Diagnosing Menopause

Key Points

- A diagnosis of menopause is made on the basis of new onset vasomotor symptoms and a change in the pattern of menstrual bleeding
- Measuring sex steroids or gonadotrophins is not helpful as these fluctuate on a daily basis
- A symptom score sheet can be helpful in measuring the severity and impact of symptoms and assessing response to any intervention

DON'T

- Measure FSH, LH, AMH (anti-Müllerian hormone), oestradiol or testosterone levels in a woman with symptoms at the normal age for menopause (over 45 years) because these results are unlikely to change your management. The indications for intervention are clinical.

DO

- Take a prior menstrual history
- Take a good history of menopausal symptoms, preferably using a standardised symptom measurement system
- Ask how the symptoms are affecting quality of life, particularly sleep disturbance
- Record personal medical history and risk factors for breast cancer, cardiovascular disease, thromboembolic disease and osteoporosis
- Ask about absolute or relative contraindications to MHT: uncontrolled hypertension, undiagnosed abnormal bleeding, previous breast or endometrial cancer and personal history or high inherited risk of thrombo-embolic disease
- Ensure that screening (breast, cervical) is up to date

Introduction

Frequently, the woman herself has already made the diagnosis of menopause. She attends her doctor with symptoms such as hot flushes or night sweats interrupting her sleep, together with changes in her menstrual cycle. Not all women with menopausal symptoms will need treatment. Most women will be glad of information about menopause and about the safe and effective treatment options available. The questions we should be asking her are "Why did you come to see me", and "What do you hope to get out of this consultation?"

Common questions are:

- How long does menopause last?
- When will I be through it?
- What are the pros and cons of taking menopause hormone therapy (MHT) for me?
- Can I treat my symptoms naturally?
- If I do decide to take MHT, for how long should I take it?
- When am I no longer fertile and when should I stop using contraception?

There is a lot of information to give, and even if a menopause information sheet is given, a long appointment will be required to give all the information required and answer questions. Menopausal women often have multiple health issues that need addressing and they may be anxious and tired due to sleep disturbance. Allowing adequate time for the consultation allows her to discuss the issues she is concerned about without feeling rushed.

Peri-menopause, Menopause or Post-menopause?

Peri-menopause refers to the time from the onset of menopausal symptoms (some or all of symptoms such as irregular periods, hot flushes, night sweats or sleep disturbance) to the last menstrual period [1]. This can last on average 4 to 8 years. Menopause is the last menstrual period. One year after the last menstrual period the woman is considered "postmenopausal". Peri-menopausal symptoms can occur when periods are still regular, but typically the symptoms worsen in the premenstrual days. The symptoms experienced during the peri-menopause are often the most distressing. Menstrual changes are common and it is normal to have periods that are less frequent or irregular. More frequent periods or those that are very heavy may not be normal and suggest that there may be pelvic or systemic pathology.

Women older than 40 years with more frequent or heavy bleeding, or intermenstrual bleeding require investigation by a gynaecologist. Hormone levels may fluctuate during this time and measurement of sex steroids is rarely clinically helpful once the diagnosis has been made[2]. At this time of hormone fluctuation, oestradiol can actually briefly be higher than normal, giving symptoms of excess oestrogen, such as breast tenderness. Explaining to women that, at a time when their body is running out of oestrogen, they may get brief periods of high oestrogen symptoms is useful. (Some women are told that because of these brief periods of high oestrogen they need progesterone treatment- not so!). Eventually, symptoms of oestrogen deficiency predominate.

Menopause is said to have occurred when there has been no menstruation for one year. If a woman has taken MHT since she was peri-menopausal, it may not be possible to assess the exact age at which she became menopausal. This may also impact on the advice provided about peri-menopausal contraception (See AMS information sheet on Contraception) If a woman has required peri-menopausal MHT for symptoms, it is a reasonable guess to expect her to be post-menopausal after 4-5 years.

Post-menopause

This starts one year after the last menstrual period. There is no reliable way of predicting how long menopausal symptoms will continue. For many women they resolve within 2-5 years but in a significant proportion hot flushes and sweats go on for many years. Ten to 20% of women will have symptoms for more than 10 years. Vaginal dryness and urinary frequency may start during the peri-menopause and tend not to resolve naturally with time. Some women only experience vaginal dryness during intercourse and others are aware of uncomfortable vaginal symptoms at other times.

For those symptomatic women who elect to use MHT, we advise that they be reviewed annually to evaluate ongoing care and the need to continue MHT.

