Menopause Update:
Focus on
Hot Flashes, Atrophic Vaginitis

R. Mimi Secor, DNP, FNP-BC, NCMP, FAANP

Onset, Massachusetts

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Mimi Secor, DNP, FNP-BC, NCMP, FAANP

- NP 39 years
- Just Us Women, Attleboro, Massachusetts
- National Speaker, Consultant
- DNP August, 2015, Rocky Mountain University, Provo, Utah
- National Certified Menopause Practitioner, (NCMP), from NAMS
- 2013 Lifetime Achievement Award, MCNP/ Massachusetts NP Association

- Coauthor, 2014, Advanced Health Assessment of Women: Skills & Procedures, AJN Book of the Year 2015- honorable mention
- Coauthor, Fast Facts: The Gyn Exam for NPs, 2012, Springer

- President Emerita, Senior Advisor, NPACE
- Fellow in the AANP
- Visiting Scholar at Boston College
- Worked in Alaska for 7 years (1992-1999)
- Owned private practice for 12 years in Cambridge, MA. (1984-1996)

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Presenter Disclosure Information

Menopause Update:
Focus on
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- **I will NOT discuss off label use or investigational use in my presentation:**

- **I HAVE financial relationships to disclose:**

Honoraria from: GenPath, Shionogi, Hologic

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Menopause Update: Objectives

- Describe epidemiology of menopause, Vasomotor Symptoms (VMS) and Vulvovaginal Atrophy (VVA)
  15 mins
- Discuss diagnosis of VMS and Vulvovaginal Atrophy
  45 mins
- Explain options for treatment of VMS and VVA
  30 mins

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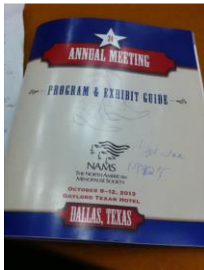
Attended NAMs on a Pfizer DNP Scholarship: North American Menopause Society: 2013



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Menopause Diagnosis 52 Million in 2010: 6,000 day

- Average age 50-52 years
- 12 months since FMP (final menstrual period)
- NO labs needed
- FSH over 30 mIU/m
  - I week off CHC*, or 1 month if inconclusive
- Estradiol < 20 pg/ml
- Vasomotor symptoms
- Contraception x 12 months after FMP!!!

*CHC/ combination contraceptive contraceptive

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Vasomotor Symptoms (VMS) Epidemiology: COMMON

- **75% of perimenopausal** women experience these
- Caused by fluctuations in hormones
- BUT exact mechanism unclear

- **Duration** x 6 months- 2 years, **up to 5-12+ years !!!**
- 10-25% C/o severe symptoms
- Ethnic variation: African American 46%, Japanese 18%

- **Surgical menopause** = **More severe symptoms**

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VMS: Non-Pharmacologic

- Dress in layers
- Cool bedroom, chilling pillows, sheets
- Healthy body weight
- Avoid smoking
  - Increases estrogen metabolism incr. VMS
- Avoid triggers: (personal)
  - hot drinks, caffeine, spicy foods, ETOH, emotional reactions!

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VMS: Non-Pharmacologic Self-Care: Variable Efficacy

- Paced respirations - effective
- Exercise
- Yoga
- Acupuncture
- Massage
- Other self-care options

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VMS: Over-the-counter? Non-prescription, Herbals, Etc.

- Isoflavones (Soy): modestly effective
- Black Cohosh: NOT effective
  (Remifemin): Studies pending
- Progesterone cream: OTC, unclear efficacy, safety, esp. endometrial effects
  (poorly absorbed transdermally)

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Estrogen for VMS? Per NAMS

- Benefits of HT/ET
  more likely to outweigh risks
  for symptomatic women
  before the age of 60 years (occult CVD)
  or
- within 10 years after menopause

NAMS, 2014

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HT* for VMS: Risk per NAMS 2013

- **Incr. Risk of VTE** & Ischemic **Stroke** with **Oral HT**
  but absolute **risk is rare** < 60 years.
- **Dose, duration**
  - consistent with treatment goals &
  - safety issues &
  - should be individualized
- S**hortest period of time, lowest dose**.

