What defines the geriatric population???

GERIATRICS: definitions

* AN OLD PERSON

* A BRANCH OF MEDICINE THAT DEALS WITH THE PROBLEMS AND DISEASES OF OLD AGE AND AGING PEOPLE

AGS
THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals. Leading change, improving care for older adults.
disclosures

• Speakers bureau: Duchensay (Diclegis)
• Trainer: Merck. Nexplanon procedure

I AM OVER AGE 65

• I received my 1st AARP solicitation at age 50
• I have been carded for purchasing alcohol beyond age 60
• I have been offered ‘senior discounts’ at Younkers 😊

GERIATRIC HEALTH MAINTENANCE

★ AVERAGE LIFE EXPECTANCY AT BIRTH
★ 1900: age 47
★ 2011: age 79

★ 2030: U.S. population over age 65
★ 20% of US Population
★ >70 million people

★ Aging is a spectrum and the population is heterogeneous

★ As health care providers, we need to adjust our management for the ‘aging’ population, taking into account many variables
Expanding geriatric training

ACOG: 2007

Goals for Older Adults

- AGE alone should NOT be the sole determinant for many interventions
- Decline in Function & Loss of Independence are NOT an inevitable consequence of aging.
- All treatments should aim to preserve function & maximize quality of life
- Treatment decisions should be based on individual needs
  - FRAIL GERIATRIC PATIENT
  - ACTIVE GERIATRIC PATIENT
Goals/Objectives: geriatric gynecology

- Identify current recommendations from leading organizations for both breast and cervical cancer screening
- Identify special considerations and populations that may have alternate recommended guidelines
- Be able to identify a treatment regimen for a woman undergoing menopausal symptoms, including HT as part of the treatment regimen
- Be able to recognize and formulate management plan for the Genitourinary syndrome of menopause (vulvo vaginal atrophy) including sexual health and quality of life issues.
- Review the utilization of FRAX calculation and BMD testing in the diagnosis and management of osteoporosis
- Become familiar with “Apps” to assist with Decision Making and Treatment options for
  - Breast and Cervical Cancer Screening,
  - Menopausal and Genitourinary syndrome of menopause management; and
  - Osteoporosis screening and management

Tools to assist with gynecologic care of the aging woman [breast, cervix, menopause, sexuality, bone]

- Co-morbidities
- guidelines
- apps
- controversies
PLEASE GET OUT YOUR CELL PHONE OR ELECTRONIC DEVICE!
OPEN YOUR APP STORE!

FOCUS OF TODAY’S PRESENTATION
ISTO GIVETHOMEASY ACCESS TO
“GUIDELINES” FOR SCREENING
AND MANAGEMENT DECISIONS
IN PREVENTIVE CARE AND
TREATMENT

CANCER SCREENING

? BENEFIT OF CANCER SCREENING IN OLDER ADULTS

RISK-BENEFIT OF SCREENING

HARMS & BENEFITS OF SCREENING AND INTERVENTIONS IN OLDER ADULTS MUST BE CONSIDERED ON INDIVIDUAL BASIS

BASED ON:

REMAINING LIFE EXPECTANCY
PERSONAL VALUES AND PREFERENCES
EVIDENCE BASED ASSESSMENT
POTENTIAL HARMS: procedural complications, anxiety, cost and overdiagnosis
Breast Cancer Screening

- Begin at what age??
  - Mammogram
  - BSE
  - Breast exam

- How often should Screening occur?

- When should Screening cease?

- Whose Guidelines should one follow??

