WA ACP Women's Health Update

November 2024

Caitlin Allen, MD MSCP

Faculty, Internal Medicine Residency Spokane

Primary Care Track Director

Disclosures

- No financial disclosures
- Will be discussing non-FDA approved uses of medications

Objectives

- Perimenopausal Transition: Symptoms and Management
  - ➢Contraceptive benefits
  - ➢Management of Hyposexual Desire Disorder (HSDD)
- New(ish) Women's Medications 2024
- Update to Mammogram/Breast Cancer Screening Recommendations

To Clarify….

- This talk will focus on persons with female reproductive anatomy/cis-women
- HRT and hormone therapy for gender diverse individuals is beyond the scope of this talk
- Anecdotes are from my own practice and IMRS Women’s Clinic
  - Novel comprehensive women's evaluation and treatment across the lifespan
  - Direct resident education

Case:

47yo Never Smoker-Female
CC: “I just don’t feel like myself” “I need my hormones checked”

HPI: Married, G2P2, family stress, full time job

LMP: 2 weeks ago, heavy x 1-3 days, then spots for 2 days
26-40 days between periods; denies spotting with intercourse

Tired, irritable, feeling overwhelmed with demands of life
Having trouble with waking up at night
Neck and back ache more
This is new for her—started 18 months ago

Exercise 2-3x a week, yoga, walking

What do we do now?

“I need my hormones checked” Is this a scenario you encounter in your practice?

A. Frequently
B. On occasion, or sometimes a friend or family member asks me
C. Almost never
D. Not really, but tell me more!

Menopause: The Journal of The Menopause Society
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OPEN

ORIGINAL STUDY

"Not feeling like myself" in perimenopause — what does it mean? Observations from the Women Living Better survey

Nina Coslov, MBA,[1] Marcie K. Richardson, MD,[2] and Nancy Fugate Woods, PhD, RN[3]

Abstract

Sleep Disturbances

Brain Fog

Headaches

Mood/Overwhelm

Vasomotor Symptoms

Breast Pain

Vaginal and Urinary Changes

Libido

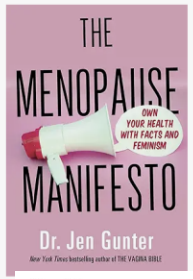
Digestive Concerns

Skin Dryness/Itchiness

Menstrual Irregularity

Perimenopause Defined

- Sleep Symptoms: Difficulty: falling asleep, waking in the middle of the night, early AM waking
- Vasomotor Symptoms: Hot flashes, night sweats, palpitations
- Mood Symptoms: Irritable, anxiety, overwhelmed, panic attacks, anger/rage, tearfulness/crying, “Can’t calm down on the inside”
- Brain Fog: forgetful, concentration, dizziness, vertigo
- Headaches
- Breast Soreness
- Skin Dryness, itchiness, breakouts, dry eyes
- Vaginal and Urinary symptoms: dryness, dyspareunia, incontinence
- Digestive: bloating, heartburn, constipation, diarrhea
- Pain and Fatigue: Joint/muscle pain, leg pain, neck pain, shoulder and joint stiffness
- Libido: Decreased vaginal lubrication, less interest, difficulty with orgasm, arousal



The Menopause Manifesto: Own Your Health with Facts and Feminism

by Dr. Jen Gunter | May 25, 2021

4.5 out of 5 stars 2,064

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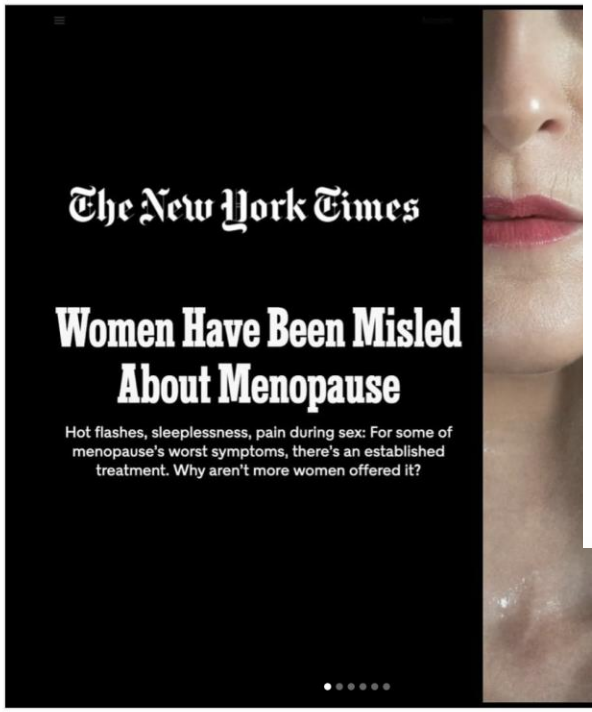
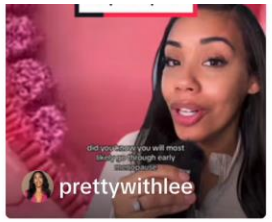




What age did you get

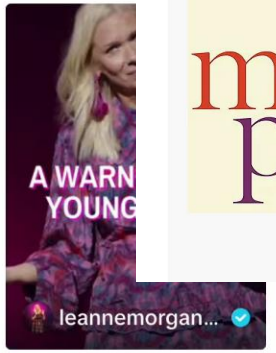
You won't get the results

"We're turning into

Like please le

7 Strange random pains

Did you know that



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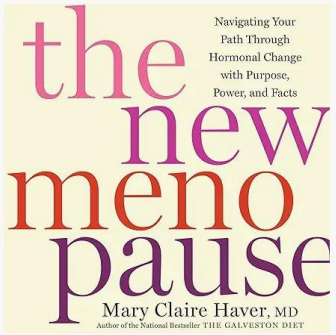

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by Mary Claire Haver MD and Random H

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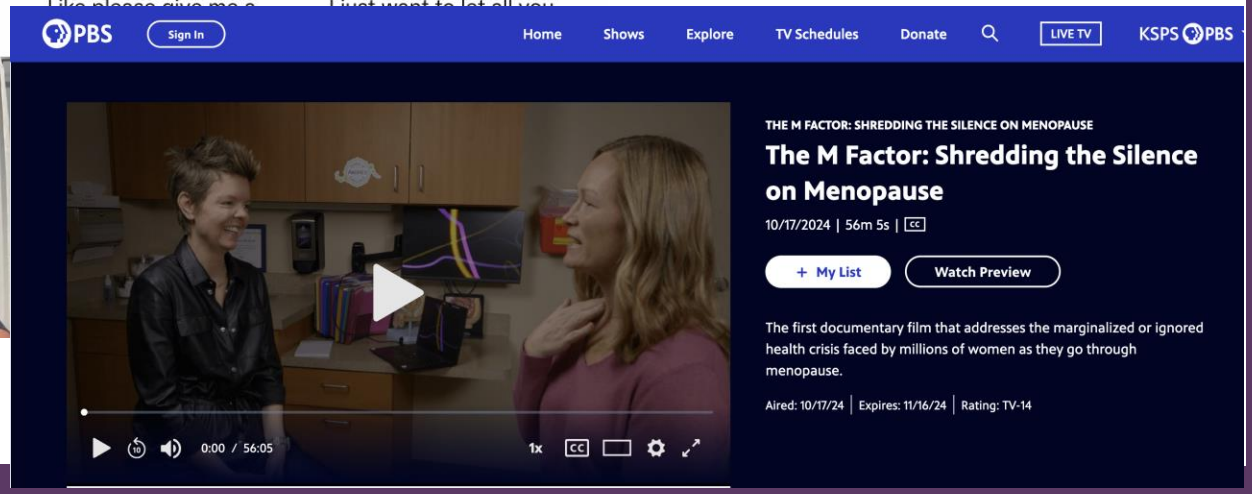
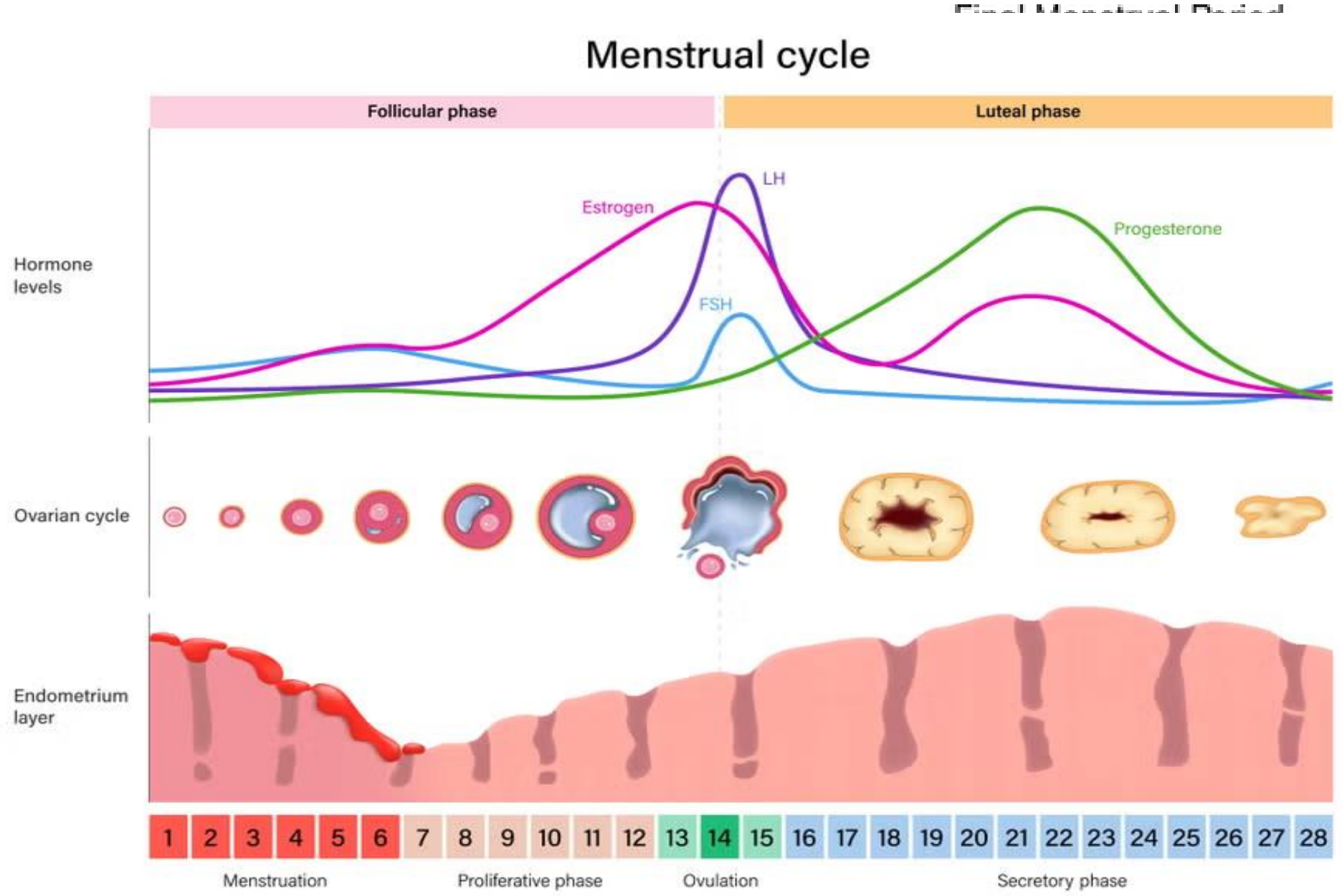
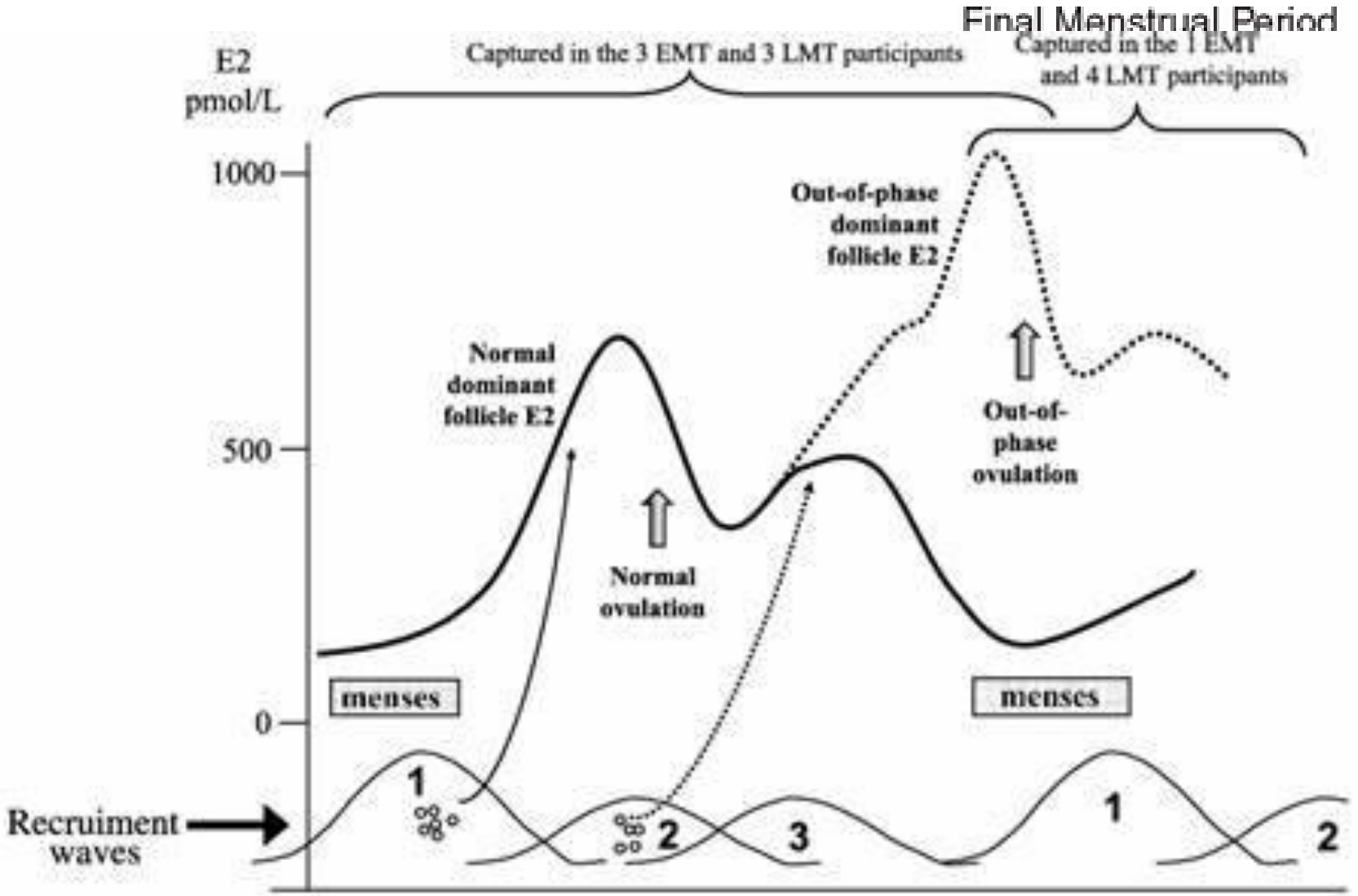



