MENOPAUSE MATTERS

APRIL 2022

Menopause workplace policies

It has become fashionable to debate recommendations about the menopause in the workplace. This trend is driven by two factors, firstly the rising proportion of women now employed in the mature workforce which has significantly increased over the last half century; and secondly, public awareness movements concerning "Diversity, Equality, and Inclusiveness" that are being fanned by social, racial and justice positions instantly achieving prominence across the social media.

By all means, let us – the medical profession – engage with workplace matters. Our numbers continue to include more women doctors who are becoming more vocal about unjust discrepancies in their treatment, such as unequal pay for equal work, discrimination in promotion, sexual harassment or exploitation and inadequate maternity leave conditions.

But are menopause workplace issues a priority and will their inclusion benefit or harm the overall striving for equity? Are there injustices experienced by women suffering from menopausal effects that need policy statements and "Global consensus recommendations" as produced by the European Menopause and Andropause Society (EMAS)[1]?

If so then SAMS and other Menopause Societies should be rallying for changes in mature women's terms of employment, but I wonder about the wisdom of an "official" approach.

If, rather, there are attitudes or prejudices that need dealing with, then persuasion needs to be called for rather than bald recommendations whose introduction may cause abreactions with their implementation generating more heat than light.

Defining the problem

By saying menopausal women are unfairly treated, are we addressing attitudes or structures? If we want to move someone in their heart, then nudging is more likely to work than legislation or policy statements.

If a woman is struggling with menopausal symptoms that are affecting her work, then sympathetic colleagues are of considerably more use than "occupational health professionals and human resource managers working together." (EMAS statement).

If someone is being unfairly dealt with because of a health issue, most organisations have mechanisms of resolving these matters. By highlighting extreme menopausal symptomology as a "case in point" of discriminatory employment malpractice, such a move could have the effect of reinforcing out-of-date stigmata.

Most women experience vasomotor symptoms during (and after) the menopause transition, and the spectrum from minimal to maximal debility is wide. To cater for the exceptional with a policy of paid leave to cope, is to risk co-workers (male and female) raising negative attitudes towards mature women workers.

There is a danger that those pushing for workplace policies concerning the menopause, can overstate their case and undermine the support they seek. For example, "menopausal symptoms can adversely affect the ability to work, which can lead to reduction of working hours, underemployment or unemployment, and consequently financial insecurity in later life." (EMAS statement). For this argument to be persuasive, data would need to accompany such an evocative scenario. Trying to make the point for women's equity by quoting outliers can weaken the "legislative" approach.

What do women want?

Are there surveys of women showing that the majority of those experiencing menopausal symptoms at work want a workplace policy? I should imagine they would want a supportive environment if they are not able to cope, but having a policy and interrogating whether it was being adhered to, or not, is probably not high on their agenda. Would it really help, or could there be unintended consequences? Again, where are the data comparing workplaces with or without such policies? Are there privacy issues at stake in implementing menopausal workplace policies? Would "having a policy" possibly be regarded by colleagues as an obligation to report under-performance?

Having a policy may "raise awareness" but do menopausal women want "awareness raised"? If they want personal issues dealt with at their own discretion, the does having a policy help of hinder?

Priorities & personal view

It is my personal view that if we want to tackle work issues then we should:

- Make menopause symptom **treatment** a priority.
- We have allowed hormonal medication to be under-prescribed and we should rectify this situation. Women are suffering unnecessarily because of out-dated fears when excellent solutions are readily available
- We should push for more pressing matters – for example the removal of systemic injustices about pay and parental leave [2, 3], sexual harassment and bullying.

Finally, I would like to reinforce some points made by three Australian women[4]

- the menopause transition is a natural occurrence and should not be "pathologised"
- any issues should be dealt with on an individual level and not managed as a "condition of the workplace"
- a fundamental change is required by the medical profession and the public to the existing treatment of the menopausal transition due to estrogen deficiency, so women can manage their symptoms as they deem suitable.

This piece was written exclusively for SAMS readers and is my opinion only. It does not necessarily reflect the views of the SAMS council or administration.

