
<td>Burning sensation</td>
</tr>
<tr>
<td>Mucosal petechiae</td>
</tr>
<tr>
<td>Micro-fissures</td>
</tr>
<tr>
<td>Ulceration, inflammation</td>
</tr>
<tr>
<td>Loss of rugae</td>
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<tr>
<td>Shortening and fibrosis or obliteration of vaginal vault</td>
</tr>
<tr>
<td>Leukorrhea and/or foul secretion</td>
</tr>
<tr>
<td>Increased retention after micturition</td>
</tr>
<tr>
<td>Decreased storage capacity</td>
</tr>
<tr>
<td>Recurrent UTIs</td>
</tr>
<tr>
<td>Decreased urethral closure pressure</td>
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<tr>
<td>Decreased urethral flow of urine</td>
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<tr>
<td>Disorders of collagen metabolism</td>
</tr>
<tr>
<td>Decreased activity of alpha adrenergic system</td>
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<tr>
<td>Innervating both bladder and urethral sphincter</td>
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</table>
Diagnosis

The diagnosis is invariably made on history as well as clinical inspection. Healthcare practitioner must enquire about these symptoms which can be variable and common. The consultation needs to be sensitive and reassuring. Other disease entities or even side-effects of medications may mimic symptoms and signs of atrophy.

Rationale for treatment

Oestrogen receptors are located in vulva, vagina, urethra, trigone, bladder dome, pelvic fascia, pelvic ligament. Oestrogen replacement replenishes and restores the urogenital physiology - it lowers the pH, thickens the epithelium, increases blood flow and improves vaginal lubrication.

Symptomatically, the patient experiences relief as well as the alleviation of vaginal dryness, superficial and deep dyspareunia, vulvodynia, vulvovaginal bleeding, inflammation and discharge, urinary sensory, urgency and UTIs.

Management options

1. Lifestyle modifications

Minor lifestyle modifications may assist in preventing worsening atrophy. These include cessation of smoking, regular coital activity or reducing the risk of UTIs with cranberry or citrus soda formulations.

2. Non-hormonal treatment

Lubricants - These are temporary measures to relieve vaginal dryness during intercourse. It is often a combination of protectants and thickening agents in water soluble base. They have a short duration of action, need frequent application and reapplication before sex. They are freely available in stores and pharmacies.

Moisturisers - These are bioadhesive polycarbophil-based polymers which adhere to mucin and epithelial cells on vaginal wall. They carry up to 60 times their weight in water and hold water in place against vaginal epithelium until cells sloughs off, about 24 hours. It requires 2-3 applications per week and there is no need for reapplication prior to sex. Moisturisers provide symptomatic relief and do have some effect on vaginal elasticity. They are less freely available despite being over-the-counter and are often ordered online.

3. Hormonal treatment

3.1 Rationale for hormonal treatment

Systemic or local HT is effective in the prevention and treatment of vulva and vaginal atrophy.

Local therapy is preferred to systemic therapy. Local low dose oestrogen is preferred for women whose symptoms are limited to vaginal dryness or associated discomfort with intercourse. Local oestrogen therapy improves symptoms of detrusor instability, frequency, urgency, urge incontinence, frequency, and nocturia and reduces the incidence of recurrent urinary tract infections.

Relief of vaginal symptoms is obtained in 80-95% of patients using local oestrogen treatment, 73% with menopausal hormonal treatment (MHT) and in 55% of patients using E2 transdermal or percutaneous gels.

3.2 Treatment options

- **Systemic hormonal therapy**
  Oestrogen, given orally or vaginally, and in all dosage regimens, is effective in the treatment of urogenital atrophy. However, the vaginal route gives better results and even in the WHI trial, 10% of women taking E+P complained of vaginal dryness. Given the safety concerns of systemic therapies, it should not be prescribed for GSM alone.

- **Low dose vaginal oestrogen**
  Creams, pessaries, tablets and estradiol rings, equally effective in relieving symptoms are significantly better than placebo/non hormone therapies.

  Low dose vaginal oestrogen has a more favourable risk profile. There are very small, if any, changes to serum oestrogen concentrations.

  - **Formulations**
    - Estadiol ring - 75ug/d
    - Estradiol tablets - 10ug 2 x week
    - Low dose vaginal creams

  - **Advantages**
    - Avoids enterohepatic circulation
    - Lowest possible dose
    - No endometrial stimulation
    - Progestogens unnecessary
    - No clinical relevant systemic side effects
    - Exerts mainly local effect (depending on the type of preparation)

  - **Disadvantages**
    - No systemic benefits on bones, vasomotor symptoms or psychological
    - Mode of administration (vaginally) may not be “polite”

  - **Treatment guidelines**
    - Prescribe the lowest effective dose
    - Delays in starting local treatment will reduce degree of response.
    - Initial loading dose to stimulate receptors followed by low maintenance dose 1-2x week.
    - Substantial improvement after 3wks (may need 4-6wks in severe cases).
    - Not to exceed the recommended frequency
however this is case dependent.

- Symptoms will return if treatment is stopped.
- No data beyond ONE year of use with regards either additional benefit or risk. It is even stated to continue treatment as long as patient has symptoms.
- If treatment fails, need to exclude skin disorders or vulvodynia.

- **Adverse events**
  - There is no evidence of increased endometrial thickness, cardiovascular, cerebrovascular, cognitive or other major adverse effects.\(^8\)
  - Side effects have been described but are very rare.
  - Vaginal irritation, itchiness, discharge, bleeding, pelvic pain, breast tenderness.
  - Creams more likely to produce adverse events than tablets/ring.
  - Starting with a low “test” dose is essential.