Breast Cancer Screening In Older Women

- **Consider:**
  - POTENTIAL HARMs AND BENEFITS
  - PATIENT VALUES AND PREFERENCES
  - CONFUSION OVER RECENT BREAST SCREENING GUIDELINES
Breast Cancer

- Breast cancer is the most common non–skin cancer and the second leading cause of cancer death in North American women.
- Decline since 1990
- 2014- 233,000 diagnosed with breast CA; 40,000 died from the disease in US
- Screening mammography has significantly contributed to reducing mortality
- **Controversy** over when to start and stop screening
- **Controversy** over self exam, health care provider exam, “breast self awareness”

To Mammogram Or Not To Mammogram…that is the question

- **Review & Comparison of Current Guidelines** :
  - ACOG
  - USPSTF
  - ACS
  - **NCCN**

*National Comprehensive Cancer Network*
Clinical Breast Exam

<table>
<thead>
<tr>
<th>ACOG</th>
<th>USPSTF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every 1-3 years in women ages 20-39</td>
<td>Insufficient Evidence</td>
</tr>
<tr>
<td>Annually after 40 years of age</td>
<td></td>
</tr>
</tbody>
</table>

2015 USPSTF Recommendations

- Women with a parent, sibling, or child with breast cancer may benefit more than average-risk women from beginning screening between the ages of 40 and 49 years

- The current evidence is insufficient to assess the benefits and harms of tomosynthesis (3-D mammography) as a screening modality for breast cancer. (I statement)

- Still recommending against clinicians teaching patients self breast examinations, (D recommendation), but now recommending “breast awareness” and self reporting any changes to patients’ healthcare provider
Breast “awareness”

- Defined as a woman’s awareness of the normal appearance and feel of their breasts
  - 50% of all breast cancer detected by women themselves (>age 50); 70% in women < age 50
- Breast self awareness should be encouraged and can include breast self-exam
- Endorsed by ACS & NCCN
- ACOG & NCCN recommend Provider exam and breast self awareness (starting at age 20)

ACS-2015 (average risk woman)

- Women ages 40-44 can begin annual screening mammography
- Women ages 45-54 should undergo annual screening mammography
- Women ages 55 and older can transition to every-other-year screening OR continue annual screening mammography
- Women should continue screening mammography as long as their overall health is good and they have a life expectancy of 10 years or longer
- Women at any age should not rely on breast examination for breast cancer screening
National Comprehensive Cancer Network (NCCN) [consistent with ACOG]

- **ANNUAL** SCREENING AT AGE 40 & continue until woman is within a decade of the predicted end of her life
- NCCN guidelines are more in conjunction with ACOG
- **Quote:** “At NCCN, we have a big problem with the harms analyses that have been done by both the USPSTF & ACS. That is they talk about the ‘harms of screening,’ but they don’t talk about the harms of not screening, so in a sense, they are comparing the harms of screening with no harms, but that’s clearly not the case...”
## SUMMARY

**Mammography Identifies 84% of Women Who Have Breast Cancer**

SQUEEZE A BOOB! SAVE A LIFE!

### Breast Cancer Screening for Women at Average Risk

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>40–49 years</td>
<td>Individualized decision-making based on a woman's values, preferences, and health history (C recommendation)</td>
</tr>
<tr>
<td>50–74 years</td>
<td>Mammography every 2 years (B recommendation)</td>
</tr>
<tr>
<td>≥75 years</td>
<td>More research needed; indefinite evidence of benefit (I statement)</td>
</tr>
<tr>
<td>ACS</td>
<td>Women should have the choice to start annual breast cancer screening with mammograms</td>
</tr>
<tr>
<td>40–44 years</td>
<td>Mammography every year</td>
</tr>
<tr>
<td>45–54 years</td>
<td>Mammography over 2 years or annually according to personal preference; screening can continue if the woman is in good health and is expected to live at least 10 more years</td>
</tr>
<tr>
<td>≥55 years</td>
<td>Mammography every 2 years or annually according to personal preference; screening can continue if the woman is in good health and is expected to live at least 10 more years</td>
</tr>
<tr>
<td>NCCN</td>
<td>Annual clinical breast exam and annual mammography; upper age limit for screening not established; screening can continue if the woman is in good health and is expected to live at least 10 more years</td>
</tr>
</tbody>
</table>