Premature menopause

Premature menopause is considered to have occurred if a woman is younger than 40 when she becomes menopausal. About 1% of women experience a spontaneous premature menopause (POI or premature ovarian insufficiency) and around another 6% have premature menopause due to surgery, chemotherapy or radiation. There has been relatively little research on symptoms in these women, but it seems that their menopausal symptoms may be more severe than in older women, particularly when menopause occurs due to surgery or chemotherapy. There are also distinct personal, sexual, social and psychological issues for younger women, particularly those who have not yet started or completed their families. These women need extra counselling, and time to come to terms with their situation. This is the one time that measuring and finding a high FSH and a low oestradiol is helpful to differentiate between menopause and other causes of secondary amenorrhoea. The measurement of FSH and oestradiol should be repeated at least once. (See AMS information sheets on Early Menopause Due to Chemotherapy and Spontaneous Premature Ovarian Insufficiency)

Symptom assessment and diagnosis

The time when most women are trying to understand what is happening to them is during the peri-menopause. During this time of hormonal fluctuation women may experience some, but not all of the symptoms listed in the table. For instance, she may come with severe joint aches and tiredness, which

may be suggestive of a rheumatological disease. Checking a symptom score will often reveal many more unreported menopausal symptoms.

In most cases, recording a symptom score helps to make the diagnosis, at the same time educates the woman and is a basis for assessing efficacy of treatment. Checking FSH or AMH levels or serum oestradiol and progesterone are unnecessary tests in diagnosing menopause for most women. AMH may in the future become a useful test to predict the age of menopause but at this stage routine use is not recommended[3]. Checking an androgen profile as a routine on all peri-menopausal women is also unnecessary and costly. Many women come to the consultation expecting a blood test to diagnose menopause, and it is important to explain to them why we use the symptom score rather than a blood test in establishing a diagnosis. It is important to explain to women that the blood tests of FSH/oestradiol can fluctuate on a daily basis and therefore are not useful or necessary. It is especially unhelpful to do hormone blood tests while women are on MHT/OCP – symptoms, not blood levels, guide your therapy. ***Respond to the symptoms, not the biochemistry.***

Symptom score sheet

This valuable diagnostic tool (see below) can be completed together with the woman, or she can do it herself in the waiting room. The woman judges the severity of her own symptoms and records the score - 1 for mild, 2 for moderate, 3 for severe and of course 0 if she does not have that particular symptom. A score of 15 or over usually indicates oestrogen deficiency that is intrusive enough to require treatment, but this is only a guideline. Women are very variable in their tolerance of discomfort, often tolerating quite severe symptoms before they will even consider taking MHT. Scores of 20-50 are common in symptomatic women, and with adequate treatment tailored to the individual, the score will reduce to 10 or under in 3-6 months.
Using the symptom score sheet at subsequent follow-up visits is a useful method of judging whether adequate oestrogen is being taken to alleviate symptoms. Generally there is a halving of the symptom score after 2-3 months on MHT and if the woman is still experiencing a lot of symptoms, she may require a dose increase. If symptoms still persist, changing from the oral route to transdermal may help if the problem is oestrogen malabsorption. Women with irritable bowel syndrome, or taking H2 antagonists commonly absorb oral oestrogen poorly.

If it's not menopause, what is it?

Depression, anaemia and hypothyroidism are the most common conditions that may mimic menopausal symptoms or indeed occur concurrently. Unstable diabetes may cause hot flushes. Medication, such as the SSRI family of anti-depressants, may also cause hot flushes.

Doing a blood count, iron studies, ferritin and/or a TSH level will usually establish the diagnosis. However, if a woman presents with low mood or anxiety, there is a need to evaluate whether this is a primary anxiety/depression or one aggravated by the lack of oestrogen. A previous history of depression or an elevated FSH may help to differentiate between the two. Hair loss may be a sign of iron deficiency or hypothyroidism rather than menopause.

Need more information?

Diagnosing menopause is something that most GPs are skilled at doing, and helping women at this difficult stage of their life can be very rewarding. If you are reading this information sheet because you have inadequate knowledge on how to counsel menopausal women, then consider joining the Australasian Menopause Society and receive the quarterly newsletter of the society, called "Changes" and the monthly educational E-blasts. Attend one of our annual meetings, which aim to be of interest to a wide range of doctors, nurses, psychologists and physiotherapists.

SYMPTOM SCORE (Modified Greene Scale) [4]

	Score before HRT	3 months after starting MHT	6 months
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS
SCORE: None =0; Mild =1; Moderate =2; Severe =3

NB. The symptoms are grouped into 4 categories, vasomotor, psychological, locomotor and urogenital. If one group does not respond to MHT, look for other causes and specific treatments for that group.
Not all of the symptoms listed are necessarily oestrogen deficiency symptoms.

References

1. McKinlay SM, Brambilla DJ, Posner JG. The normal menopause transition. Maturitas 1992;14:103.
2. Burger HG. Unpredictable endocrinology of the menopause transition: clinical, diagnostic and management implications. Menopause Int 2011;17:153.
3. Broer SL, Eijkemans MJ, Scheffer GJ, et al. Anti-mullerian hormone predicts menopause: a long-term follow-up study in normoovulatory women. J Clin Endocrinol Metab 2011;96:2532.
4. Greene JG. Constructing a standard climacteric standard. Maturitas 1998;29:25-31

January 2016