- **Endometrial protection**
  - There is systemic absorption with all oestrogen products. However this is low and show no significant effect on ET, hyperplasia or adverse outcome.\(^8,9\)
  - **THERE IS NO NEED FOR PROGESTERONE OPPOSITION WITH VAGINAL OESTROGEN**
  - This has been proven in the literature and societies such as SAMS, NAMS and IMS guidelines do not advocate routine use.\(^10,11\)

- **Treatment dilemmas**
  - **Compliance**
    This is the commonest treatment dilemma. Women DO NOT use their oestrogen. Discontinuation rates are very high. It is occasionally because they read the package inserts (applied to systemic use) and are too scared to continue. The role of the HCP is to better educate the user to avoid this. Often vaginal tablets are better tolerated than rings or creams.\(^12\)
  - **Candidiasis**
    This is a common problem. Oestrogen deficient women are often resistant to vaginal yeast infections. With re-estrogenisation, the risk of yeast increases, especially in the first 3-4 weeks. Proactively treating these patients with oral or vaginal anti-fungal formulations may prevent this. Consequently also educating the patient of her risk for vaginal candidiasis may also assist in compliance.
  - **Infections**
    With replenishing the vaginal epithelium and pH, the patient may experience an increased but normal vaginal discharge. This may not be acceptable to some patients and many often perceive they have an infection. Education and probiotics are essential here to maintain vaginal health and prevent infections.
  - **Irritations**
    Topical preparations can be irritating to the patient. To prevent this, compound the oestrogen in a bland base or even petroleum (a compounding pharmacy can assist).

4. **Differential diagnosis/Special considerations**

- **Postmenopausal bleeding (PMB)**
  All relevant investigations and screenings must be excluded if PMB is present.

- **Urinary issues**
  Incontinence can worsen vaginal irritation and delay healing due to constant leaking of urine. This must be investigated and treated.

- **Pelvic organ prolapse**
  Prolapse and its surgical treatments may require additional longer local oestrogen replenishment prior to planned surgery.

- **Lesions**
  Atrophy can cause many changes to vulva and vaginal. However, if there are any suspicious or hard lesion, ulcers, skin changes or there is a failure to improve with topical therapy - the differential diagnoses listed in **Table 3** must be considered. Specialist referral or biopsies must be considered.

<table>
<thead>
<tr>
<th><strong>Table 3. Differential diagnosis</strong></th>
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<tr>
<td><strong>GSM Differential diagnoses</strong></td>
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<tr>
<td><strong>Lichen sclerosis</strong></td>
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<tr>
<td><strong>Lichen planus</strong></td>
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<tr>
<td><strong>Lichen simplex chronicus</strong></td>
</tr>
<tr>
<td><strong>Contact dermatitis</strong></td>
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<tr>
<td><strong>Vulvar intraepithelial neoplasm (VIN)</strong></td>
</tr>
<tr>
<td><strong>Vulvar cancer</strong></td>
</tr>
<tr>
<td><strong>Estramammary Paget disease</strong></td>
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5. New therapies in development/use

- **Vaginal laser therapy**
  Laser therapy is becoming a promising (office based) treatment for improving the vagina health of postmenopausal women. Fractional CO₂ laser energy assists in repopulating the vagina with normally existing lactobacilli species and constituting the normal flora to pre-menopausal state. Studies have come out to show significant improvement of vulvovaginal symptoms.

- **Ospemifene**
  This daily oral treatment is a Selective Oestrogen Receptor Modifier (SERM). It has as positive effect on vaginal epithelium and therefore dyspareunia, dryness, dryness, maturation index and pH. There is no endometrial or breast stimulation, it is bone sparing and even decreases hot flushes. The American FDA licensed it at the end of 2013 as first non-oestrogen oral treatment approved for moderate to severe dyspareunia in women for menopause related atrophy.

- **Vagitocin**
  This oxytocin receptor agonist, which can be vaginally applied, increases intracellular calcium and stimulates vaginal epithelium proliferation.

- **DHEA**
  This local application (0.65%) vaginal cream. There is conversion to oestrogen and androgens. The steroid precursor is converted by aromatisation in extra-gonadal tissues, into sex steroid with androgen and oestrogen action (vaginal maturation effect). It affects all three layers of the vaginal wall and increases the density of collagen in the lamina propria. There is no significant leakage of active sex hormones into the circulation (no systemic effects). However, some prospective studies showed an association of DHEAS with breast cancer. Therefore caution is advised.

- **Testosterone**
  There is very little data on vaginal testosterone use alone. Many studies show its combined use with estrogen. Testosterone does allow a greater improvement in sexual function. There is, however, a lack of safety data and there is significant systemic absorption of testosterone which is known to aromatise to estrogen.

### Conclusion

Managing GSM with local intravaginal oestrogen appears safe; improves urogenital health; is effective in treating recurrent UTIs, improving urinary incontinence, nocturia and frequency, will reverse urogenital atrophy and significantly decreases vaginal dryness, irritation, dyspareunia and improves sexual enjoyment.

In the South African CLOSER survey, 61% of patients used products to treat the symptoms of their vagina discomfort, primarily lubricants, creams or multivitamins. Only 21% of patients had actually received vaginal oestrogen treatment. The benefits of oestrogen replacement were clearly evident in these 21% of patients receiving treatment:

- 76% of woman felt happy about their bodily functions
- 72% to gain confidence as sexual partners
- 64% felt more like a woman

In fact, 9 out of 10 women and men reported looking forward to having sex. This clearly highlights the benefits of vaginal hormones.