### Breast Cancer Screening for Women at Average Risk

<table>
<thead>
<tr>
<th></th>
<th>American Cancer Society</th>
<th>National Comprehensive Cancer Network</th>
<th>U.S. Preventive Services Task Force</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mammography</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informed decision-making with a health care provider ages 40-44</td>
<td>Informed decision-making with a health care provider ages 40-49</td>
</tr>
<tr>
<td></td>
<td>Every year starting at age 40 for as long as a woman is in good health</td>
<td>Every year starting at age 40 for as long as a woman is in good health</td>
<td>Every year starting at age 40 for as long as a woman is in good health</td>
</tr>
<tr>
<td></td>
<td>Every 2 years or every year if a woman chooses to do so starting at age 55 for as long as a woman is in good health</td>
<td>Every 2 years or every year if a woman chooses to do so starting at age 55 for as long as a woman is in good health</td>
<td>Every 2 years or every year if a woman chooses to do so starting at age 55 for as long as a woman is in good health</td>
</tr>
<tr>
<td><strong>Clinical Breast Exam</strong></td>
<td>Not recommended</td>
<td>Every 1-3 years ages 25-39</td>
<td>Not enough evidence to recommend for or against</td>
</tr>
<tr>
<td></td>
<td>Every year starting at age 40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Women at higher risk may need to get screened earlier and more frequently than recommended here. Find more on screening.*
## WEIGHING THE BENEFITS & RISKS OF MAMMOGRAPHY

### Results among 1,000 women who get a mammogram (estimates for a single screening)

<table>
<thead>
<tr>
<th>Age</th>
<th>False positive result</th>
<th>Need a biopsy</th>
<th>Diagnosis of DCIS or invasive breast cancer</th>
<th>Number of women needed to be screened with mammography to prevent one breast cancer death</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 to 49 years</td>
<td>98</td>
<td>9</td>
<td>3</td>
<td>1,904</td>
</tr>
<tr>
<td>50 to 59 years</td>
<td>87</td>
<td>11</td>
<td>5</td>
<td>1,339</td>
</tr>
<tr>
<td>60 to 69 years</td>
<td>79</td>
<td>12</td>
<td>7</td>
<td>377</td>
</tr>
<tr>
<td>70 to 79 years</td>
<td>69</td>
<td>12</td>
<td>8</td>
<td>Not available</td>
</tr>
<tr>
<td>80 to 89 years</td>
<td>59</td>
<td>11</td>
<td>2</td>
<td>Not available</td>
</tr>
</tbody>
</table>

Adapted from U.S. Preventive Services Task Force, 2009 [13].

### Screening Modalities

<table>
<thead>
<tr>
<th>Screening Modality</th>
<th>AMERICAN CANCER SOCIETY</th>
<th>AMERICAN COLLEGE OF OBSTETRICIANS and GYNECOLOGISTS</th>
<th>U.S. PREVENTIVE SERVICES TASK FORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Self Exam</td>
<td>Recommends against self breast exam, but encourages breast self awareness</td>
<td>Breast Self Awareness encouraged</td>
<td>Recommends against</td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
<td>Recommends against clinical exam at any age</td>
<td>Every one to three years from 20 to 39 years of age and annually thereafter</td>
<td>Insufficient evidence to support clinical breast exams.</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging</td>
<td>Offer annually to women at high risk</td>
<td>Offer annually to women at high risk</td>
<td>Insufficient evidence to support clinical breast exams.</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Routine annual screening beginning at 45 years of age until age 54. And biennial screening for women 55 years or older if they have a life expectancy greater than 10 years</td>
<td>Routine annual screening beginning at 40 years of age</td>
<td>Routine biennial screening for women 50 to 74 years of age</td>
</tr>
</tbody>
</table>

### COMPARISON
COMPARISON
Recommendations for Breast Cancer Screening for Average-Risk Women Differ Among Guidelines

<table>
<thead>
<tr>
<th>ACS</th>
<th>USPSTF (DRAFT)</th>
<th>NCCN</th>
<th>NICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 45-54y: recommends annual screening mammography</td>
<td>Age 40-49y: the decision to start screening mammography should be an individual one [Grade C]</td>
<td>Age 25-39y: recommends clinical breast examination every 1-3y</td>
<td>Age 50-70y: invited for screening mammography</td>
</tr>
<tr>
<td>Age ≥55y: recommends biennial screening mammography as long as women’s overall health is good with life expectancy &gt; 10y</td>
<td>Age 50-74y: recommends biennial screening mammography [Grade B]</td>
<td>Age ≥40y: recommends annual clinical breast exam. annual screening mammography</td>
<td></td>
</tr>
<tr>
<td>Clinical breast examination is not recommended</td>
<td>Age ≥75y: concludes insufficient evidence to assess benefits and harms of screening [Grade I]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


