

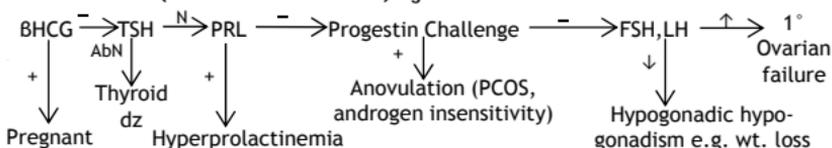
The authors and reviewers have made every attempt to ensure the information in this Family Medicine Clinical Card is correct - it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Card is not meant to replace customized patient assessment nor clinical judgment. The Card is meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when this card is used.

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Menopause

Diagnosis of Menopause

- Clinical retrospective diagnosis of 12 months without menses in women above 40. Average age: 52. *Remember to R/O pregnancy.*
- Perimenopause: Period of hormonal/menstrual variation preceding menopause up to 1st year after last menses. Avg. duration 4-8 years. Do not d/c contraception
- Amenorrhea (6 months w/o menses) age<40 = INVESTIGATION for 2° amenorrhea



Common Concerns in Menopause

Vasomotor Symptoms / Sleep Disturbances	<p>Sx: Hot flashes, sweating, palpitations, night sweats, insomnia Management: Treatment based on patient preference</p> <ol style="list-style-type: none"> 1. Lifestyle: Sleep hygiene, exercise, wt loss (if obese), smoking cessation, trigger avoidance (EtOH, hot drinks, warm ambient temp) 2. Hormonal Replacement Therapy HRT <ul style="list-style-type: none"> - Oral: Conjugated estrogens 0.3mg/d (starting dose) - Transdermal: 0.5 mcg/day 17 B-Estradiol patch (starting dose) - Add progestin if pt has intact uterus - Contraindications to HRT: VTE, CAD, pregnancy, severe liver dz, undiagnosed vaginal bleeding, breast or uterine cancer. 3. Non-Hormonal Rx: SSRIs/SNRIs, clonidine, gabapentin, zopiclone 	
Bleeding	<p>Anovulatory (irregular) bleeding may be expected in perimenopause. Act on prolonged/heavy/intermenstrual bleed. If ↓BP↑HR: ABCs+activate EMS</p> <p>Inv: CBC (if prolonged bleeding), U/S (for anatomical cause e.g. fibroids, hyperplasia). Biopsy if Endometrial CA risk (age>40, nulliparity, PCOS unopposed estrogen, or BMI>30)</p>	<p>Initial Mgmt:</p> <p>Non Hormonal (during menses): NSAIDs, Tranexamic acid. Hormonal: combined OCP, Levonorgestrel-releasing IUD</p>
Urogenital Atrophy	<p>Sx: Vaginal dryness, dyspareunia, dysuria, frequent UTI. DDX: Lichen sclerosis (thin white lesions, intense pruritis, burning → biopsy) Management: Vaginal Moisturizers e.g. Replens™, lubricants for intercourse. Vaginal Estrogen (progestin not required) - Vaginal Tablet (e.g. Vagifem™), Cream (e.g. Premarin™), Vaginal Ring (e.g. Estring™)</p>	
Bone Health	<p>Assessment: Canadian FRAX score for 10 year hip fracture risk: use FRAX tool to stratify into low (<10%), moderate (10%-20%) or high risk (>20%) (Web search for "FRAX tool", make sure to select Canadian version) Management: All risk groups: Exercise (wt. bearing, balance and strength), smoking cessation, caffeine reduction, Ca²⁺ >1500mg/day, Vit D >800IU/day. Low risk: reassess in 5 years. Moderate risk: TL spine x-ray if concerns for vertebral fracture. If fracture or other risk factor, treat as high risk. Otherwise repeat BMD in 1-3 years. High risk: Along with general mgmt: 1. Bisphosphonates 2.SERMs 3.HRT if pt has vasomotor Sx</p>	
Incontinence	<p>General Management of Incontinence: Wt. loss, physiotherapy (bladder training, pelvic muscle exercises, biofeedback), trigger avoidance (EtOH, caffeine, excessive fluids), absorptive pads. Stress Incont. (i.e. with ↑pelvic pressure): Consider pessaries, surgery Urge Incont.(i.e. spontaneous): Consider antimuscarinics e.g. oxybutinin</p>	

Key References: Papaioannou, A et al. (2010). 2010 clinical practice guidelines for the diagnosis and management of osteoporosis, *CMAJ* Vol 182(17), 2010. Brockie, J et al. EMAS position statement: Menopause for medical students. *Maturitas*, 78(1), 2014 67-9. Fairbanks, J., & Sams, D. Menopause and Osteoporosis Update 2009. *Journal of Obstetrics and Gynecology Canada*, 31(1), 2009.