References

1. *Rees et al Maturitas 2021;151:55-62*
2. *Buyske & Hawn Acad Med 2022 doi 10.1097/ACM.0000000000004642*
3. *Hanchuk et al Acad Med 2022 doi 10.1097/ACM.0000000000004629*
4. *Carter et al ANZJOG 2021;61:986-9.*

Menopause Hormone Therapy & CVD

Lipoprotein(a) (Lp(a)) is a protein manufactured in the liver and has the function of lipid transport. It is not usually measured as part of a standard lipid profile, but has a close correlation with cardiovascular disease risk, particularly atherosclerosis. High Lp(a) levels are associated with high CVD risk, low levels with low risk and it is suggested that menopause hormone treatment (MHT) reduces serum levels by about 20%. However, MHT also increases C-reactive protein, prothrombin, and inflammatory markers so the nett effect on CVD risk is the subject of ongoing investigation.

The UK Biobank is a prodigious source of data, and in a recent survey, 90 000 women were available for scrutiny over a decade with reference to their MHT use and Lp(a) measurements (Honigberg et al *JAMA Cardiol* 2022 doi 10.1001/jamacardio.2022.0716). Those currently using MHT had lower Lp(a) levels than past users and never users. The research confirmed that those in the highest quartile had the highest risk of cardiovascular events.

The reduction in Lp(a) levels and the lowered CVD risk were modest, and MHT is not indicated for the risk-reduction of atherosclerotic disorders. On the other hand, MHT does not raise CVD risk, which is reassuring for users and prescribers.

Estrogens for GSM

Estrogens are used topically in the treatment of the genitourinary syndrome of menopause (GSM) both as intravaginal creams and tablets. Vulvo-vaginal symptoms of dryness and dyspareunia can be improved by medications to restore moisture and "recreate" a premenopausal environment, and various criteria are used to assess quite what constitutes restoration. These are pH, vaginal fluid metabolites and squamous cell maturation indices, but have not included measures of the vaginal microbiome. It is unknown how moisturisers compare with estrogen tablets in producing microbiome diversity which would provide an objective measure of "health".

Where these have been assessed head-to-head, estrogens "promoted significant changes in the vaginal microbiota in postmenopausal women, compared with vaginal moisturiser or placebo" (Splete *Medscape* 2022). Data from a trial of women suffering from moderate to severe GSM symptoms 10 years past their menopause transition showed that estrogen therapy in the form of 10 µg vaginal tablets resulted in greater micro-organism diversity than inert moisturisers which "may offer additional genitourinary health benefits to postmenopausal women (Srinivasan et al *JAMA Netw Open* 2022;5:e225082).

Editorial comment – The use of local estrogens to treat hypo-estrogenic symptoms appears to work on an anatomical level with tissue changes and also enhances the microbiotic environment which should logically improve resistance to infection. Defining well-being in any situation may one day include the genetic make-up of the microbiome so we will have to expand what we mean by "health" to include not only a lack of illness, but a positive symbiotic presence of micro-organisms on and in our bodies.

Will this be the ultimate definition of health in the era of precision medicine?

Stress Urinary Incontinence surgery

Comprehensive conservative approaches should always precede the decision to embark on surgery for stress incontinence. Surgical procedures have evolved from radical combined abdominal/pelvic operations to sling placements which involve mesh or tape supporting the urethra.

"In the first generation of procedures, mesh was placed through the retropubic space. A second-generation approach passed the mesh through the obturator space, to minimise the risk of bowel or bladder injury with trocars inserted into the retropubic space." (Nygaard & Norton *NEJM* 2022;386:1280-1).

The midurethral slings gave satisfactory outcomes with good safety profiles, but similar operations using mesh kits for pelvic organ prolapse were developed without rigorous and long-term research. These "extrapolations" of the wider use of mesh were ill-advised and brought the use of artificial support materials into question and disrepute for the incorrect indications. Some countries, for example the UK, banned mid-urethral slings for stress incontinence except in clinical trials, despite little evidence of risk.

In an attempt to clarify the situation, a comparative, non-inferiority surgical trial was carried out comparing the second generation mid-urethral sling with a third generational mini-sling in which "mesh is placed under the urethra through a single incision that does not approach the abdominal cavity." Only a quarter of the mini-slings were placed under general anaesthesia, whereas most (90%) of the mid-urethral slings were under general anaesthesia. The results, with 300 patients in each arm, revealed positive outcomes using both techniques, as judged by improved continence, in more than three quarters of participants (Abdel-Fattah et al *NEJM* 2022;368:1230-4). These first year findings dropped to around 70% in both groups at three years so, although not offering a cure, many women had a significant improvement in their symptoms using the mini-sling approach.

Athol Kent

Email address atholkent@mweb.co.za