4. NICE. Early and Locally Advanced Breast Cancer: Diagnosis and Treatment. Published February 2009. Last Reviewed April 2012. Available at: http://www.nice.org.uk/guidance/cg159

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MORE CONTROVERSY

∗ DOES 3D DIGITAL MAMMOGRAPHY IMPROVE DIAGNOSTICS?
### Current Guidelines- 3D Mammography: digital with tomosynthesis

<table>
<thead>
<tr>
<th>ACOG</th>
<th>USPSTF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further study will be necessary to confirm whether <strong>digital mammography with tomosynthesis</strong> is a cost-effective approach capable of replacing digital mammography alone as the first-line screening modality of choice for breast cancer screening.</td>
<td>• 2015 statement does include a statement of insufficient evidence</td>
</tr>
</tbody>
</table>

### RISK ASSESSMENT:

**HOW CAN YOU ENHANCE BREAST CANCER RISK SCREENING?**
Breast Cancer Risk Assessment B.C.R.A

Open iTunes to buy and download apps.

9 QUESTIONS

Does the woman have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS)?

Men < 35

What is the woman’s age?
This tool only calculates risk for women 35 years of age or older.

Men ≤ 35

What was the woman’s age at the time of her first menstrual period?

Men 7 to 11

What was the woman’s age at the time of her first live birth of a child?

Men ≤ 20

How many of the woman’s first-degree relatives - mother, sisters, daughters - have had breast cancer?

5 Year Risk
This woman (age 34): 0.0%
Average woman (age 34): 0.3%

Based on the information provided, the woman’s estimated risk for developing invasive breast cancer over the next 5 years is 0.0% compared to a risk of 0.3% for a woman of the same age and race/ethnicity from the general U.S. population. This calculation also means that the woman’s risk of NOT getting breast cancer over the next 5 years is 99.5%.

Lifetime Risk
This woman (to age 90): 19.9%
Average woman (to age 90): 20.0%

Based on the information provided, the woman’s estimated risk for developing invasive breast cancer over her lifetime (to age 90) is 19.9% compared to a risk of 20.0% for a woman of the same age and race/ethnicity from the general U.S. population.
Cervical Cancer

- Malignancy arising from uterine cervix
- 80% squamous type
- 20% adeno type
- Staging - clinical evaluation
- Management - staging and bulk
Cervical Cancer

- U.S. Death rate has declined by 74% in the past 50 years
- 4% decline every year continues
- Average age of diagnosis is 50
- Precursor lesion precedes invasive carcinoma by 10 years, but can be quicker in some

Screening for Cervical CA

- Age related frequency of screening
- Cytology or HPV (or both)???
- When to stop screening
- Management guidelines
### 2016 GUIDELINES

#### Cervical Cancer Screening

**Table 1. Screening Methods for Cervical Cancer for the General Population: Joint Recommendations of the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology**

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommended Screening Method</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women younger than 21 years</td>
<td>No screening</td>
<td></td>
</tr>
<tr>
<td>Women aged 21–29 years</td>
<td>Cytology alone every 3 years</td>
<td></td>
</tr>
<tr>
<td>Women aged 30–65 years</td>
<td>Human papillomavirus and cytology cotesting (preferred) every 3 years</td>
<td>Screening by HPV testing alone is not recommended*</td>
</tr>
<tr>
<td></td>
<td>Cytology alone (acceptable) every 3 years</td>
<td></td>
</tr>
<tr>
<td>Women older than 65 years</td>
<td>No screening is necessary after adequate negative prior screening results</td>
<td>Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should continue routine age-based screening for a total of 20 years after spontaneous regression or appropriate management of CIN 2, CIN 3, or adenocarcinoma in situ</td>
</tr>
<tr>
<td>Women who underwent total hysterectomy</td>
<td>No screening is necessary</td>
<td>Applies to women without a cervix and without a history of CIN 2, CIN 3, adenocarcinoma in situ, or cancer in the past 20 years</td>
</tr>
<tr>
<td>Women vaccinated against HPV</td>
<td>Follow age-specific recommendations (same as unvaccinated women)</td>
<td></td>
</tr>
</tbody>
</table>