Menstrual cycle
Follicular phase
Luteal phase
Hormone levels
LH
Estrogen
Progesterone
FSH
Ovarian cycle
Endometrium layer
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Menstruation
Proliferative phase
Ovulation
Secretory phase

Stage:	+2
Termir	pause
	Late
Durati of Sta	until emise
Menst cycles	
Endoc	



adapted from estradiol (E_2) data in the current study and ultrasonography data from Baer

Perimenopause/Pre-Menopause → FMP → Menopause

~7 day difference consecutive menstrual cycles	Clinical Diagnosis: Hypergonadotropic hypogonadal amenorrhea = low estradiol and elevated gonadotropin
<25 days or >35 days (indicative of anovulatory cycles)	12 months amenorrhea
↓Inhibin B ↓ Progesterone	
↓Anti-mullerian hormone	Women > 50 → FSH > ↑30 on two occasions 4-6 weeks apart
↑↓ FSH ↓↑Estradiol	Estradiol ↓

Early Menopause vs POI

~52 average age of natural menopause; “Early” menopause age <45

Loss of ovarian follicular activity (spontaneous or induced) age < 40 = primary ovarian insufficiency (POI)

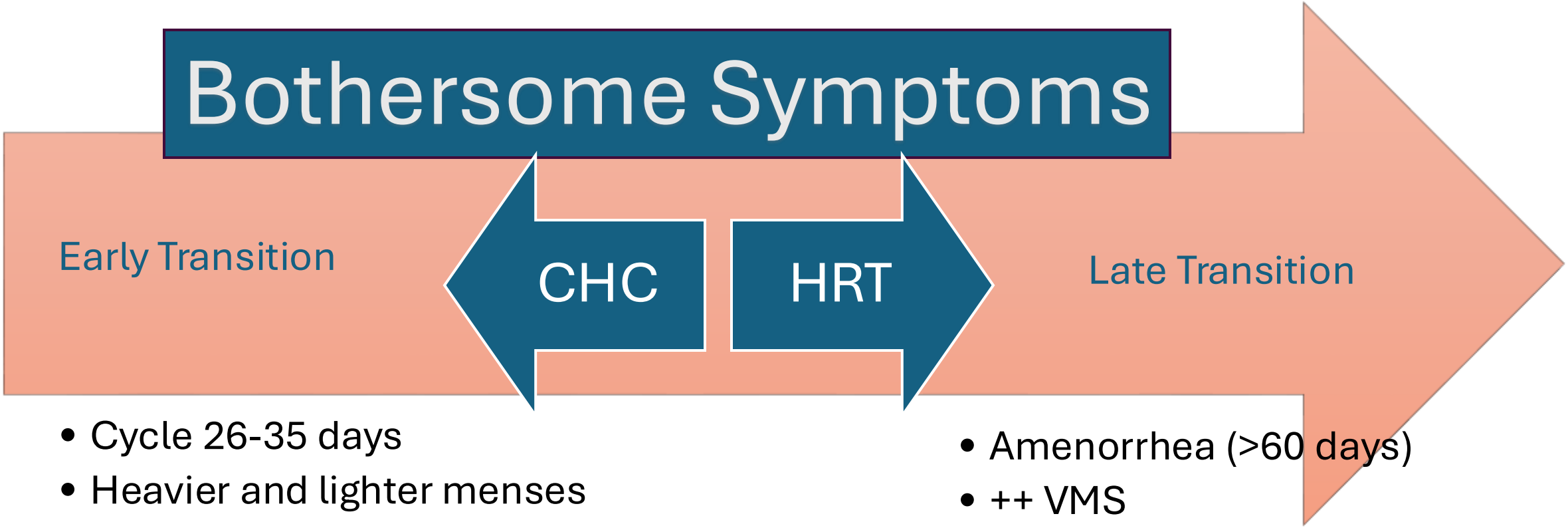
Turner Syndrome or mosaicism Fragile X premutation	Immune mediated injury via autoimmune polyendocrine syndromes (hypothyroidism and Addison disease)	Bilateral oophorectomy, pelvic radiation, chemotherapy

Unless true contraindication exists = MHT (truly replacement therapy) is recommended

Use MHT for women with surgical menopause age < 45	Do not need to have VMS/Can be asymptomatic	Continue until at least age 50-55	↑BMD, ↓Dementia ↓CVD risks

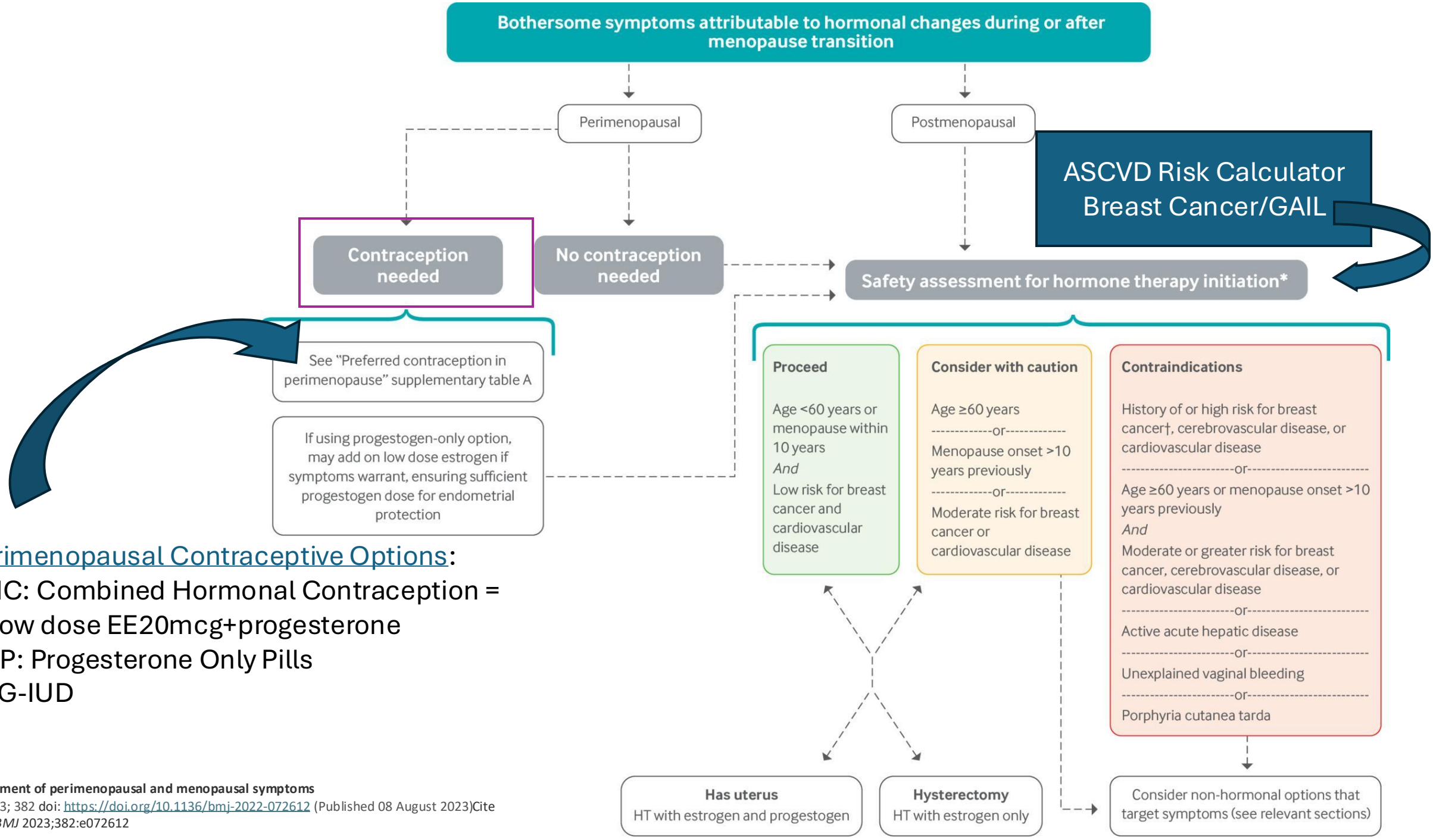
Kaunitz AM, Kapoor E, Faubion S. Treatment of Women After Bilateral Salpingo-oophorectomy Performed Prior to Natural Menopause. *JAMA.* 2021;326(14):1429–1430. doi:10.1001/jama.2021.3305

