

CONTROVERSIES AND CONCLUSIONS

CASE

- 42 yr old with mild pain lower abd off and on
- MH : Reg cycles, 4-5/30, normal flow
- Clinically NAD
- USG : 1 cm fundal intramural fibroid
- Has been advised Hysterectomy
- What would you do?

OPTIONS

- 1) Do pre-op inv and post for Hysterectomy
- 2) Advise Myomectomy
- 3) Ask her to rpt USG after 6 months
- 4) Tell her that she does not need surgery

ANY THING ELSE WHICH ALL OF US ARE MISSING?

CASE



- **45 yr old, irregular, heavy periods**
- **Cycles 8-10/15-45 days**
- **USG : ET : 18 mm rest NAD**



OPTIONS

- 1) TAH
 - 2) TAH, BSO
 - 3) Vaginal Hysterectomy
 - 4) Endometrial sampling
- Pipelle, D&C, Hysteroscopy?
 - Gold Standard : Hysteroscopy
 - Outpatient Endometrial sampling adequate

- **HPE : Proliferative endometrium, no atypia**
- **Treatment ?**
- **LNG- IUS**
- **Endometrial ablation**
- **Endometrial resection**
- **Low dose OCP,New progestogens**
- **Role of Tranexmic acid**
- **Anemia correction**

Controversies



- **Primary prevention of CVD**
- **Removal of ovaries during Hysterectomy for benign Disease**
- **Long term MHT**



Approach At MT



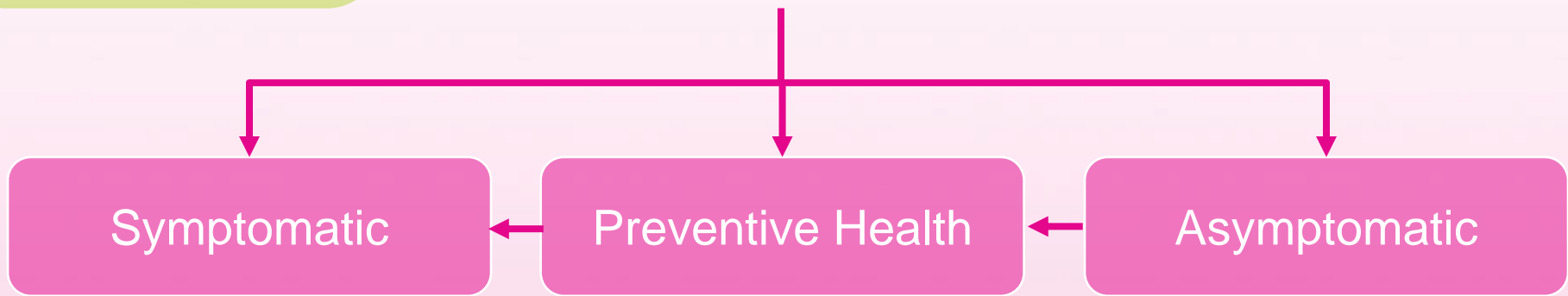
Women's perception

Menopause

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Ageing

Physician's approach



Vasomotor Symptoms(VMS)

- **Life style modifications recommended to reduce mild symptoms (GRADE A)**
- **The most effective treatment for moderate to severe symptoms is Hormone Therapy (GRADE A)**
- **Low dose oral contraceptive pills in the menopause transition phase for relief of symptoms(GRADE A)**
- **Non-hormonal prescription agents may relieve VMS but have side effects**
- **Complementary and alternative treatments should be advised with caution due to insufficient data**

Urogenital symptoms

- **Vaginal moisturizers can be offered for vaginal dryness and dyspareunia (GRADE A)**
- **Estrogen therapy (GRADE A)**
- **Lifestyle modification, bladder drill, pelvic floor exercises are recommended for urinary incontinence (GRADE B)**
- **Vaginal lubricants recommended for subjective symptom improvement of dyspareunia (GRADE C)**
- **Recurrent UTI (after ruling out all other causes) respond to ET (GRADE A).**

Osteoporosis

- **Lifestyle management :Balanced diet, adequate physical activity and exposure to sunlight, avoidance of bone depleting agents like tobacco.alcohol etc.**

The Recommended Dietary Allowance (RDA) of calcium

GROUP		CALCIUM (mg)
Adult	Men	600
	Women	600
Pregnancy		1200
Lactation		1200
Post- menopausal		800

OSTEOPOROSIS

- **Daily salt intake should not exceed 5gm (1 tsp); Protein should be 1gm/Kg body weight**
- **Decrease caffeine (< 3cups/day), limit alcohol and avoid tobacco(GRADE B)**
- **Vitamin D:**
 - **Adequate sunlight exposure**
 - **For deficiency:Cholecalciferol(Vit D 3) tablet or powder 60,000 IU/once a week for eight weeks preferably with milk**
 - **Maintenance therapy: Cholecalciferol tablet or powder 60,000 IU once or twice a month**
 - **Physical activity, prevention of falls**