#### Case: 45 year old female, average risk

- Patient at age 45, decides to have testing every 5 years with HPV testing
- At age 50, she has a pap smear with ASCUS, HPV NEGATIVE
- What would you suggest now?
She should have repeat co-testing in 3 years

If she had been HPV positive – colposcopy

Everything else – Proceed to colposcopy:
  - LGSIL/HGSIL
  - ASC-H
  - AGUS
Case (She’s Diligent)

☆ Your patient is now 65 and wants to discuss stopping pap smears
☆ She has not had an abnormal pap smear since her one at 45
☆ How would you counsel her?

Cervical Cancer Screening

• ACOG Guidelines (SAME AS ASCCP)
• Cervical Cancer Screening should start at age 21

• Cytology alone for women between 21-29 years of age, once every 3 years

• Cytology + HPV co-testing every 5 years is preferred for women ages 30-65; alternative is cytology alone every 3 years (acceptable); HPV testing alone is not recommended (BUT IS ACCEPTABLE, FDA APPROVED)
Cervical Cancer Screening-
When to Stop

* Women may consider stopping screening at age 65, IF
  * no history of neoplasia, adenocarcinoma or cancer
  * either 3 consecutive negative pap tests or 2 consecutive negative co-tests within the last 10 years (most recent within last 5 years)
  * She may discontinue pap tests at this time based on criteria - this does NOT guarantee she won’t develop cervical cancer

Women aged 65 and older*:

*Continue to offer screening* for cervical cancer to women with a good life expectancy who have risk factors for cervical cancer
  * a history of an abnormal Pap test
  * current smoker or history of smoking,
  * unknown prior Pap test history,
  * previous HPV-related disease
  * new partners beyond age 65 years
    *ASCCP says NO PAP after age 65*
  * (generally until about age 80, but the upper limit of offering screening may vary with the risk factor).

*from UP TO DATE: Literature review current through: Apr 2016.
This topic last updated: Apr 04, 2016.
STOP SCREENING AT AGE 65

- SCREENING “SHOULD NOT RESUME FOR ANY REASON, EVEN IF A WOMAN REPORTS HAVING A NEW SEXUAL PARTNER”

ASCCP, 2012

Rationale for stopping at 65 years

- CIN 2+ is rare after age 65
  - Most abnormal screens, even HPV +, are false + and do not reflect precancer
- HPV risk remains 5-10%
- Colposcopy/biopsy/treatment more difficult
  - Harms are magnified
- Incident HPV infection unlikely to lead to cancer within remaining lifetime

ASCCP, 2012
Special Circumstances

- Screening in a patient who has had a total hysterectomy (uterus and cervix)
- No screening is necessary if
  - no cervix AND
  - no history of CIN 2 or 3, adenocarcinoma in situ, or cancer in the past 20 years

Special Circumstances

If a patient has received the **HPV vaccination**, they should still follow **recommended guidelines** (same as unvaccinated women)
Abnormal Pap Results

- **Age 25-29**
  - HGSIL, ASC-H, AGUS- Colposcopy

- **Age 30-65**
  - ASCUS
    - HPV positive- colposcopy
    - HPV negative- repeat co-testing in 3 years
  - LGSIL, HGSIL, ASC-H, AGUS- all Colposcopy

2016 GUIDELINES
Cervical Cancer Screening

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<td>hysterectomy</td>
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<td>Women vaccinated against HPV</td>
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</tr>
<tr>
<td></td>
<td>recommendations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(same as unvaccinated women)</td>
<td></td>
</tr>
</tbody>
</table>
MANAGEMENT OF CERVICAL CANCER SCREENING RESULTS