The evidence around GSM and its treatment options proves that it is essential for healthcare practitioners to engage with their patients about genitourinary symptoms such as vaginal discomfort and painful intercourse. It is also essential to assist in choosing the intervention most suitable to individual needs and circumstances; to initiate treatment and discuss or review compliance. The most effective treatment solution is often vaginal oestrogen, using lubricants and maintenance of sexual activity.

### References

Clinical assessment in uro-gynaecology

Professor Peter Roos
Past President of SAMS
Adjunct Associate Professor, Department of Gynaecology, UCT; Cape Town

This article would be better titled Clinical Assessment in Uro-Gynaecology for the general gynaecologist, general practitioner and primary health care providers.

The journals and textbooks aimed more directly at the specialist uro-gynaecologist contain chapters and numerous articles on clinical assessment including questioning the validity of the history given by women concerning lower urinary tract symptoms. Having been on the fringe of uro-gynaecology and attending ward rounds for many years where I hear the presentations given by medical students and junior hospital staff, I am convinced that for the general gynaecologist and general practitioner, accurate history taking and examination goes a long way to providing a fairly accurate diagnosis which may result in avoiding unnecessary referrals to tertiary institutions and at the same time not missing those women who need to see a sub specialist in the field of uro-gynaecology. Therefore this article will be based mostly on scientific information, but also I have to declare that some will be based on personal opinion gained from my privileged access to my fellow sub specialists, medical students and training gynaecologists.

The subject of clinical assessment in uro-gynaecology is important for those practitioners who see the maturer women. Lower urinary tract symptoms and pelvic floor dysfunction is common in women who pass the menopause due to both the changes associated with oestrogen deficiency and the natural ageing process.

Specific questioning of the maturer women about incontinence both urinary and faecal, sexual dysfunction and symptoms of prolapse are our obligation as frequently women are too embarrassed to mention these symptoms without being specifically asked.

History

Lower urinary tract symptoms (LUTS)
When it comes to history taking, I am of the opinion that if great care is taken when taking the urinary history from a woman, one can get very close to an accurate diagnosis. Because of the confusion in some women’s minds about the nature of the urinary symptoms, it is extremely important to take this history carefully and accurately. I find it very useful at the very end of the consultation to repeat the symptoms as I understood them and even put it in writing for the patient to read in order to be sure that the patient and the practitioner both understand that they have got the history correct.

Typical confusion occurs in the understanding the different types of urinary incontinence. Other important factors to consider in history taking are:

- Onset of disabilities both cognitive and physical as women age.
- Accurate knowledge of the woman’s symptoms and even her families understanding of lower urinary symptoms is important in order to best manage their expectations of what can be done to improve quality of life problems. Furthermore understanding history is important in uro-gynaecology as many of the treatments will be aimed at quality of life symptoms rather than conditions which are associated with significant morbidity or mortality.

Overactive bladder symptoms
The overactive bladder is associated with frequency, urgency, nocturia, all with or without urge incontinence.

Frequency
The International Uro-Gynaecology and International Continence Society definition of frequency is the passage of urine more than 7 times a day. Unfortunately they also state that frequency is considered a relevant symptom, if the patient believes she is passing urine more frequently than she thinks is normal. This introduces a subjective element to the history and one should spend some time asking the questions of why she thinks it is more than normal, how much urine she passes and if there are any triggers for her need to empty her bladder. Ask if the frequency is associated with urgency or urge incontinence.

Nocturia
Nocturia is defined as the passage of urine more than once between going to sleep and waking in the morning. Nocturnal frequency does increase by about 1 episode a night per decade over 70, although my experience is that there are many women who are completely normal who pass urine twice at night. The reason for getting up at night should also be carefully elicited. There is what you might call “opportunistic” nocturia which is when a woman gets woken for some other reason and decides it would be a good idea to empty her bladder while she is awake. The nocturia associated with the overactive bladder usually represents many episodes of passage of urine during the night with relatively small volumes. Nocturia can also been associated with nocturnal polyuria when there is an excess of urine passed and one should ask the woman whether she has significant oedema towards the end of the day as this will be redistributed.
during the night and passed via the bladder from the kidneys. Obviously the amount of fluid intake during the later part of the day, alcohol and drugs will also be important aspects of the history.

**Urge incontinence**

Urge incontinence is the uncontrollable loss of urine when there is an urge to pass urine. Most women understand this very well and the relatively common symptom of “latchkey incontinence” when a woman has postponed passing urine and arrives home and as soon as the key goes in the front door she starts leaking before getting to the toilet. I find it very useful to ask about this symptom as there are quite a number of relatively normal women who can experience this and they are reassured that they are not the only ones who experience this symptom. Stress induced incontinence should also be differentiated from stress urinary incontinence.

Stress induced incontinence is where a cough or sneeze might induce an uncontrollable contraction of the detrusor muscle, leading to what is essentially the same as urge incontinence. This will follow the stress event and not usually be immediate.

When taking the history concerning overactive bladder symptoms, one should obviously consider the symptoms of urinary tract infection and the genito-urinary syndrome of the menopause where atrophic changes might lead to some urgency and frequency as well as recurrent urinary tract infection. It should be remembered that overactive bladder symptoms might also follow urinary obstruction and for this reason the history should include asking about recent incontinence procedures, pelvic floor surgery, neurological symptoms and any symptoms which might suggest a pelvic or urethral mass causing obstruction. This would include symptoms of prolapse as severe degrees of prolapse can cause urinary obstruction.