Perimenopausal Management



- Cycle 26-35 days
- Heavier and lighter menses
- +/- VMS

- Amenorrhea (>60 days)
- ++ VMS
- Vaginal symptoms



[Perimenopausal Contraceptive Options]:

CHC: Combined Hormonal Contraception =
low dose EE20mcg+progesterone

POP: Progesterone Only Pills

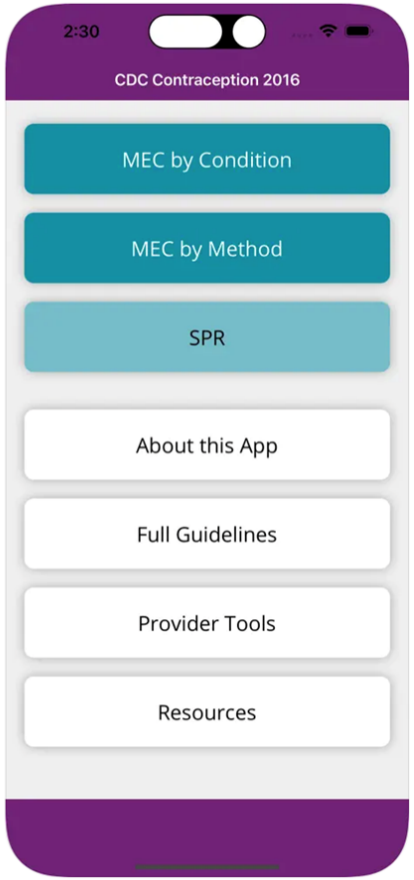
LNG-IUD

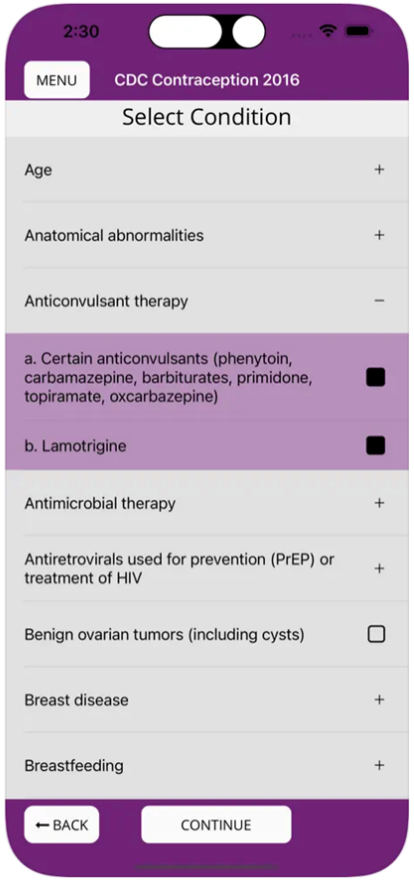
Management of perimenopausal and menopausal symptoms
BMJ 2023; 382 doi: https://doi.org/10.1136/bmj-2022-072612 (Published 08 August 2023)Cite this as: *BMJ* 2023;382:e072612

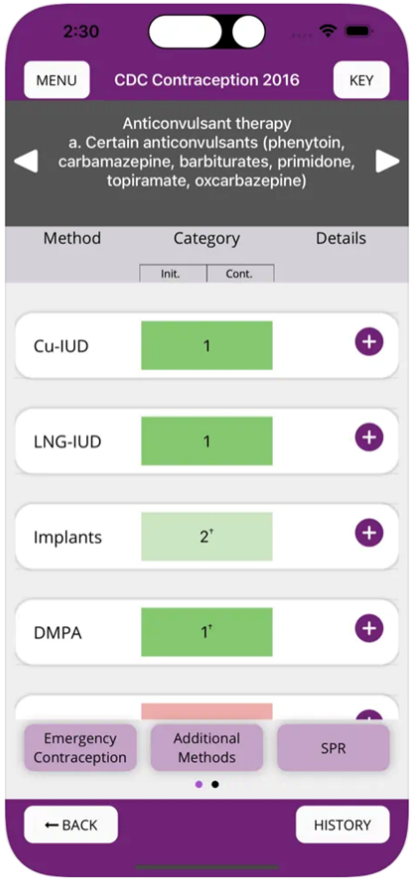
No contraception is contraindicated by age alone

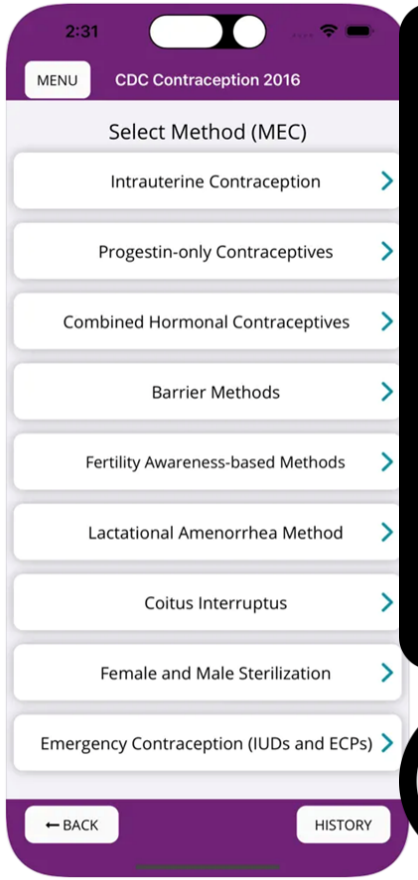
CDC: US MEC/US SPR

Newly ***Revised 2024***









SCAN ME

Importance of Contraception during Perimenopause

- USA ~ 48% Unintended Pregnancy rate with 49% Women > 40
- 25% of cycles are ovulatory up until the FMP (final menstrual period)
- Higher rates of comorbid maternal conditions
- Trisomy 21 rates 1:85 at age 40 to 1:35 age 45
- Increased rate of pregnancy complications
- Higher rates of twins/multiples
- SAB rate ~35% women age 40-44; ~53% age >45

Voedisch AJ, Ariel D. Perimenopausal contraception. Curr Opin Obstet Gynecol 2020;32(6):399-407

Non-Contraceptive Benefits in Perimenopause

Combined Hormonal Contraception (CHC)	Progestin- Only Pills	LNG-IUD 52mg (Mirena or Liletta)
Menstrual Cycle Regulation * - Continuous cycling, 24/4 pills	Menorrhagia treatment -Can still have break thru bleeding	Amenorrhea for Many
Menorrhagia/AUB treatment	Some Migraine Reduction	Menorrhagia/AUB treatment
↓Vasomotor Symptoms ↓Menstrual Migraine	Oncological protection (ovary, ?endometrial)	Endometrial lining protection **OFF Label use during HRT
BMD Protection (unclear improvement in fracture risk)		
Oncological protection (ovary, endometrium, colon)		

Grandi, G., Di Vinci, P., Sgandurra, A., Feliciello, L., Monari, F., & Facchinetti, F. (2022). Contraception During Perimenopause: Practical Guidance. *International Journal of Women's Health*, *14*, 913–929. https://doi.org/10.2147/IJWH.S288070

Estrogen Comparison – How much HRT vs CHC?

Physiologic Estrogen Dosing

LH/FSH Suppression

Estrogen	Standard	Low Dose	Ultra Low Dose	Contraception
Oral Conjugated Equine Estrogen (CEE) (Premarin)	0.625 mg	0.3mg		
Oral 17ß Estradiol (Estrace)	1 mg	0.5mg		
Transdermal 17ß Estradiol (Vivielle, Climara, Estraderm)	0.05 mg	0.025mg	0.014mg	
Oral Ethinyl Estradiol (EE)	0.005-0.01mg			0.020-0.035 mg or 20-35 mcg

CHC (Combined Hormonal Contraception) in Perimenopause

CHC Benefits

12% reduction in any cancer
29% reduction in endometrial/ovarian
18% reduction in colon cancer

↓AUB: abnormal uterine bleeding

Vasomotor symptom relief

BMD possible improvements (unclear)

Chemoprotective in BRCA young women

CHC Risks

VTE: 20.8 per 10,000 women years aged 45-49
(compared to 8.7 in women 30-34)

Breast Cancer RR 1.2-1.4 compared to non-users*

MI/Stroke ↑ with age ~RR 1.5; significantly higher if comorbid CVD risks

Non-smokers only > age 35
Do not use in Migraine with Aura

When to Stop Contraception

Oral Contraception	
Age 50-55	Age 55
Stop CHC or POP Pill wait at least 2 weeks to check FSH	Stop CHC/POP
Use Back Up or Alternate/ Barrier Methods	Spontaneous conception very rare
Repeat FSH 4-6 weeks	Consider switching to HRT
If FSH > 30 both times→Stop CHC	

CDC, ACOG, NAMS

- DMPA users can check FSH test on day of injection, repeat in 90d
- IUD users – Higher FSH levels, check anytime
- Nexplanon users—Check FSH any time

Perimenopause Take Aways #1

- No contraceptive is limited based on age alone, important to discuss "Is being pregnant in your plans for this year?"
- CHCs are oral estrogen/progesterone that not only provide contraceptive benefits, but can manage many symptoms of the perimenopause transition
- Review women's surgical history for TAHBSO and ensure menopausal HRT was used to the average age of menopause for BMD protection, cardiovascular and dementia benefits regardless of VMS/Symptoms

What do we do now?