Premature Menopause



- **Appropriate counseling, life style modification and hormone replacement therapy form the mainstay of treatment**
- **HT should be started as early as possible in women with POF and continued till age of natural menopause**
- **Untreated premature menopause increases risk of Osteoporosis, CVS, dementia, cognitive decline & Parkinson's**
- **Hysterectomy alone can sometimes cause early menopause**



SURGICAL MENOPAUSE



- **Routine HT is not recommended for surgical menopause in postmenopausal women as primary prevention for chronic conditions**
- **HT should be considered in women less than 50 who have undergone surgical menopause.**



HT: DURATION OF USE

Premature menopause-

- upto the natural age of menopause

Natural Menopause-

- Safety data of EPT therapy with CEE +MPA is 3-5yrs,with ET safety data for use is 7yrs with a 4 yr follow up

Stopping HT:

- May be abrupt or the dose and dosage tapered.

INDIVIDUALIZED



- **The decision to use HT must be individualized based on specific patient factors and anticipated risks and benefits.**
- **These include quality-of-life priorities, age, time since menopause, and risk for VTE, heart disease, stroke, and breast cancer**



Hormone therapy- Indications



- **3 most beneficial effect of estrogens - symptom relief, urogenital atrophy and bone**
- **The most effective treatment for vasomotor symptoms is HT(GRADE A).**
- **Progesterones or Low dose oral contraceptive pills can be used in the menopause transition phase for relief of symptoms(GRADE A)**
- **Vaginal estrogen therapy - most effective in the treatment of urogenital atrophy**

CLINICAL PRACTICE GUIDELINE ON MENOPAUSE , Executive Summary and Recommendations, Indian Menopause Society. J Mid Life Health 2013



Hormone Therapy- Indications



- **Local therapy for atrophic vaginitis : use of smallest effective dose; can be continued indefinitely, safety data do not go beyond 1 yr**
- **Vaginal estrogen can be used for Recurrent UTI after ruling out other causes (GRADE A)**
- **EPT/ET- for prevention and treatment of osteoporosis; reduces the risk of spine, hip and other osteoporotic fractures by 33-40%. (GRADE A)**
- **HT for bone protection within ten years of menopause**

CLINICAL PRACTICE GUIDELINE ON MENOPAUSE , Executive Summary and Recommendations, Indian Menopause Society. J Mid Life Health 2013



GLOBAL CONSENSUS STATEMENT ON MENOPAUSAL HORMONE THERAPY [MHT] 2013



- **MHT is the most effective treatment for vasomotor symptoms associated with menopause at any age, but benefits are more likely to outweigh risks for symptomatic women before the age of 60 years or within 10 years after menopause.**
- **MHT is effective and appropriate for the prevention of osteoporosis-related fractures in at-risk women before age 60 years or within 10 years after menopause.**

CLIMACTERIC 2013;16:203–204



HT: PRECAUTIONS



- **Pre HT work up and an annual follow up**
- **The dose and duration of HT individualized and a risk – benefit assessment carried out annually**
- **A full gynecological assessment mandatory prior to starting HT and at regular intervals thereafter**
- **Self-breast examination - monthly and clinical breast examination at least annually**
- **A mammogram [where available] -1-3 yearly if the initial mammogram is normal.(GRADE C.)**



HRT: MAXIMIZING EFFICACY, MINIMIZING PROBLEMS ESTROGENIC SIDE-EFFECTS



- **Start with low-dose estrogen in most cases**
- **1.0 mg E 2 or 0.3 mg CEE**
- **Warn re possibility of side-effects initially and reassure**
- **Consider local use of estrogens for new/persistent urogenital symptoms, e.g. vaginal dryness, even when systemic therapy has been initiated**



WHY LOWER HT DOSES?



- **Continued efficacy with fewer side-effects and possibly fewer risks**
- **Potential for greater acceptance by women**
- **Improved continuance to achieve potential long-term health benefits**
- **Efficacy in prevention of osteoporosis is not compromised**



HT CONTRAINDICATIONS

- **Current, past or suspected breast cancer**
- **Known or suspected estrogen-dependent malignant tumors (e.g. endometrial cancer)**
- **Undiagnosed genital bleeding**
- **Untreated endometrial hyperplasia**
- **Previous idiopathic or current venous thromboembolism (deep venous thrombosis, pulmonary embolism)**

Burger H, et al. Climacteric 2004;7:210–16

HT CONTRAINDICATIONS

- **Active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction)**
- **Untreated hypertension**
- **Active liver disease**
- **Known hypersensitivity to the active substances or to any of the excipients**
- **Porphyria cutanea tarda (an absolute contraindication)**

Burger H, et al. Climacteric 2004;7:210–16

CONCLUSION



- **Aim should be to help patients make informed choices**
- **Keep abreast**
- **Evaluate quality**
- **Individualise treatment**
- **Full range of effective choices**
- **Behavioral & pharmacologic approach**