**Stress urinary incontinence**

Stress urinary incontinence is the inadvertent leakage of urine when anything causes increased intra abdominal pressure. This is the commonest form of incontinence in women and the history should carefully look at what activities cause the stress incontinence, its frequency and the degree to which it causes discomfort or embarrassment. As treatment for stress urine incontinence is often surgical, it is important to be sure that the surgery would be really necessary. For instance, in your history if you find that a woman with a very full bladder leaks a little bit when jumping on a trampoline, this would be considered as part of normality and perhaps just a warning to her to concentrate on pelvic floor muscle exercises.

**Mixed urinary incontinence**

Mixed urinary incontinence, this term is self explanatory, it is incontinence when there is combined urge incontinence and stress incontinence. The important question to ask these women is whether they have developed the habit of passing urine more frequently because they are concerned about the leakage associated with stress urinary incontinence.

**Continuous leakage**

If a woman has continuous leakage of urine, one must think of conditions such as fistula, urinary obstruction and a neuropathic underactive detrusor muscle. It is therefore important to ask about recent pelvic surgery, obstetric history of difficult labour, radiotherapy and the possibility of sexual abuse causing vaginal trauma as well as medical and neurological symptoms.

**Incontinence with sex**

It is also important to ask about urinary leakage associated with sexual intercourse, typically leakage of urine on penetration would be due to a cystocele or stress urinary incontinence when leakage of urine associated with orgasm is more likely to be due to the overactive bladder.

**Voiding dysfunction**

Voiding dysfunction has already been mentioned. The symptoms are numerous, including hesitancy with an inability to start passing urine, incomplete bladder emptying, straining to empty the bladder and post micturition dribbling.

Retention of urine would usually be obvious in cases of obstruction due to the pain associated with the over filled bladder. Retention related to a neuropathic bladder may be painless, but both can be associated with significant upper urinary tract disease. Certain medication can also cause voiding dysfunction.

**Pelvic organ prolapse**

The symptoms of pelvic organ prolapse are usually quite obvious in that the patient will complain of a bulge in the vagina or a dragging sensation in the pelvis and lower back. It is particularly important to question these patients carefully regarding associated symptoms as often a woman who has found a small bulge will be satisfied by reassurance rather than treatment. It is therefore important to find out if there are associated symptoms which might require treatment. Specifically ask about unusual urinary symptoms especially recurrent urinary tract infections and all the other urinary symptoms mentioned above. You should also enquire about bowel habit, asking about constipation and the possible need to reduce a rectocele in order to pass stool. Also ask about any sexual dysfunction which might result from the prolapse or from vulvo-vaginal atrophic changes.

Detailed obstetric history is also necessary.
Ano-rectal symptoms

Ano-rectal symptoms are now starting to fall more into the sub-speciality of uro-gynaecology, but essentially still remains within the domain of the colorectal surgeons. For this reason, other than highlighting constipation and rectocele, ano-rectal symptoms are not discussed.

General medical history and examination

Once one has carefully understood the patient’s symptoms related either to the urinary or genital system it is important to go carefully through a general history and general examination.

All practitioners understand the importance of a general medical history and examination, regardless of the condition they are investigating.

It only remains to highlight the important aspects which affect uro-gynaecology which is often associated with other co-morbidities. Therefore careful questioning about cardio-vascular disease and its treatment, obesity, diabetes and importantly all medications that are being taken.

There are long lists of medication that can affect the urinary system, the commonest would be diuretics, anti depressants, anti cholinergics and numerous others. With the vast amount of medication available these days, and with different generic preparations, I am inclined to look up the side effects of any drug that I am unfamiliar with, in order to see if it has any specific effect on lower urinary tract symptoms.

General examination should also include a simple neurological examination to exclude early onset of multiple sclerosis or Parkinson’s disease. Testing for sensation in the vulval and perineal areas as well as testing reflexes causing anal sphincter contractions and checking adductor muscle strength are all helpful in assessing sacral nerve complex integrity.

Abdominal and pelvic examination

Abdominal palpation should take note of central obesity and evidence of any abdominal masses or scars from previous surgery.

Vaginal examination includes careful inspection of the vulva and vagina, looking for post menopausal atrophy and also assessing the degree of utero-vaginal prolapse. One cough is usually not enough to be able to assess vaginal or uterine prolapse. It takes at least 3 or 4 coughs and I find it useful to get the patient to bear down with a valsalva manoeuvre which gives an idea of the maximum descent of the vagina or uterus, which one might not see in a simple examination with one cough. Noting any signs of infection or ulceration is important.

When assessing stress urinary incontinence, once again it is important to have at least 3 or 4 coughs before saying that this test is negative. It is also important to ensure that the patient’s bladder is indeed full and if not visible to repeat the cough test with the patient standing up. Examination standing up is also useful in assessing the degree of utero-vaginal descent. When getting the patient to cough, it is useful to note the degree of mobility of the urethra in assessing stress urinary incontinence. In the presence of grade 11-111 prolapse reducing the prolapse could reveal occult stress urinary incontinence.

A normal speculum examination to assess the cervix and do a pap smear is fine, but one should also consider using a Sims speculum in the left lateral position making it far easier to inspect that anterior vaginal wall and assess uterine descent using very gentle traction with the vulsellum. There are people who feel that this is an unkind and unpleasant procedure, however it is exactly the same as when inserting intra uterine devices, which we do also with gentle traction on a vulsellum grasping the cervix.