47yo Cis-Woman
CC: “I just don’t feel like myself” "I want my hormones checked"

HPI: Married, 2 kids, her mother just moved in with increased needs, full time job

LMP: 2 weeks ago, heavy x 1-3 days, then spots for 2 days
26-40 days between periods

Tired, irritable, feeling overwhelmed with demands of life
Neck and back ache more
Restless sleeping
Exercise 2-3x a week, yoga, walking; New for her in last 18 months

Menstrual Hx:
Menarche: age 12
First Baby: 27
Periods mostly regular throughout life, no known fertility problems
Tubal ligation with 2nd C section age 31

FamHx:
No known fam hx of Breast, Ovarian or other CA in Mom, Dad

Consider Validated Menopause Symptom Tools

Table 2 Overview of assessment tools for menopausal symptoms in general, specific menopausal symptoms and quality of life

Assessed feature	Assessment tool
Climacteric symptoms in general	Kupperman Index
	Menopause Rating Scale
	MENQOL-MENQOL-Intervention
	Greene Climacteric Scale
Vasomotor symptoms only	Daily Hot Flash Diary
	Revised Daily Hot Flash Diary
	Hot Flash Rating Scale
	Hot Flush Behavior Scale
Quality of life	Hot Flash Related Daily Interference Scale
	Women's Health Questionnaire
	Utian Quality of Life Scale (UQOL)
	36-item short-form (SF-36)
	MENCAV questionnaire

Sourouni, M., Zangger, M., Honermann, L. *et al*. Assessment of the climacteric syndrome: a narrative review. *Arch Gynecol Obstet* **304**, 855–862 (2021). https://doi-org.offcampus.lib.washington.edu/10.1007/s00404-021-06139-y

What about Lab Work?

Options to Consider

- Urine HCG
- FSH and Estradiol (is the diagnosis not clear?)*
- Thyroid function testing
- CBC, CMP, Iron Studies
- Lipid Panel
- ?Any concern about vitamin deficiencies
- ?Total Testosterone

*will need to be repeated, should not be done in isolation

Clearblue FSH test stick

Urinary FSH concentrations correlate well with Serum[1]

<u>Qualitative FSH levels in urine</u>

- FSH test result:
  - Positive if FSH ≥ 25mIU/mL,
- >99% accurate results in lab conditions

In-app instructions guide her on how and when to test

nizuka Y, Nagai K, Ideno Y, *et al*. Association between FSH, E1, and E2 levels in urine and serum in premenopausal and postmenopausal women. *Clin Biochem*. Nov 2019;73:105-108.

Clearblue

Perimenopause Management by Symptom

VMS | Weight Gain | Disordered Sleep | Mood Changes | Decreased Libido | GSM

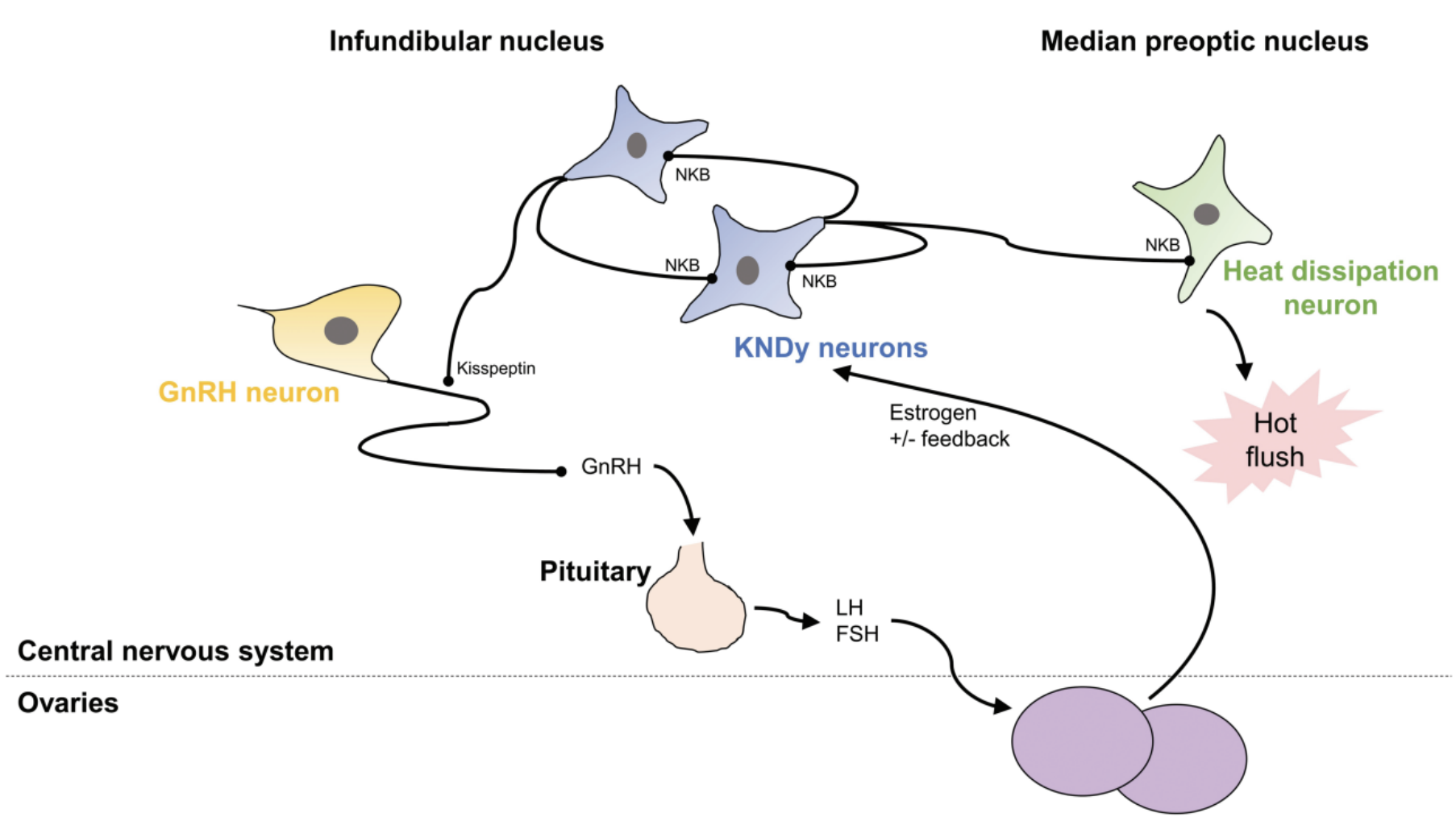
Key Points:

- VMS and GSM are best treated/first line with hormonal therapy after careful discussion of risks and benefits
- Weight changes in perimenopause transition are best treated with guideline-based obesity treatment
- Disordered sleep is highly prevalent in the menopause transition: CBT and consider micronized progesterone/HRT
- Depression is 3x more likely in perimenopause
- Decreased Libido with significant distress = Hypoactive sexual desire disorder which has FDA and nonFDA approved treatments, including off label testosterone

Management of perimenopausal and menopausal symptoms *BMJ* 2023; 383 :p2636 doi:10.1136/bmj.p2636

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM



Adapted from: Nanette Santoro, Cassandra Roeca, Brandilyn A Peters, Genevieve Neal-Perry, The Menopause Transition: Signs, Symptoms, and Management Options, *The Journal of Clinical Endocrinology & Metabolism*, Volume 106, Issue 1, January 2021, Pages 1–15, https://doi.org/10.1210/clinem/dgaa764

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Systemic Hormonal Treatment	Nonhormonal Therapy
Estrogen Pill or Patch +/- Progesterone*	Fezolinetant 45mg/day*
Vaginal Estrogen Ring (Femring)*	Paroxetine 7.5mg/day*
SERM: Bazedoxifene/conjugated estrogens (Duavee)*	Venlafaxine
	Gabapentin
	Oxybutynin

*FDA Approved for VMS of Menopause

Perimenopause Management by Symptom

VMS | Weight Gain | Disordered Sleep | Mood Changes | Decreased Libido | GSM

↓ Estrogen → ↓ Muscle Mass and ↑ Fat Mass →↓Resting Energy Expenditure→ Weight Gain/Visceral Obesity

- CHC/HRT does not appear to *create* weight loss
- Oral HRT: ↑ Lean body mass, HDL, ↓Insulin Resistance
- Oral HRT: ↑Triglycerides, CRP
- Utilize weight loss medications and lifestyle interventions
- Focus on protein/whole grains/fiber/vegetables
- Recommend strength training 2-3x per week

Management of perimenopausal and menopausal symptoms *BMJ* 2023; 383 :p2636 doi:10.1136/bmj.p2636; Hurtado MD, et al. Weight Gain in Midlife Women. Curr Obes Rep. 2024 Jun;13(2):352-363

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

- 40-60% Women report sleep symptoms
- DDX: Periodic limb movement, RLS, Sleep Apnea →assess risk and treat
- Bidirectional relation with night sweats/VMS
- CBT/Sleep Hygiene is First line
- Micronized Progesterone reduced sleep disturbance (sedating effects)
- Oral and Transdermal Estrogen-self reported improvement (but lacked sleep study results)

Management of perimenopausal and menopausal symptoms *BMJ* 2023; 383 :p2636 doi:10.1136/bmj.p2636

Perimenopause Management by Symptom

VMS | Weight Gain | Disordered Sleep | Mood Changes | Decreased Libido | GSM

- 3x ↑ risk of major depression (compared to younger cohort)
- Evaluate with GAD7 and PHQ9 → Assess for Primary Mood Disorders, consider SSRI/SNRI first-line
- Fluctuating symptoms → Hormone therapy improves mood w/ or w/o antidepressant (perimenopause)
- SWAN study: HRT = Improvement in verbal memory, processing speed
- WHI showed dementia risk for HRT started >65yo

Management of perimenopausal and menopausal symptoms *BMJ* 2023; 383 :p2636 doi:10.1136/bmj.p2636

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Sexual well-being: complex interplay of biologic, psychologic, and sociocultural factors

Disorder: Hypoactive Sexual Desire Dysfunction (HSDD): Absence or marked reduction in desire/motivation to engage in sexual activity resulting in distress

Evaluate: Profile of Female Sexual Function or Personal Distress Scale

Associated with: PCOS, Adrenal Insufficiency, Diabetes, Chronic Pain
Consider “androgenicity” of OCP, review medications (naltrexone, SSRIs)
No Testosterone “cut off” = Sexual dysfunction, nondiagnostic

Sexual Dysfunction in Women Susan R. Davis, M.B., B.S., Ph.D.Author Info & Affiliations
Published August 21, 2024N Engl J Med 2024;391:736-745 DOI: 10.1056/NEJMcp2313307 VOL. 391 NO. 8

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Tx (Premenopausal only):

- Flibanserin-- ↑0.5 sexual encounters/month, SE: dizzy, nausea, fatigue, avoid with EtoH
- Bremalantide—melanocortin receptor agonist ↑dopamine

$$$

Off Label Considerations:

- Buproprion or Busparione

Sexual Dysfunction in Women Susan R. Davis, M.B., B.S., Ph.D.Author Info & Affiliations
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Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Hypoactive Sexual Desire Dysfunction (HSDD): Testosterone Therapy in Post Menopausal Women/ISSWSH used in late perimenopausal women

Gel
Initial Dose: 1% Testosterone
~1/10th of a tube/packet or
roughly 0.5mL every other day

- Counsel the patient regarding use
  - **Consent**
  - **Application**
  - **Risk of transference**
  - **Alternatives on the market --> generally not recommended (ie pellets, patches, oral)**

Sexual Dysfunction in Women Susan R. Davis, M.B., B.S., Ph.D.Author Info & Affiliations **Published August 21, 2024N Engl J Med 2024;391:736-745 DOI: 10.1056/NEJMcp2313307** VOL. 391 NO. 8
Davis SR, Baber R, Panay N, et al. Global consensus position statement on the use of testosterone therapy for women. J Sex Med 2019;16:1331-1337. doi: 10.1016/j.jsxm.2019.07.012

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Hypoactive Sexual Desire Dysfunction (HSDD): Testosterone Therapy in Post Menopausal Women/ISSWSH used in late perimenopausal women

Initiate Testosterone	3-6 weeks Check in	6-12 weeks	~4-6 Months
• Labs: CMP, Lipid Panel, Total Testosterone, SHBG	• Recheck Total Testosterone • Physiologic Premenopausal Goal	• ↑Improvement in Sx, maxing ~week 12	• Recheck Total Testosterone • Discontinue if no improvement

Sexual Dysfunction in Women Susan R. Davis, M.B., B.S., Ph.D.Author Info & Affiliations
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Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Hypoactive Sexual Desire Dysfunction (HSDD): Testosterone Therapy in Post Menopausal Women/ISSWSH* used in late perimenopausal women

Side Effects:

- Hair Growth and Acne (at physiologic dosing!)
- Supraphysiologic: alopecia, voice deepening
- Abnormal Uterine Bleeding (evaluate, but no increased risk of endometrial CA

No Effect/Change:

- Lipid profile, carbohydrate metabolism
- Mammogram Breast Density
- BMD
- Memory or cognition

*ISSWSH: International Society for the Study of Women's Sexual Health/Global Consensus Position Statement on Testosterone for Women

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Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

GSM: Genitourinary Symptoms of Menopause
= Vulvar-Vaginal Atrophy and dryness , Dyspareunia, Urinary incontinence, frequent UTI

Vaginal Lubricants	Vaginal Moisturizers	Vaginal Estrogen Products	Oral Osphemifene SERM/ERAA
• Use with intercourse and masturbation	• Use daily/after bathing	• Most Effective • Ring >Tablet>Cream • $$$>> $	• Vaginal dryness/dysparunia

Other Treatments:
DHEA (Intrarosa) alternative Vaginal Suppository
Pelvic Floor PT

For women at high risk or hx of breast cancer: NAMS/ISSWSH recommend nonhormonal options first

What do we do now?

47yo Cis-Woman
CC: “I just don’t feel like myself” "I want my hormones checked"

HPI: Married, 2 kids, her mother just moved in with increased needs, full time job

LMP: 2 weeks ago, heavy x 1-3 days, then spots for 2 days
26-40 days between periods

Tired, irritable, feeling overwhelmed with demands of life
Neck and back ache more
Restless sleeping
Exercise 2-3x a week, yoga, walking; New for her in last 18 months

Menstrual Hx:
Menarche: age 12
First Baby: 27
Periods mostly regular throughout life, no known fertility problems
Tubal ligation with 2nd C section age 31

FamHx:
No known fam hx of Breast, Ovarian or other CA in Mom, Dad

Knowledge Check In:

What would you offer this Patient next:

A. Zolpidem for her insomnia
B. Estradiol, Progesterone, FSH, LH lab testing
C. After an exam, discuss hormonal treatment such as CHC
D. Refer to a specialist

47yo Cis-Woman
CC: “I just don’t feel like myself” “I want my hormones checked”

HPI: Married, 2 kids,
full time job

LMP: 2 weeks ago, he
26-35 days between

Tired, irritable, feelin
Neck and back ache
Restless sleeping
Exercise 2-3x a week

Menstrual Hx:
Menarche: age 12
First Baby: 27
Periods mostly regul
Tubal ligation with 2n

FamHx:
No known fam hx of E

What do Dr Allen do now?

Assess Breast Ca Risk

Plan
- Offer Basic Labs (if not done- would try NOT to do FSH, Estradiol now- explain variability in this stage)

Assess
- Libido, PHQ9, GAD7
- Pelvic exam and discuss GSM

Consider:
- No contraception needed, but would consider low dose (20mcgEE) CHC vs IUD for irregular menses

VS
- Low dose micronized oral progesterone for sleep +/- estradiol patch if desired

Perimenopause Management by Symptom

VMS Weight Gain Disordered Sleep Mood Changes Decreased Libido GSM

Perimenopause Take Aways #2

- VMS is best treated/first line with hormonal therapy after careful discussion of risks and benefits
- Weight changes in perimenopause transition are best treated with guideline-based obesity treatment
- Disordered sleep is highly prevalent in the menopause transition: CBT and consider micronized progesterone/HRT
- Depression is 3x more likely in perimenopause→assess primary mood disorders
- Decreased Libido with significant distress = Hypoactive sexual desire disorder which has FDA and nonFDA approved treatments, including off label testosterone
- GSM can be treated with lubricants, moisturizers, vaginal estrogen and oral SERM

Management of perimenopausal and menopausal symptoms *BMJ* 2023; 383 :p2636 doi:10.1136/bmj.p2636

New (ish) Women's Medications

- Over the counter continuous Progesterone-only Pill “Opill” is available online and local retailers ~$20/month
- Depot medroxyprogesterone acetate (DMPA-SC) self-injected subQ is available
- Progestin-only pill: SLYND (Droseripone/DRSP): anti-androgenic)
- Fexolinetant (Veozah): novel non-hormonal VMS treatment

Norgesterol 0.075mg (Progestin); no placebo

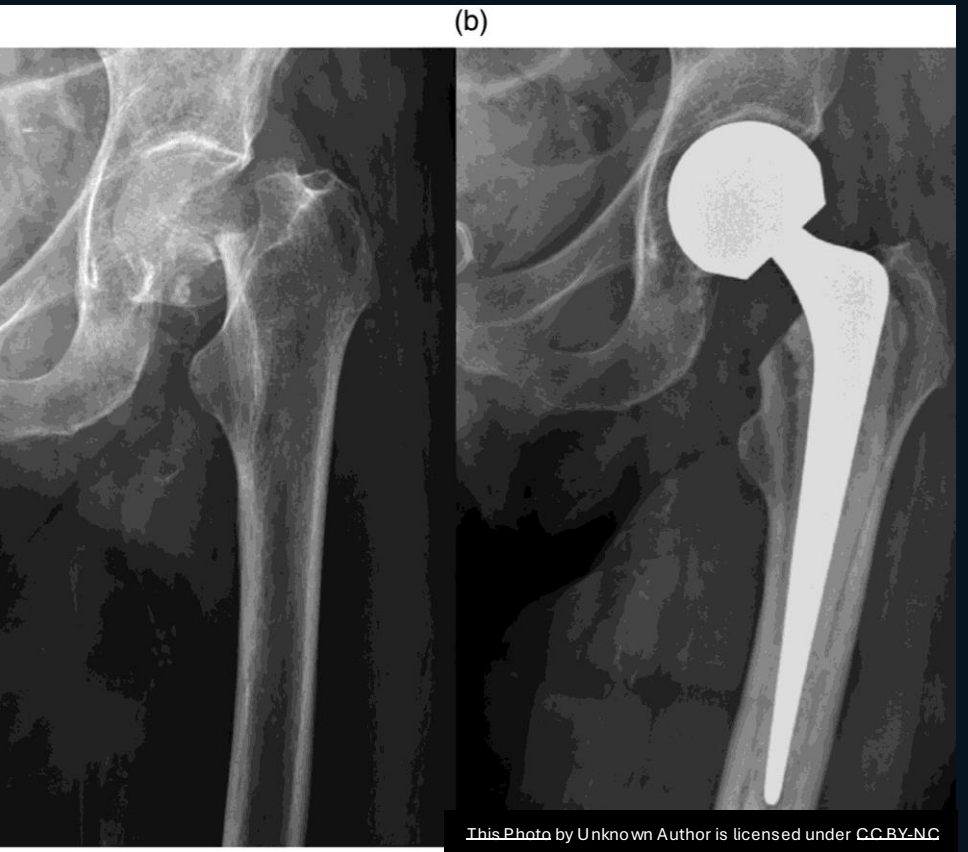
- OTC ~$20/month
- No Age Restrictions
- Inhibit ovulation in about 2/3rd of women
- Cervical mucous changes
- Dose delay > 3 hours = 48 hours back up method
- Category 4 in known breast cancer
- Category 3 (risk > benefit, but can be considered in VTE, Liver Disease)

- Public Health Importance
- OTC options in nearly 100 countries outside of USA
- Adherence is similar to Rx CHC
- 4.4 Pearl index

- ThePearlIndexis a measure of contraceptive effectiveness that is calculated by dividing the number of unintended pregnancies by the cumulative number of cycles ofexposure Compared to Condoms 14 % pearl index

Allen, R. & Bartz, D. (2024). Opill. *Obstetrics & Gynecology, 143* (2), 184-188. doi: 10.1097/AOG.0000000000005455.
Evaluation of adherence to a daily progestin-only pill in a simulated over-the-counter setting Laurora, Irene et al.Contraception, Volume 133, 110388
https://opill.com/products/opill?variant=47067484487984

DMPA: depot medroxyprogesterone acetate



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- SubQ Rx allows for self-injection
- 4x per year dosing
- Not recommended in Women > 45-50
- Hypoestrogenic state → Critical BMD in perimenopause
  - Consider “add back” estrogen
- Amenorrhea rates ~50% at 1 year
- Return to fertility delayed up to 10 months

Drospirenone (DRSP)

- 24 Days (active): 4mg
- 4 Days: Placebo

- Suppresses ovulation/thickens cervical mucus
- Strong anti-mineralocorticoid/anti-androgenic properties
- SE: Headache, breast tenderness, low libido
- Check Potassium 1-2 weeks after starting
- Lower rates of unscheduled bleeding vs. traditional POP
- ~CHC for timing for missed doses (24 hours)