*Hormone therapy = Estrogen, Progesterone/progestin

NAMS. (2012). Position statement: The 2012 HT position statement of the North American Menopause Society. *Menopause, 19* (2), 258-271.

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HT for VMS: Risk Breast Cancer

- R**isk** >50 years associated with HT is a **complex** issue!!!
- Increased risk is primarily associated w/ addition of **progestogen (MPA)** to estrogen therapy and **duration** of use
- The **risk is small** and **decreases after treatment is stopped**
- **No increase** seen in **Estrogen-only** arm (CEE) of WHI study up to 7.1 years
  (Anderson et al. (2012). *Lancet Oncol, 13* (5), 476-486).
- **Increase with EPT (estrogen/progestin) group after 3-5 years**
  (NAMS position statement, 2012)

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VMS Treatment Options

Hormonal	**Non-Hormonal**
•Estrogen	•Non-estrogen

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VMS: Treatments Systemic Estrogen for VMS

- Systemic estrogen; Oral, Vaginal, Transdermal
- Estrogen (versus non-estrogen)
- Very effective
- Safe in early peri, post-menopause
- Less safe age 70 and over
- Less safe as BMI increases
- Lowest dose for the shortest duration

Per NAMS, www.menopause.org

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VMS: Treatments- Estrogen Systemic for VMS

- **Oral**:
  Estrogen (Premarin, Estrace) 0.625-0.4, 0.3 mg
  Progesterone (Prometrium) 100-200 mg @hs
- **Transdermal**: safer per Observational studies
  Steady blood levels, lower dose,
  wt gain & libido neutral
  Estradiol Patch (Vivelle, Climara, etc.)
  Estradiol Gel (Estragel, DiviGel (3 doses), etc.)
  Estradiol Spray (Evamist) 1-3 sprays to forearm in AM
- **Ring:** Estradiol (FemRing) every 3 months

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Plenary Symposium: NAMS Convention Bioidentical Hormones, What are the Issues?

- Compounded vs FDA Approved:

Compounded: Lack of research
- Safety, Efficacy, Dosing: UNCLEAR

FDA approved: Robust literature
  Estradiol (Estrace)
  Progesterone (Prometrium)

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Bioidentical Hormones: FDA Approved Options

Pharmaceutical, FDA approved:
- Estradiol: Oral, transdermal, vaginal
- Progesterone: Oral

Non-Pharmaceutical, NOT FDA approved: CAUTION
- Compounded estrogen, progesterone, testosterone
- Progesterone cream: over-the-counter

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3 New Medications: FDA Approved

- **Paroxotine (Brisdelle)**: (7.5 mg): First non-hormonal treatment (SSRI) for moderate to severe hot flashes associated with menopause
- **Conjugated Equine Estrogen/Bazedoxifene (DuaVee)**: Combination estrogen/SERM for moderate to severe hot flashes associated with menopause
- **Ospemifene (Osphena)**: Non-estrogen (SERM) to treat moderate to severe dyspareunia due to vaginal changes that occur with menopause

Paroxitene* (Brisdelle) Low Dose

- Approved by the FDA for VMS/ hot flashes
- Dosing 7.5 mg PO daily
- **Effective, safe, few side effects**
- **Alternative if estrogen** contraindicated
- Possible **reduced anxiety**
- **Avoid** with patients who are on **Tamoxifen**
  - Potential for interaction w/ cytochrome P-450 2D6 inhibitors

***Paxil (brand name)**

Non-Hormonal Options for Managing Vasomotor Flushes: SSRIs, SNRIs: Off-label

- **Venlafexine (Effexor XR)** 37.5 mg a day-titrate as needed; Average dose 75 mg/day
- **Desvenlafexine (Pristiq)** 50-100 mg/day
  - Studied extensively
  - 4 randomized, placebo controlled trials found **significant reduction of hot flashes at 100 mg daily**

(Speroff et al., 2008; Archer et al., 2009; Archer et al;., 2009; Pickar et al., 2007).