A pelvi- abdominal examination is necessary to exclude any pelvic or abdominal masses which might be contributing to the symptoms.

Simple investigations that can be performed by the general gynaecologist or general practitioner

1. **Urine testing** is obligatory with at least a dipstix being performed or a mid stream urine to the laboratory to exclude blood and infection.

2. **A bladder diary** which can be downloaded from the International Uro-Gynaecology Association Website free is a simple and helpful test. The patient records all her fluid intake and her urine output over 24 hours, preferably repeated twice. This gives you an idea of the degree of frequency, the volume of urine passed during the day or day time frequency and most importantly if nocturia is a symptom. This helps distinguish between nocturnal frequency due to an overactive bladder from nocturnal polyuria. In younger women about 20% of her urine output is produced at night but as one ages, this can rise to 30-35% of the total 24 hour urine output. The patient is given the chart to fill in and advised to buy wide measuring jug. To make life easier for her, I also suggest she measures at the outset the volume contained in her teacup, glass or mug, so she does not have to measure each time she has a cup of tea, or a drink.

3. **Post voiding residual volume.** This can be done to ascertain whether the bladder is emptying properly. Immediately after a woman has emptied her bladder to what she thinks is completion, the residual volume is measured. This can be by ultrasound or catheterisation.

4. **The Q Tip test** which involves putting a Q Tip into the urethra and asking the patient to cough or sneeze. This
is seldom done these days, but does help differentiate between stress urinary incontinence due to a mobile urethra and that where there is intrinsic sphincter defect. This is slightly unpopular and uncomfortable for women, but can be used together with a local anaesthetic gel.

Specialist investigation requiring referral

1. **Uroflowmetry.** This requires specialised equipment to measure the rate of urinary flow. This helps in the diagnosis of bladder outlet obstruction as well as detrusor underactivity due to neuropathy.

2. **Urodynamic studies** involve catheterisation of both the bladder and the rectum. Guidelines suggest that in very obvious cases of stress urinary incontinence which are uncomplicated, urodynamic studies are not necessary. The guidelines also suggest that you can commence medical treatment for overactive bladder symptoms without having done urodynamic studies. Urodynamic studies would be indicated in the following circumstances.4,5

<table>
<thead>
<tr>
<th>Table 1. Indications for urodynamic studies</th>
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<tbody>
<tr>
<td>Mixed urinary incontinence</td>
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<tr>
<td>Complex symptoms</td>
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<tr>
<td>Failed previous surgery</td>
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<tr>
<td>Concern about obstructive symptoms</td>
</tr>
<tr>
<td>The assessment of detrusor muscle – under or overactivity</td>
</tr>
</tbody>
</table>

3. **Cystoscopy.** Reasons for referral for cystoscopy are found in Table 2^6 |

4. **Imaging.** Ultrasound and MRI are being used more frequently to assess pelvic floor abnormalities. Interpreting these images is a special skill and one should be careful to refer only to those practitioners who have these skills. Indications for referral would be to look for levator avulsion, position of meshes and tapes and anal sphincter integrity etc.

<table>
<thead>
<tr>
<th>Table 2. Reasons for referral for cystoscopy</th>
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</thead>
<tbody>
<tr>
<td>Unexplained haematuria or haematuria which persists after treatment of urinary tract infection particularly in women over 45.</td>
</tr>
<tr>
<td>Visible and unexplained haematuria with a white cell count on blood test in people aged 60 and over.</td>
</tr>
<tr>
<td>Dysuria with unexplained non visible haematuria in people aged 60 years and over</td>
</tr>
<tr>
<td>Recurrent urinary tract infection.</td>
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<tr>
<td>Bladder pain syndrome</td>
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<tr>
<td>Difficulty with voiding</td>
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<tr>
<td>History suggestive of a fistula</td>
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<tr>
<td>History suggestive of urethral obstruction</td>
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<tr>
<td>Unexplained symptoms after pelvic surgery.</td>
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</tbody>
</table>

**References**

Medical treatment of osteoporosis

Dr Tobie J. de Villiers
Past president of the International Menopause Society, Chairman National Osteoporosis Foundation of South Africa (NOFSA)
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The aim of osteoporosis treatment is the prevention of fractures.

Osteoporosis is a systemic skeletal condition defined by a reduction in bone strength and micro architectural deterioration resulting in increased risk of fracture. Osteoporosis is typically characterised by an increase in bone-turnover that favours resorption of old bone by the osteoclasts at the expense of new bone formation by the osteoblast. Typical osteoporotic fractures are fractures of the distal forearm, vertebral fractures and hip fractures sustained after falling from own body height.

Everyone at risk of fracture should adopt a bone-friendly lifestyle. This includes a diet with a daily protein content of 1 mg per kilogram body weight, 1000 mg of elemental calcium, 800 iu of vitamin D, adequate weight bearing exercise, avoidance of bone-toxic medication, cessation of tabaco smoking, restriction in alcohol intake and the avoidance of falls.

Bone specific medication should be considered if dual X-ray absorptiometry (DXA)-derived T-score is less than -2.5 at the spine or hip, or the presence of osteoporotic fractures or a high risk of fracture in the next 10 years as calculated by the FRAX model based on a combination of risk factors and DXA values.