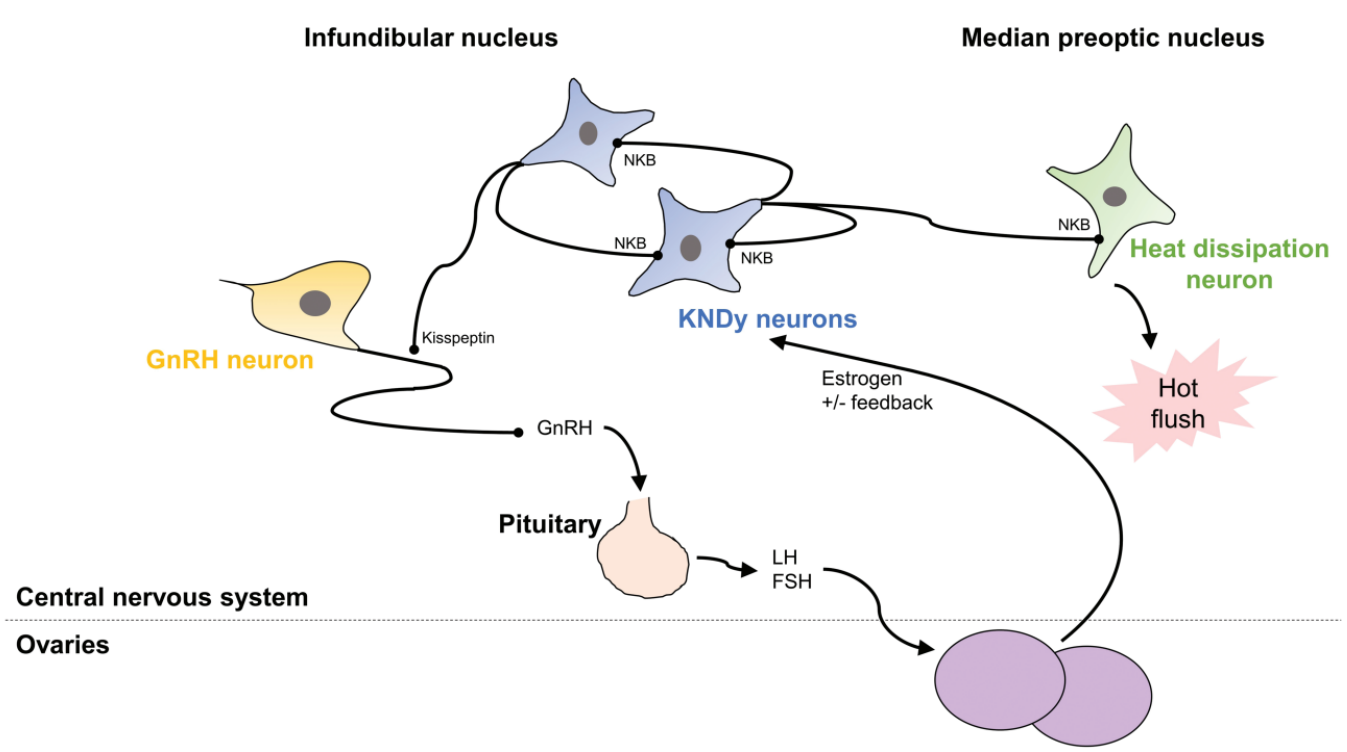
Fezolinetant (VEOZAH)

FDA approved for the treatment of vasomotor symptoms in menopause

NK3R antagonist: blocks the binding of neurokinin B to KNDy neurons which affects thermoregulation

Paroxetine 7.5mg (low dose) only other FDA approved non-hormonal treatment for vasomotor symptoms of menopause

Fezolinetant



- ↓Estrogen = ↑NK3Rs
- Bypass Estrogen receptors
- No direct comparison to other nonhormonal therapies (only placebo)
- At least 50% reduction in VMS in 81-94% of women (*Skylight trials)*
- AE rare: cholelithiasis/LFT ↑ (CYP1A2 inhibitors contraindicated)

Chavez MP, Pasqualotto E, Ferreira ROM, Hohl A, de Moraes FCA, Schmidt PHS, Rodrigues ALSO, de Sa JR. Fezolinetant for the treatment of vasomotor symptoms associated with menopause: a meta-analysis. Climacteric. 2024 Jun;27(3):245-254. doi: 10.1080/13697137.2024.2334083. Epub 2024 Apr 15. PMID: 38619017.

Fezolinetant

FDA approved 45mg daily taken with or without food

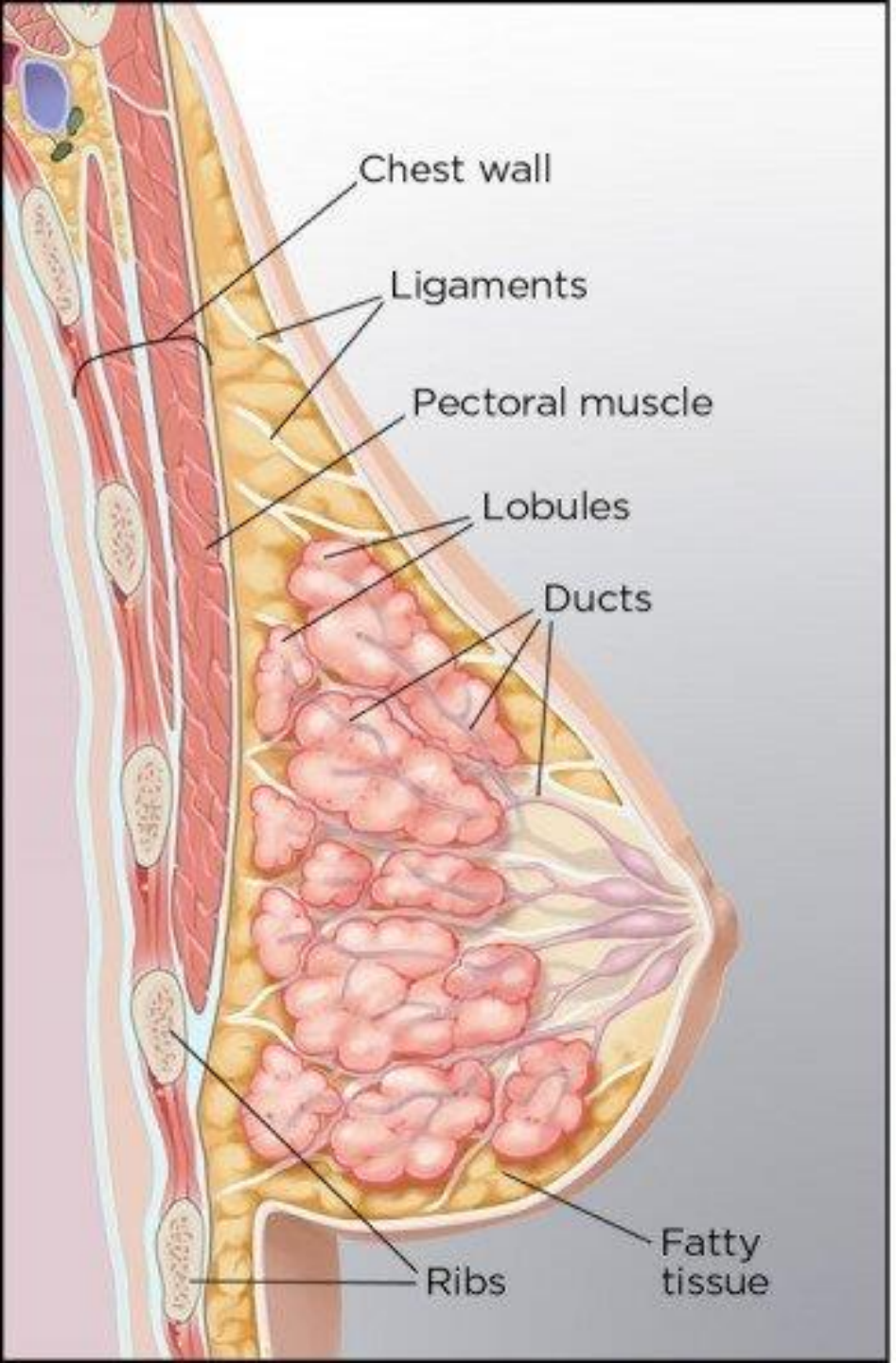
Monitor LFTs at 3, 6, and 9 months

Expensive, GoodRx ~$532/month

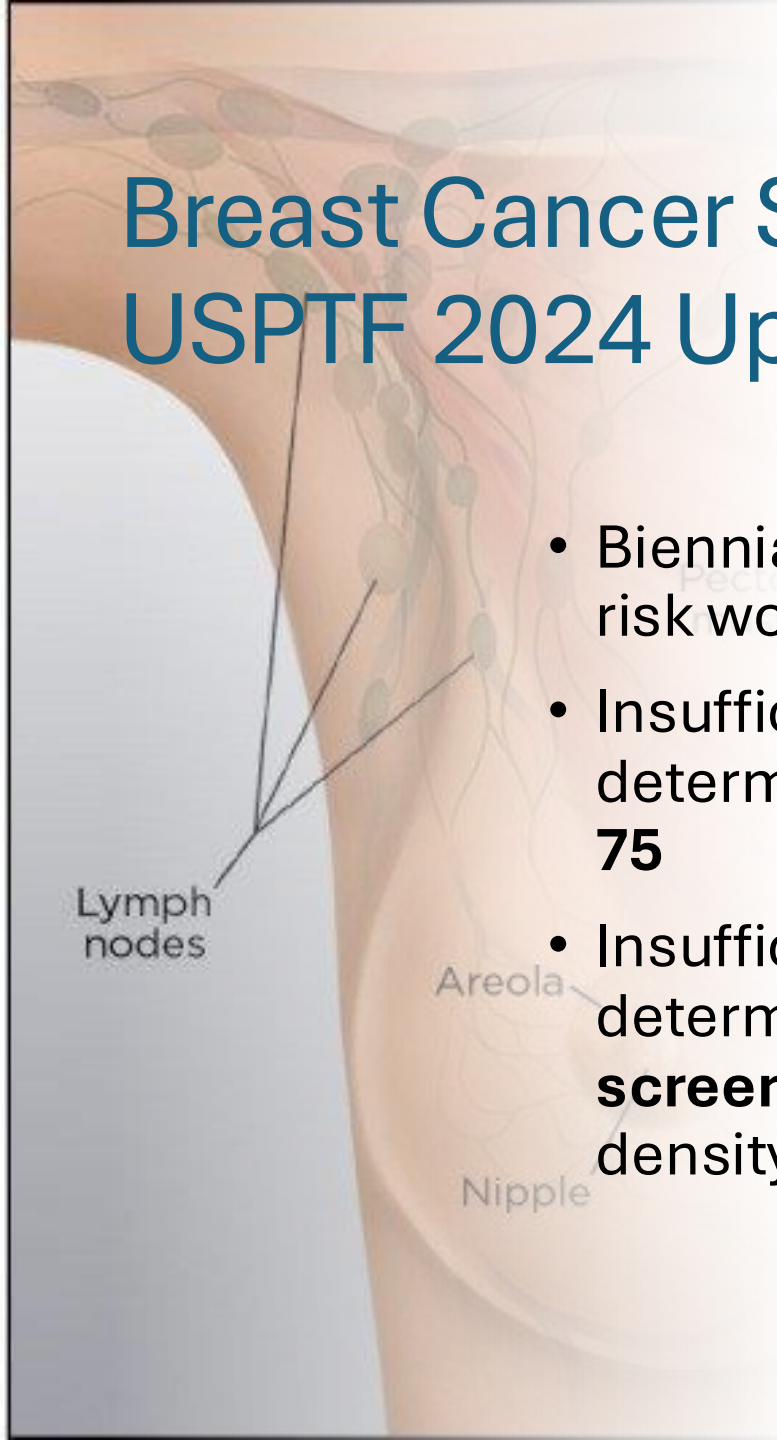
Women with a hx of Breast Ca excluded from studies

New (ish) Women's Medications

- Over the counter continuous Progesterone-only Pill “Opill” is available online and local retailers ~$20/month
- Depot medroxyprogesterone acetate (DMPA-SC) self-injected subQ is available for Rx
- Progestin-only pill: SLYND (Drospirenone/DRSP): anti-androgenic)
- Fexolinetant (Veozah): novel non-hormonal VMS treatment



Breast Cancer Screening USPTF 2024 Update



- Biennial screening for **average** risk women age **40-74** (Grade B)
- Insufficient evidence to determine screening **over age 75**
- Insufficient evidence to determine **supplemental screening** regardless of breast density

Breast Cancer Screening Question

At what age have you started your discussion about breast cancer screening with your patients?