Non-Hormonal Options for Managing VMS: Off-label

- **Clonidine (Transdermal)**: centrally acting, for Rx of HTN.
  - Studied more extensively in 1970s-1990s
  - Reporting mixed results in reducing VMS
  - Trial using clonidine for patients on tamoxifen therapy showed a 38% reduction in hot flushes per day (Pandya et al., 2000)
- **Clonidine (Oral)**
  - Initial oral dose for hot flash treatment is 0.05 mg twice daily, but some women may require at least 0.1 mg twice daily
  - Modest effect on symptoms, adverse side effects (insomnia, dry mouth, constipation, drowsiness.)
- **Hypertension also**: May be a good choice

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Non-Hormonal Options for Managing VMS: Off-label

- **Gabapentin** indicated in treatment of partial seizures and post herpetic neuralgia; studied in Hot Flash reduction
  - Initiated at a daily dose of 300 mg at HS
  - Can be increased to 300 mg twice daily and then to 3 times daily at 3- to 4-day intervals.
  - Pandya et al., (2005) studied with breast cancer patients (n=420) and found hot flush frequency was reduced by 44% at 900mg/day.
  - Studied: titrated to an 1800 mg daily dose, taken orally, 600 mg with the morning meal and 1200 mg with the evening meal.
  - Adverse effects: dizziness, somnolence, peripheral edema, wt gain

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VMS: Patient Education

- Must be thorough, empathetic, resourceful
- Handouts, websites, et
- Menopause.org (NAMS
- NAMS certification
  As a NCMP

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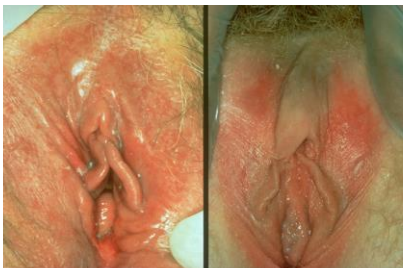
Vulvovaginal Atrophy (VVA)
Atrophic Vaginitis (AV):
NEW TERM:
Genitourinary Syndrome of Menopause (GSM)

1/3 of menopausal women affected

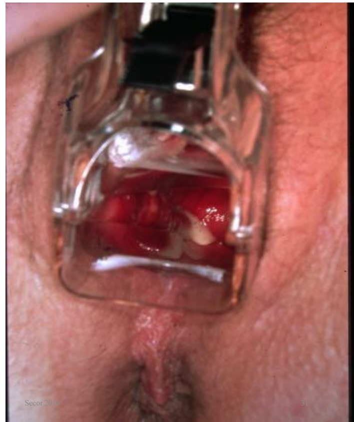
- Irritation
- Dryness
- Dyspareunia
- Discharge- variable
- Urinary symptoms: Dysuria, urgency, frequency, UTIs, incontinence

Vulvitis: Need to Clarify
Vaginal, Cutaneous Yeast, Contact, Allergic, Other



VVA/GSM

- Vulva
  'Sticky glove sign'
- Erythema, mottling
- Pallor
- Flattening of rugae
- Leukorrhea variable
  Esp. amount
- Mimics BV, Trich, HSV
  other etiologies



Diagnostic Work up of VVA, GSM

- Vaginal pH abnormally high ≥ 5
  - Proxy test for estrogen levels = maturation index
- Negative Amine KOH "Whiff "test
- Few Lactobacilli
- Mixed bacteria, grainy epithelial cells
- WBCs variable
- Immature epithelial cells, maturation index
- Avoid non-specific vaginal cultures, Pap inaccurate
- Test for STIs as appropriate!

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NEW: Vaginal pH Swab Test (VS-Sense)

negative positive

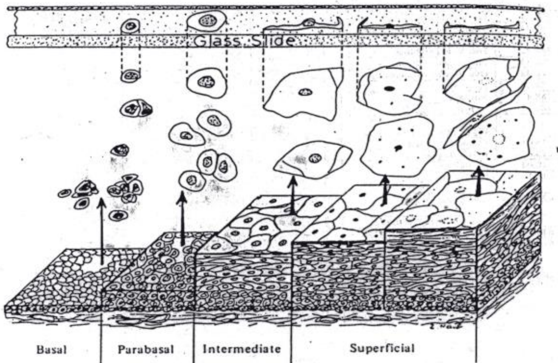

Figure 19–11. Different histologic layers of vaginal stratified squamous eipthelium. (From Naib Z. *Exfoliative Cytopathology*, 3rd ed. Boston, Mass: Little, Brown; 1985.)