<table>
<thead>
<tr>
<th>Screening Method</th>
<th>Result</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytology screening alone</td>
<td>Cytology negative</td>
<td>Screen again in 3 years</td>
</tr>
<tr>
<td></td>
<td>ASC-US cytology and reflex HPV negative</td>
<td>Cotest in 3 years</td>
</tr>
<tr>
<td></td>
<td>All others</td>
<td>Refer to ASCCP guidelines*</td>
</tr>
<tr>
<td>Cotesting</td>
<td>Cytology negative, HPV negative</td>
<td>Screen again in 5 years</td>
</tr>
<tr>
<td></td>
<td>ASC-US cytology, HPV negative</td>
<td>Screen again in 3 years</td>
</tr>
<tr>
<td></td>
<td>Cytology negative, HPV positive</td>
<td>Option 1: 12-month follow-up with cotesting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 2: Test for HPV-16 or HPV-18 genotypes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* If positive results from test for HPV-16 or HPV-18,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>referral for colposcopy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* If negative results from test for HPV-16 and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HPV-18, 12-month follow-up with cotesting</td>
</tr>
<tr>
<td></td>
<td>All others</td>
<td>Refer to ASCCP guidelines*</td>
</tr>
</tbody>
</table>

What is the role for Cervical cancer screening with HPV testing alone?

- Approved for women \textgreater \text{age 25}
- Alternative to current cytology-based cervical cancer screening methods
- If negative, repeat 3 years
- + results, should be triaged with genotyping for 16-18, and if neg. , cytology screening
- If positive for 16-18, colposcopy
- If genotype and cytology neg, repeat test 1 year
MOBILE APP: GUIDELINES
MANAGEMENT OF MENOPAUSAL ISSUES

VASOMOTOR SYMPTOMS
GENITOURINARY SYNDROME OF MENOPAUSE (GSM)
[VULVOVAGINAL ATROPHY (VVA), SEXUAL DYSFUNCTION]
BONE HEALTH/OSTEOPOROSIS

Hormone (Replacement) Therapy

HT = E + P
ET = E ONLY
Case

* A 53 year-old woman comes to your office to discuss difficulty with sleep.
* LMP: 18-24 months ago
* During your history gathering, you note that she states she ‘sweats constantly’ at night and this is the primary cause for her insomnia.
* You suspect she is suffering from vasomotor symptoms related to menopause.
* How might you approach helping her?

* Based on ACOG guidelines:
  * You might discuss using systemic hormone therapy
    * E: ORAL, VAGINAL, TRANSDERMAL (ESTRADIOL, CONJUGATED)
    * P: ORAL (MEDROXYPROGESTERONE, NORETHINDRONE, MICRONIZED)
    * E+P: ORAL, TRANSDERMAL
    * E + BAZEDOXIFENE
  * If she has a uterus, should use Progestin with any systemic Estrogen therapy
    * Progestin can be PO, or Levonorgestrel IUD
  * Avoid estrogen in women with:
    * History of (or active) thromboembolic disease
    * Factor V Leiden (most common thrombophilia)
    * History of (or active) breast cancer
Case (Continued)---oh, by the way

* In discussing with her, you identify she has had a stroke and a heart attack.
* She is worried about taking any sort of estrogen, because her cardiologist told her to avoid it.
* How might this change your approach?

* **Non-hormonal alternatives** which benefit in relieving **vasomotor symptoms**:
  * SNRIs,
  * SSRIs (paroxetine)
  * Clonidine
  * Gabapentin
  * HERBAL REMEDIES----data no better than placebo

* These can be used without risk for the mentioned medical conditions

* **Lifestyle solutions** may also help
  * Layered clothing
  * Lower room temperature
  * Consume cool drinks
Case #4 (Here It Comes…)

As you discuss these options, she also says she has had ‘other issues’.
She admits to having significant pain with vaginal intercourse due to feeling dry ‘down under’ and a sensation of burning.
She asks if the medications you mentioned might help with this, as she thinks it is related to her menopause.
What might you suggest?