Bone-specific medication:

Antiresorptive medication

Menopausal Hormone Therapy (MHT)
Estrogen (alone or in combination with a progestin) acts as an antiresorptive by inhibiting osteoclast function via the RANK-ligand pathway. The Women’s Health Initiative study (WHI) showed that MHT significantly lowers the risk of all osteoporosis related fractures, even in women at low risk of fracture. This makes MHT first line therapy for initiation in postmenopausal women before age 60 who are at risk of fracture or with osteopenia. MHT should not be initiated after age of 60 for the sole purpose of prevention of fractures if other drugs are appropriate. If initiated before 60, MHT may be continued after the age of 60 for the prevention of fractures. The risk of DVT can be lowered by the use of transdermal therapy. Risk of breast cancer was lowered in the WHI follow-up studies for estrogen alone. Risk of breast cancer in women with a uterus can be managed by the use of natural progesterone, didroprogestrone or bazedoxifene to oppose the effect of estrogen on the uterus.

Selective Estrogen Receptor Modulator (SERM)
Raloxifene is the only SERM registered for the prevention of fractures that is available in SA, at a dosage of 60 mg daily per mouth. This synthetic drug acts as an estrogen receptor agonist in bone, heart and the brain but as an antagonist in the breast. It is registered for vertebral fracture protection as well as the prevention of estrogen receptor positive breast cancer in women at risk of fracture. Utilisation is limited by the lack of efficiency in the prevention of hip fracture and the non-suppression of menopause related hot flushes. It is recommended by NOFSA for women at risk of vertebral fracture and breast cancer.

Bisphosphonates (BP’s)
BP’s are recommended as first line therapy in confirmed osteoporosis by NOFSA. BP’s act by binding to bone mineral elements and by the inhibition of the enzyme farnesyl pyrophosphate synthase that results in decreased osteoclast survival and function. BP’s can be absorbed by the gut or be administrated intravenously. After absorption, about 50% of the dosage will bind to bone and the kidneys will rapidly clear the rest. Reasonable kidney function (glomerular filtration rate > 30ml per hour) is thus essential. The utility of BP’s has been compromised by two rare complications:

Osteonecrosis of the jaw (ONJ) is a rare condition where exposed bone is present in the maxillofacial region for more than 8 weeks in the absence of radiotherapy in a patient who has been on bisphosphonate therapy. It is generally only associated with dosages greater than that recommended for fracture prevention. It is further associated with dental procedures, poor oral hygiene, steroidal usage, radiation, antiangiogenic drugs and chronic diseases such as HIV/AIDS. BP therapy is not an absolute contra-indication to planned dental procedures but any planned procedures should be completed before initiation of BP therapy. Dental procedures in patients on BP therapy should be done with minimal trauma, under antibiotic coverage followed by impeccable oral hygiene.

Atypical femur fractures (AFF) are fractures of the femur shaft that typically appears in the sub trochanteric region and is often preceded by pain and may occur bilaterally. It has been shown to be associated with bisphosphonate use of more than 3-5 years but a direct causal relationship has not been proven. The risk of AFF is very small compared to the amount of typical femur hip fractures that are prevented by BP therapy. In view of these complications NOFSA recommends that after 5 years of oral or 3 years of intravenous therapy, a drug...
holiday of about the same time should individually be considered.

The following BP's are available in South Africa: Alendronate is registered for the prevention of vertebral and non-vertebral fractures. 70 mg per mouth is administered weekly.

Risedronate is registered for the prevention of vertebral and non-vertebral fractures. 150 mg per mouth is administered monthly.

Zoledronic acid is registered for the prevention of vertebral and non-vertebral fractures. 5 mg is infused intravenously once year.

Ibandronate is registered for the prevention of vertebral fractures. 150 mg is administered monthly per mouth or 3 mg as an intravenous injection every 3 months.

**Denosumab**
Denosumab is a human monoclonal antibody that acts as a rank ligand inhibitor with inhibition of the development of osteoclasts. Denosumab prevents vertebral and non-vertebral fractures. 60 mg is administered subcutaneously 6-monthly. Unlike BP’s it is not dependent on renal clearance. Incremental increase of bone mineral density has been reported over 10 years with a good safety profile. Although it is advised by NOFSA as first-line therapy, it can only be obtained in SA under section 21, as registration is still awaited.

**Anabolic medication**

**Teriparatide** is a recombinant protein form of parathyroid hormone. When given continuously as a daily subcutaneous injection of 20 ug for 2 years, it reduces the risk of vertebral and non-vertebral fractures. The anabolic window lapses after 2 years and should then be followed by antiresorptive therapy. A recent study showed that teriparatide's anti-fracture efficacy is superior to risedronate in both osteoporosis treatment-naive and prior bisphosphonate-treated women with severe osteoporosis. The study also suggests that teriparatide might improve acute fracture healing. Because of cost consideration, NOFSA restricts the use of teriparatide to severe osteoporosis or failed treatment with other medication. Recent opinion is that in new cases of severe osteoporosis, optimal sequencing is 18 months of anabolic treatment followed by potent antiresorptive treatment.

**Future medication**

**Abaloparatide** is a more selective form of PTH that is available in the USA. When compared to teriparatide, efficacy with abaloparatide was better but not significantly so but a lower incidence of hypercalcemia was noted. The registration of abaloparatide was recently refused in Europe.

**Romosozumab** is an anabolic agent in current development. It is a humanised monoclonal antibody that inhibits sclerostin. In a randomised placebo-controlled trial, no safety issues were raised but although the primary endpoint of vertebral fracture prevention was met, it failed to prevent non-vertebral fractures. In a smaller study with the comparator alendronate, all the efficiency endpoints were met but a higher rate of cardiovascular events were found in the romosozumab arm.