A. I recommend women start at age 40
B. I discuss risks/benefits in their 40s and but strongly recommend by age 50
C. Whenever my EPIC metrics reminds me to talk to my patient about it!

Breast Cancer Screening 2024

- 2nd most common cancer and cancer related mortality in women
- Screen with DBT or 3D Mammography only
- Non-Hispanic white women high incidence of breast cancer*
- Black women more likely to be dx > stage 1 or triple negative; mortality highest (5 yr adjusted age 27.6 per 100000 women vs 19.7 per 100000 white women)*

*health care system disparities, sociocultural and built environments, behavioral factors, genetic factors leading to health inequities →structural racism

US Preventive Services Task Force; Nicholson WK, Silverstein M, Wong JB, Barry MJ, Chelmow D, Coker TR, Davis EM, Jaén CR, Krousel-Wood M, Lee S, Li L, Mangione CM, Rao G, Ruiz JM, Stevermer JJ, Tsevat J, Underwood SM, Wiehe S. Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 2024 Jun 11;331(22):1918-1930. doi: 10.1001/jama.2024.5534. Erratum in: JAMA. 2024 Sep 30. doi: 10.1001/jama.2024.19851. PMID: 38687503.

Breast Cancer Screening Follow-up

- Completion of appropriate and effective follow up evaluation and treatment
- Concern for harm and return to future screening after “false” positive result
- Fear, anxiety, frustration

BI-RADS Abnormal Finding Scores	Recommended Follow-Up
0 – Need additional imaging because result is incomplete/unclear	Follow-up diagnostic mammogram+/- US within a few weeks
3 – Probably benign	Diagnostic Mammogram in 6 months
4 – Suspicious abnormality	May require a breast biopsy
5 – Highly suggestive of cancer	Breast biopsy

Higher Risk Populations

- BRCA1 or BRCA2 genetic variations
- High dose RT to chest at young age
- Previous breast cancer dx/high risk breast lesion on bx
- *Increased Risk due to Family History (GAIL/IBIS models)
- *Dense breast tissue

Modifiable Risk Factors:

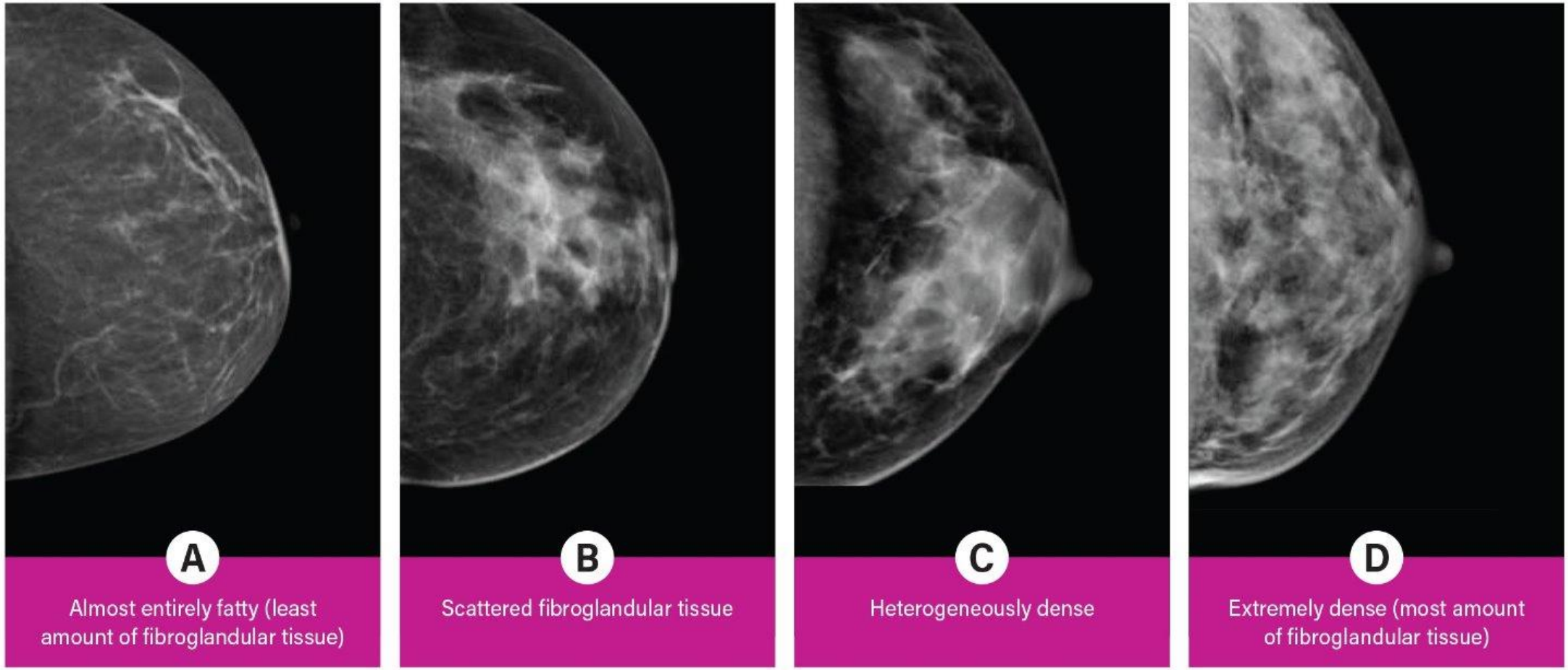
BMI, Alcohol, Tobacco, Exercise

Assess Risk: Family History of Breast Cancer

GAIL MODEL	Tyrer-Cuzick Model (IBIS)
Easily “googled”	Harder to find/download; requires clinical license
Age, Menarche, Age at First Live Birth	Age, **BMI**, Menarche, Age of First Live Birth, **Menopause status**
First Degree Relative	First and **Second Degree** Relatives
Breast Biopsy History/Results	Breast Biopsy History/Results
Race/Ethnicity-less precise for non-white women	Ethnicity and Ashkenazi Jewish Heritage
	Breast Density Report

Supplemental Cancer Screening for Women With Dense Breasts: Guidance for Health Care Professionals Vegunta, Suneela et al.Mayo Clinic Proceedings, Volume 96, Issue 11, 2891 - 2904

Breast Density Results



Dense Breast Tissue

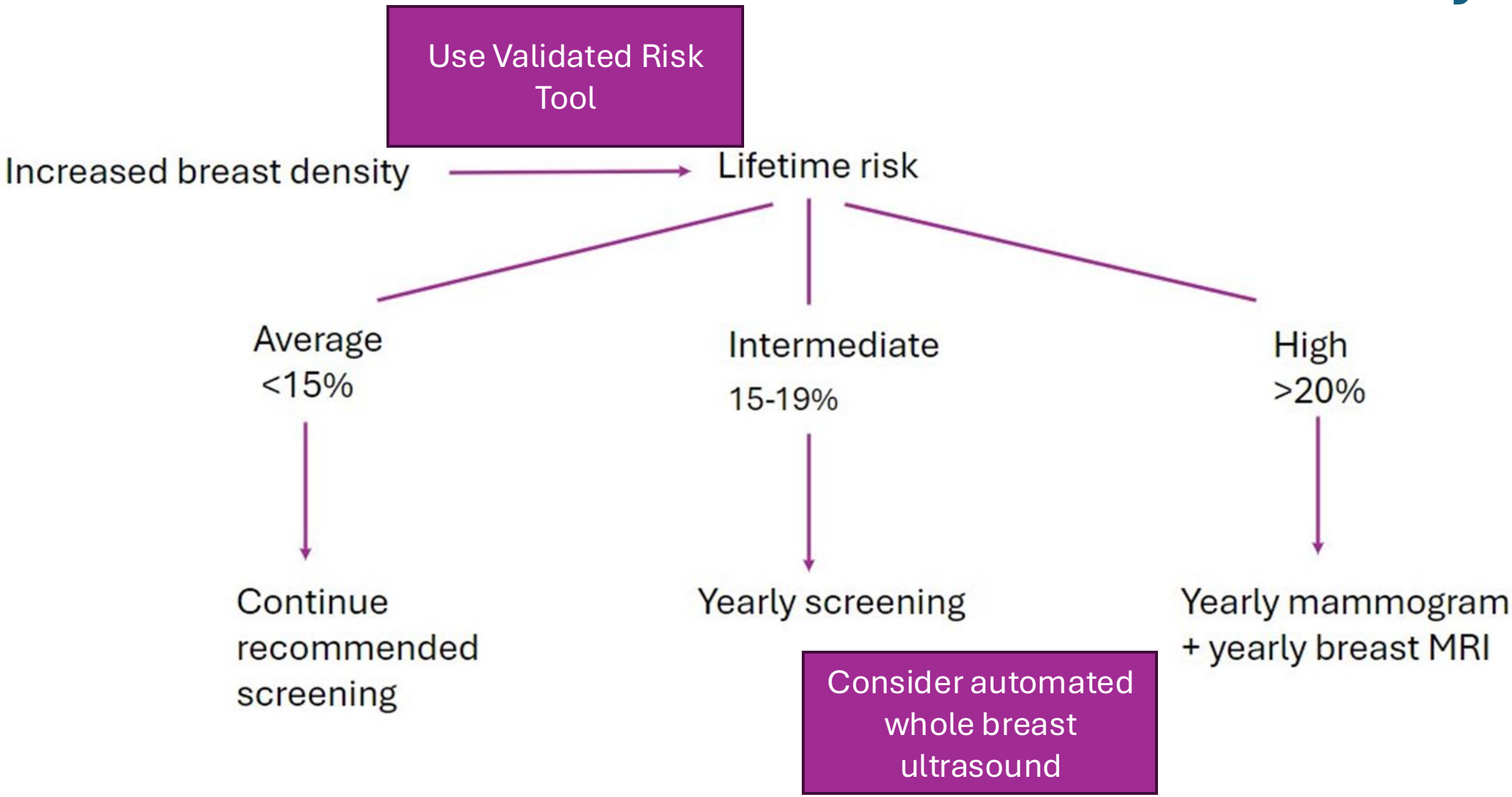
- ↑ dense tissue associated with younger age, lower BMI, alcohol consumption, BRCA changes
- Increased risk of breast cancer, but no increased risk of mortality from breast cancer
- September 2024 FDA required all mammography centers in the USA to report breast density and “increases the risk of breast cancer”