For vaginal dryness, lubricants (water or silicone-based) may relieve pain associated with sex

Local (topical) estrogen therapy
- Cream (conjugated Estrogens or Estradiol)
- Vaginal tablet (Vagifem)
- Estrogen ring (Estring)
  - May be used only for atrophic findings/vaginal symptoms (no help with vasomotor symptoms or bone health)

Ospemifene* is approved to treat dyspareunia
- *Is a SERM (ESTROGEN AGONIST in the vagina; no estrogenic activity on the endometrium or breast)
- May have increase in Hot Flushes, and potentially in thrombosis
Menopause

• Hot flushes affect 50 -80% of women in the US who experience natural menopause
  • Of those that have hot flushes, **87% suffer on a daily basis**
  • 33% report greater than 10 episodes daily
  • Median duration is 4-10 years for vasomotor symptoms
  • **May extend well into the 60-70+ year old group**
  • 10-40% report **vaginal atrophy**

Menopause—**questions & controversies**

✶ What is the most effective treatment for vasomotor symptoms?
✶ Who can take Hormone Therapy?
✶ How long can I take HT safely?
✷ What about bioidential hormone therapy?
✷ What are benefits?
✷ What are risks?
✷ What is “evidence based”?
✷ What is evidence for Non-Hormonal Options?
✷ What are options for GSM (genitourinary symptoms of menopause)?
SUMMARY: Recommendations, Benefits & Indications for HT

- **Vasomotor symptoms** associated with menopause at any age
  - Benefits outweigh risks before age 60 (or within 10 years of menopause)
  - ET decreases CHD in woman <60
  - HT ‘may’ decrease CHD in women < 60
- Local ET is preferred for symptoms of **GU syndrome of menopause** (*atrophic vaginitis*)
- **Prevention of Osteoporosis** related fractures

*Global Consensus Statement on Menopausal Therapy, 2013, International Menopause Society*

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SUMMARY: Recommendations, Benefits & Indications for HT

- ET is appropriate after Hysterectomy
- HT (E&P) appropriate if uterus is present
- Risk of VTE increases with HT, but absolute risk is rare at <age 60 (may be lower risk with transdermal therapy)
- Risk of Breast Cancer is complex issue (ET, or HT)
- Option of HT is an individual decision
  - QOL, Health Priorities
  - **Personal Risk factors**: age, time since menopause, risk of VTE, Stroke, Ischemic Heart Disease, Breast Ca

*Global Consensus Statement on Menopausal Therapy, 2013, International Menopause Society*
SUMMARY: Recommendations, Benefits & Indications for HT

- In women with premature ovarian insufficiency, HT is recommended at least until the average of natural menopause
- The use of custom-compounded bioidentical HT is not recommended (nor is blood E or salivary testing)
  - Lack of regulation, rigorous safety and efficacy testing, batch standardization, and purity measures.
- Current safety data do not support the use of HT in breast cancer survivors

*Global Consensus Statement on Menopausal Therapy, 2013, International Menopause Society*

What about women aged 65 and older?

**NAMS** (north american menopause society):

- Provided that the woman is aware of the risks and has clinical supervision, extending HT use is acceptable under certain circumstances, including
  - For the woman who has determined that Benefits>Risks
  - For the woman at high risk of fracture for whom alternative therapies not appropriate
- **INDIVIDUALIZE THERAPY**

*North American Menopause Society: WWW.MENOPAUSE.ORG*
Hormone Therapy


- **NAMS:** (free online): [www.menopause.org](http://www.menopause.org)
  - Position statements/recommendations on:
    - non hormonal therapy
    - hormone therapy
    - Genitourinary syndrome of menopause: (vulvovaginal atrophy)
    - osteoporosis
    - Calcium in peri- & postmenopausal women
    - HT after age 65

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**MenoPro Mobile App**

- **MenoPro** is a free mobile app from The North American Menopause Society (NAMS) to help clinicians and women work together to personalize treatment decisions based on a woman’s personal preferences (hormonal vs nonhormonal options), taking into account her medical history and risk factor status. The app has two modes, one for clinicians and one for women, to facilitate shared decision making. **MenoPro** is available for **iOS** (iPhone, iPad) and **Android** devices.