**Acknowledgement**

This paper is based on the National Osteoporosis Foundation of South Africa's revised guidelines (2017) available online at osteoporosis.org.za.

All other references are available from the author on request at Tobie@iafrica.com
The internet and social media has transformed the patient experience. Previously, if a patient required information about menopause, a doctor would be the first “port of call”. Patients relied heavily on their doctors to give them the most relevant and up-to-date information. This was usually obtained from journals, congresses and academic sources that only the doctor was privy to. General practitioners referred patients to specialists when necessary. Opinions of friends and information obtained from popular print media like newspapers and magazines were of secondary value.

Today, the situation is vastly different: the first reference that a patient will have to request information from, is the internet. Google has now become the first “port of call”. Information previously only available to the medical profession is now available to all. In addition, recommendations from family and friends via social media and online reviews, play a significant role not only in choosing a doctor or specialist, but also in deciding the diagnosis and planning any treatment strategies. So in this age of information, often a patient will present to a doctor to confirm what they already suspect, and to get help in obtaining the necessary treatment, which they already know about. The doctor then merely becomes the facilitator of this process or a sounding board to finalise an already prepared treatment plan.

The issue of hormone replacement therapy (HRT) for menopause is no exception to this process. When the WHI was published in 2002 most women were taken off HRT due to fears around the increased incidence of cardiovascular disease, breast cancer and stroke, shown in the initial analysis. However 16 years down the line, after many re-analyses and new studies, the information regarding the initial safety concerns of HRT has been revised. These revisions have been slow to make it to mainstream media and internet sites, most of which still carry dire warnings regarding HRT.

I am constantly amazed at how much negative publicity HRT still has. This has led many women, including those who present to my practice on a daily basis, to seek alternatives to HRT and often self manage their menopause symptoms with expensive and sometimes even potentially dangerous products that do not have proven efficacy.

My intention with this article is to highlight and dispel some of the myths regarding HRT and related issues in the menopause that has been part of my own patient experience. In so doing, I hope to assist my fellow health professionals and increase confidence levels with advising and treating patients in the menopause. I understand that every practice is unique and while what follows may not be applicable to all circumstances, the discussion will be aimed at all clinicians willing to incorporate and adapt the information into their own experience.

Common comments from patients:

- “I am only in my forties. That is way too early for menopause”
- “Menopause is temporary and short-lived. If I am patient and wait, it will fix itself.”
- “Do I have to take HRT? What happens if I don’t want to? I don’t want to age prematurely.”
- “My previous doctor was amazing with my pregnancies but now that I am older, I feel unheard. I feel like my concerns are being brushed away.”
- “HRT is bad for me. I heard it causes breast cancer.”
- “HRT is not for me. My GP says it will give me a heart attack.”
- “Bio-identical hormones are safer for me.”
- “I don’t know enough about menopause. What do you think I should do?”
- “What is going on with me? Am I going mad?”
- “Sex is more painful since my period stopped. This is normal at my age right?”

If this was an article written for a women’s health newsletter in Roman Times, (would that even have been a thing), it would address very different questions. In those times, the average life expectancy of a woman was 25 years. What happened was that soon after puberty, women got pregnant, had babies, and then died. Very few women made it to menopause. Today, the average life expectancy of a woman is much more than a paltry 25 years. We can expect a woman in the first world to live well into her eighties and a woman in the third world, well into the fifth decade of life and even beyond. This essentially means that a woman could spend a third of her life in the menopause. With the demands of modern living, women need to be happy and healthy.
We need to function at our peak because this is what society demands of us. More importantly, this is what we demand for ourselves!

The patient comments above, highlight the fears and concerns of women who not only want to age well, but want to do so in a manner that is respectful of their wishes to function at their full potential, with minimal self inflicted health risks. Recognition of her individuality and her own unique set of issues are key to her. An unwillingness to listen empathically and involve her in important decision making will alienate her and drive her to seek counsel elsewhere.

Giving a woman the latest, most up-to-date information will maintain credibility. We cannot be naïve. They will double check information received from us, not only verifying with “Dr Google” but also obtaining certainty from friends and peers. Admitting that we don’t know something and then committing to researching it and getting back to them, suggests that we are merely human and cannot know everything all the time. In my experience this earns respect.

My own counselling

The conversation around perimenopause /menopause usually starts with a discussion of what the patient is currently experiencing. This covers not only physical symptoms but also her quality of life experience and how the changes have impacted her and those around her. We discuss her attitude to aging in general and her expectations for her life and future health. Unique personal and family health history is also considered. We then talk about her opinion of HRT, whether she has one or not, and if she has any burning concerns or questions related to this. We talk about literature she has read and I refer her to relevant information as required.

We also talk of tests necessary to elicit underlying issues. Mammograms, bone density scans, cholesterol tests and other relevant hormone tests like thyroid tests are discussed.

My finding is that once the initial panic of a diagnosis of menopause has abated, when a woman understands what is happening to her at this stage of her life, she is able to engage in a decision making process where she feels empowered to retain ownership of her health and her life.

I realize that the process above requires a long uninterrupted consultation-something that may be difficult to achieve in a busy GP practice. My advice is to refer to the appropriate specialists, who should have the time to initiate this process. A GP can then take over once the initial groundwork has been done and manage the uncomplicated scenarios.

Of course no consultation is complete without a full examination. That should go without saying.

Special comments

Bio- Identical hormones

Oprah Winfrey and the resident doctor on her show, Dr Oz have really brought this option into the spotlight. Patients arrive armed with information obtained from high profile endorsements like celebrity gynaecologist Dr Christianne Northrup. Not all of it may be factually correct.