Supplemental Screening Options

	Digital Breast Tomosynthesis (DBT)	Whole Breast Ultrasound	Breast MRI
Additional CA Found per 1000 women screened	1.2-2.7 (compared to 2D)	1.8-4.6	8.2-15.9
Specificity	42-82%	69-86%	75-97%
Radiation Exposure	Yes	No	No
Advantages	Reduced Recall Rate	No radiation Accessible Reduces interval CA in dense breast tissue	Most sensitive test Reduced interval CA
Drawbacks	Sensitivity modest in extremely dense breasts Coverage variable by insurances	High recall rates Low PPV = ↑Biopsies Large # images to review	Costly Requires Contrast Laying prone MRI machine

1.Supplemental Cancer Screening for Women With Dense Breasts: Guidance for Health Care Professionals Vegunta, Suneela et al. Mayo Clinic Proceedings, Volume 96, Issue 11, 2891 – 2904
2.Stout NK, Miglioretti DL, Su Y, et al. Breast Cancer Screening Using Mammography, Digital Breast Tomosynthesis, and Magnetic Resonance Imaging by Breast Density. *JAMA Intern Med.* 2024;184(10):1222–1231. doi:10.1001/jamainternmed.2024.4224

How to counsel women with breast density



2024 Breast Cancer Screening Guidelines Summary

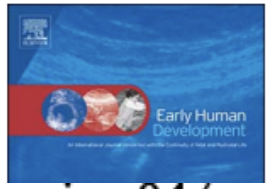
- Risk Assessment by age 30
- Age 40 → begin at least biennial screening (USPTF)
- Counsel about dense breast results
- High risk > 20% Lifetime Risk → Yearly mammogram + Breast MRI

ARGARET JACKSON PRIZE ESSAY 2014

The impact of romance novels on

Contents lists available at ScienceDirect

Early Human Development

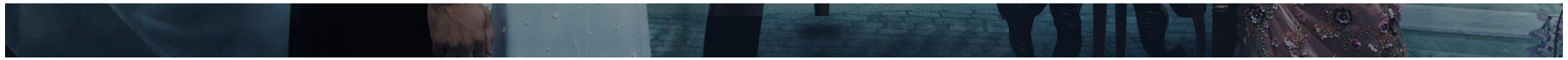


discernible spikes in total births or M/T at annual level, or circa nine months after FSOG book releases i.e. 04/2012 and 01/2013.

Discussion: The absence of spikes in births or M/T may have been due to exaggeration of the FSOG effect, it may only have provoked planned pregnancies, or modern contraception was sufficiently effective to prevent extra conceptions. The media build-up may also have stimulated a Hawthorne effect, with FSOG-affected individuals employing effective contraception. This study highlights the importance of measurement of cause and effect since anticipated results may not always ensue from events.

Victor Grech

Academic Department of Paediatrics, Mater Dei Hospital, Malta



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(https://www.sciencedirect.com/science/article/pii/S0378378217301603)

Dr Allen's Favorite Reviews/Articles

- GSM Treatment
- BMJ Article: Perimenopause Hormone Management
- Nonhormonal management of VMS in Menopause
- Supplemental Breast Cancer Screening Recs

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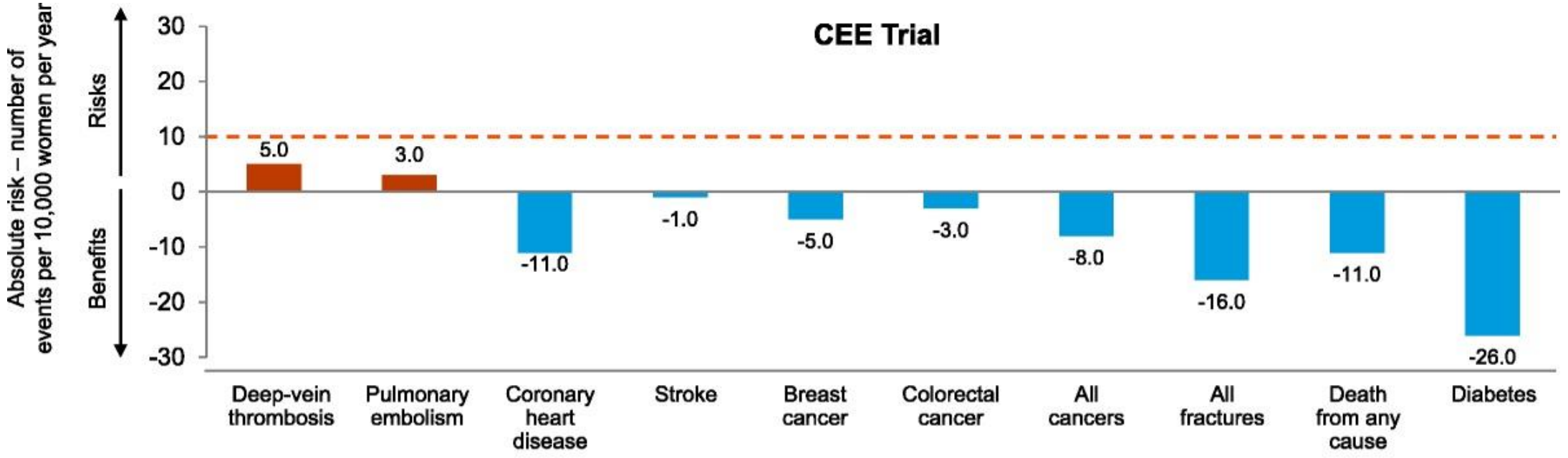

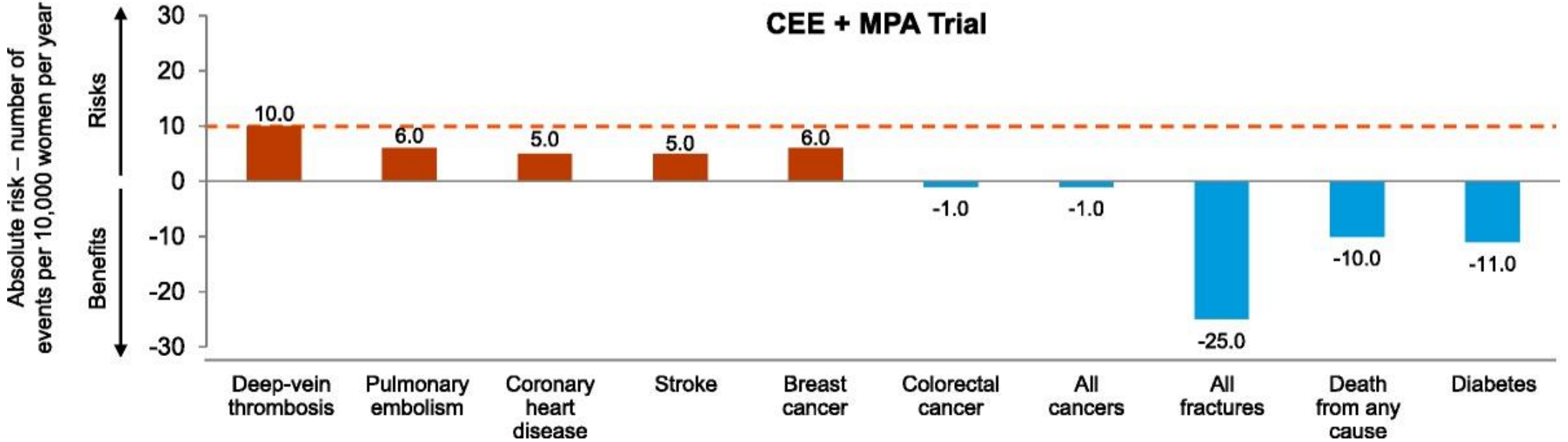

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TABLE 1

Lubricants	Moisturizers
Water based	Replens
Astroglide Liquid	Me Again
Astroglide Gel Liquid	Feminease
Astroglide	K-Y SILK-E
Good Clean Love	Luvena
Just Like Me	Revaree
K-Y Jelly	Silken Secret
Pre-Seed	Hyalo-gyn
Slippery Stuff	
Liquid Silk	
YES WB	
SYLK	
Sliquid	
Silicone based	
Astroglide X	
ID Millennium	
K-Y Intrigue	
Pink	
Pjur Eros	
Uberlube	
Sliquid	
Oil based	
Elégance Women's Lubricants	
Olive oil	
YES OB	

MENOPAUSE

The 2020 genitourinary syndrome of menopause position statement of The North American Menopause Society

Menopause27(9):976-992, September 2020.

doi: 10.1097/GME.0000000000001609

Examples of nonhormone therapeutic options for dyspareunia secondary to GSM

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TABLE 2

The 2020 genitourinary syndrome of menopause position statement of The North American Menopause Society Menopause27(9):976-992, September 2020. doi: 10.1097/GME.0000000000001609

Type	Composition	Product name	Commonly used starting dose	Commonly used maintenance dose	Typical serum estradiol level (pg/mL)
Vaginal creams	17B-estradiol 0.01% (0.1 mg active ingredient/g)	Estrace vaginal cream[a]	0.5-1 g/d for 2 wk	0.5-1 g 1-3 times/wk	Variable
	Conjugated estrogens (0.625 mg active ingredient/g)	Premarin vaginal cream	0.5-1 g/d for 2 wk	0.5-1 g 1-3 times/wk	Variable
	Estrone 0.1% (1 mg active ingredient/g)	Estragyn vaginal cream[b]		0.5-4 g/d, intended for short-term use; progestogen recommended	Variable
Vaginal inserts	17B estradiol inserts	Imvexxy[a]	4 or 10 μg/d for 2 wk	1 insert twice/wk	3.6 (4 μg) 4.6 (10 μg)
	Estradiol hemihydrate tablets	Vagifem Yuvafem	10 μg/d for 2 wk	1 tablet twice/wk	5.5
	Prasterone (DHEA) inserts	Intrarosa	6.5 mg/d	1 insert/d	5
Vaginal ring	17β estradiol	Estring	2 mg ring releases approx 7.5 μg/d	Replace ring every 90 days	8
Oral tablet	Ospemifene	Osphena[a]	60 mg/d	1 tablet by mouth/d	N/A

DHEA, dehydroepiandrosterone.
Products not marked are available in both the United States and Canada.
[a]Available in the United States but not Canada.
[b]Available in Canada but not the United States.
Estrace[89]; Premarin[90]; Estragyn[91]; Imvexxy[92]; Vagifem[93]; Yuvafem[94]; Intrarosa[95]; Estring[96]; Osphena.[97]

MENOPAUSE

Government-approved therapies for genitourinary syndrome of menopause in the United States and Canada

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