- The **MenoPro** app has several unique features, including the **ability to calculate a woman’s 10-year cardiovascular disease risk score**, which can be incorporated into clinical decision making. It also has links to the **Gail breast cancer assessment tool** and to the **FRAX® fracture risk assessment tool**.

**aids decision making process and treatment options**
HT: summary

- **Level A "good or consistent scientific evidence":**
  - Systemic HT, with just estrogen or estrogen plus progestin, is the most effective approach for treating vasomotor symptoms.
  - Low-dose and ultra-low systemic doses of estrogen have a more favorable adverse effect profile than standard doses.
  - Healthcare providers should individualize care and use the lowest effective dose for the shortest duration.
  - Thromboembolic disease and breast cancer are risks for combined systemic HT.

HT alternatives

- Selective serotonin reuptake inhibitors, selective serotonin and norepinephrine reuptake inhibitors, clonidine, and gabapentin relieve vasomotor symptoms and are **alternatives to HT**.
- **Local estrogen therapy** is advised for isolated atrophic vaginal symptoms.
- The only non-hormonal therapy approved to treat vasomotor symptoms is **paroxetine**, and to treat dyspareunia is **ospemifene**.
HT

Level B conclusions "limited or inconsistent scientific evidence":

• Data do not support use of progestin alone, testosterone, compounded bio-identical hormones, phytoestrogens, herbal supplements, and lifestyle modifications.

• "Common sense lifestyle solutions" are layering clothing, lowering room temperature, and consuming cool drinks.

• Non-estrogen water-based or silicone-based lubricants and moisturizers may alleviate pain.

Osteoporosis
Screening for Osteoporosis

- Who should be screened?
- At what age?
- How often?
- Risk Factor assessment

ALL POSTMENOPAUSAL WOMEN (& men)

> Age 50 should be evaluated for osteoporosis risk in order to determine the need for BMD testing and/or vertebral imaging

FRAX: Tool for Risk Assessment

* Developed for the Primary Care Physician, with or without BMD testing. FRAX integrates clinical risk factors and BMD at the femoral neck to calculate a ten-year fracture probability (HIP or Any major osteoporotic fracture)

* Best used for women > age 40 or postmenopausal in women with risk factors for osteoporosis
FRAX Algorithm

www.nof.org
http://www.shef.ac.uk/frax/

Osteoporosis Risk Factors

- Low bone mineral density (BMD)
- Previous (low trauma) Fracture
- Advanced age & genetics
- Low calcium and vitamin D intake
- Thinness (< 127#, BMI < 21))
- Menopause status
- Cigarette smoking (primary or secondary)
- Excess Alcohol intake
- Long term glucocorticoid therapy
- Sedentary activity
WHO Fracture Risk Assessment Tool (FRAX®) offers the medical practitioner an easy-to-use tool to calculate an individual patient’s 10-year probability of an osteoporotic fracture. Osteoporosis management guidelines around the world now increasingly recommend that fracture risk assessment be part of any clinical evaluation to help inform treatment decisions.

FRAX CALCULATION
BMD Testing *(for whom?)*

Recommend BMD testing for:

- All women age 65 and over
- Postmenopausal women with medical causes of bone loss
- Postmenopausal women age 50 and over with additional risk factors
- Postmenopausal women with a fragility fracture
How often should a DXA scan be repeated in a woman older than 65 years who does Not have osteoporosis?

LOW BONE MASS---FRAX

* IF LOW RISK FOR FRACTURE, screening interval of:
  * 15 years: normal BMD or T score ≥ -1.5
  * 5 year interval: T score -1.5 to -1.99
  * 1 year interval: T score -2.0—2.49

The FRAX should continue to be used on an annual basis to monitor the important effect of age on fracture risk
REFERENCES

Clinician’s Guide App

NOF’s 2013 Clinician’s Guide is now available as an app.

Download today to access the latest clinical decision making information right from your iPhone and iPad.

Our goal

[Image of a senior person exercising]
THANK YOU

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