What I am always surprised by, is when patients relay stories of their gynaecologists’ anger and rudeness when broaching the subject of bio-identicals. Patients feel chastised, confused and alienated by their doctor’s attitude and refusal to even discuss the idea. Some colleagues have even refused treatment to patients if they were even thinking of considering bio-identicals as part of a menopausal treatment plan.

This is disappointing: In my opinion, even though there is no clear evidence for the safety and efficacy of bio-identical hormone creams over that of conventionally available prescription HRT, not to mention the lack of regulation of such products by local regulatory bodies, physicians can certainly use this opportunity to discuss the issue in an objective, non-emotional way. We would be remiss in ignoring the value of educating a patient on risks that were not highlighted on online platforms and in the media. It seems that we may be failing our duty in this regard when despite cautionary advise by British, American, and even South African academics and consensus groups5,6,7 regarding non endorsement of the use of bio-identicals, many women still gravitate towards this as an option.8 An important motivating factor is often an “overarching distrust of a medical system perceived as dismissive of their concerns and overly reliant on pharmaceuticals.9

HRT and cardiovascular disease

Cardiovascular disease is a major cause of death in older women.7 This is what I emphasise to my patients.

Key points to bring up

- HRT is most effective in reducing risks of cardiovascular events when used in women within 10 years from the onset of menopause or under the age of 60.6
- Women who initiate HRT more than 10 years from the onset of menopause have an increased risk of cardiovascular disease. This risk is higher when estrogen is combined with a progestogen (medroxyprogesterone acetate) than when estrogen is used alone.3

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I also like to incorporate the following NICE guidelines in planning treatment:

- The presence of cardiovascular risk factors is not a contraindication to HRT
- It is essential to optimally manage any underlying cardiovascular risk factors (e.g. blood pressure, cholesterol) whether or not a patient chooses to take HRT.

### Atrophic Vaginitis

This can be an extremely distressing symptom affecting quality of life and relationships. Dyspareunia, vaginal dryness, urge incontinence, frequency and recurrent urinary tract infections are the common manifestations. Low dose vaginal estrogen preparations are generally considered safe. Application of a local estrogen product may still even be necessary in 15% of women who use systemic hormone therapy. When used correctly, there is no need to use progesterone for endometrial protection. Local estrogen can be continued indefinitely. An interesting fact that I often share with my patients is that a year's supply of low dose vaginal estrogen (10ug twice weekly) is equivalent to one oral estrogen tablet. Because of even this minute potential increase in plasma estradiol levels, the decision to use vaginal estrogen in a woman with breast cancer should be made in consultation with her oncologist. This is particularly important for women on aromatase inhibitors (AIs) where suppression of plasma estradiol levels is a crucial therapeutic goal. No increased risk was seen in an observational study of breast cancer survivors on Tamoxifen or AI therapy with low dose vaginal estrogen after 3.5 years mean follow up.11

Vaginal lubricants and moisturisers are also of benefit. So is the newer drug ospemifene.12

### HRT and breast cancer

Anyone who is involved in the business of seeing patients daily understands the emotions that a potential diagnosis of cancer can generate in a patient. No woman wants to willingly participate in treatment that will increase her risk of developing breast cancer no matter what other benefits may be achieved by the same treatment. So let me put things into perspective:

- All woman should have a normal mammogram prior to instituting HRT. When increased breast density impedes diagnostic accuracy of a mammogram, cessation of HRT for 2-4 weeks and re-imaging may be helpful.13
- Differences exist in breast cancer risk depending on the HRT preparation used. The risk is highest when conjugated equine estrogen (CEE) is combined with medroxyprogesterone acetate (MPA). The increase in risk with the CEE+MPA combination is only slightly up compared to the risk of a daily glass of wine; less than with two daily glasses and similar to that of obesity or low physical activity.6,14
- Limited observational evidence suggests that HRT use does not further increase the breast cancer risk in women with a family history of breast cancer or in women after oophorectomy for BRCA1 or BRCA 2 mutations6
- The use of systemic HRT in not advised in breast cancer survivors unless under special consideration in consultation with the oncologist.6

### Final thoughts

This article highlights just some of the most common issues raised by patients in a typically affluent, high socio-economic gynaecological practice in Johannesburg. It would be interesting to hear from other clinicians elsewhere regarding their own challenging experiences.

**References available on request.**
DON’T WORRY PEE HAPPY

FROM 55 MINUTES

PAIN

BURNING

FREQUENCY

EFFECTIVE UTI SYMPTOM RELIEF

UTI - Urinary Tract Infection

References:
The first once monthly tablet for postmenopausal osteoporosis\textsuperscript{1,2}

Lower risk of vertebral fractures vs. weekly bisphosphonates\textsuperscript{3}

- **12 tablets a year** vs. **52 with current weekly bisphosphonate**\textsuperscript{4}
- **Sustained low clinical fracture rate** over 5 years of treatment\textsuperscript{5}
- **Maintained lumbar spine BMD** with further gradual increases up to 5 years\textsuperscript{6}
- **Well-tolerated** with a proven 5-year safety profile\textsuperscript{6}

BMD = Bone Mineral Density

www.healthywomen.co.za

References:

Boniva\textsuperscript{R} 150 mg tablets. Each tablet contains bisphosphonate and 150 mg of calcium carbonate. Reg. No. 4173/20027. Roche Products (Pty) Ltd. For full prescribing information, refer to the package insert approved by the medicines regulatory authority.

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