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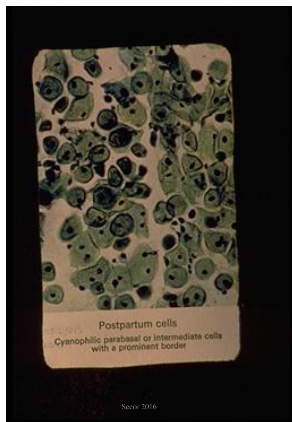

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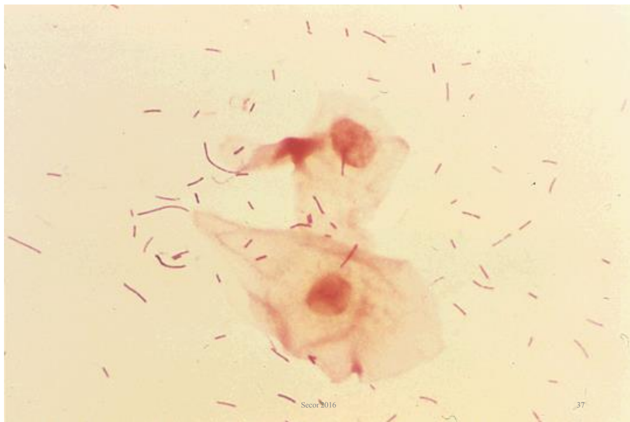

Differential Diagnosis

- BV
- STIs; Trichomoniasis, Herpes, etc.
- Precancers

- Vulvar dermatoses
  - Lichen sclerosis
  - Lichen simplex chronicus
  - Lichen planus
  - Irritant, allergen, eczema, etc..

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Rule out Dermatoses: LSC, LS, LP

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VVA, GSM Treatments: Low Dose Rx for VVA Vaginal or Oral (NEW-Ospemifene)

- Pt preference, symptoms, safety, efficacy, impact decision to treat
- Do NOT use ORAL estrogen for VVA symptoms only

Estrogen- Local Vaginal Options: Minimal Systemic Absorption, Progestin NOT NEEDED

Sig: Daily for 2-4 weeks, every other day, then twice weekly PRN

- **Vaginal estrogen creams**: 0.5-2 gms pv at bedtime
  - Conjugated Equine Estrogen /CEE (Premarin)
  - Estradiol (Estrace)
- **Estradiol vaginal tablets** (Vagifem): 10 mcg dose ONLY
  - If dry atrophy, or introital dyspareunia, less effective?
- **Vaginal estradiol ring** (Estring): every 3 months Effective, convenient, may help OAB as pessary
- **Risk of secondary yeast, approx. 50% !!**

Bachman et al. (2009). Ob Gyn111(1), 67-76 (RCT)

Ospemifene (Osphena)

- NEW: Shionogi, www.MyOsphena.com
- Non-estrogen, SERM, agonist to vulvar/vagina
- Oral 60 mg tablet
- Daily with food (fatty meal best)
- Similar efficacy to estrogen, 4 week response
- Avoid: Current cancer, CVD, stroke
- Side effects: Hot flashes, incr. vaginal discharge
- Breast (unclear)
- Bone effects (appears protective)

Mona Lisa Touch

- Reepithelializes vaginal epithelium
- Laser
- Yearly in 3 procedures
- Expensive
- Insurance coverage- plan specific
- Limited availability

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NEW: DHEA Vaginal for Post-Menopausal VVA, GSM

- Improved symptoms of dryness and dyspareunia
- Daily use
- Dosing 6.5% (cream, suppositories) vaginal at hs
- Similar effects to estrogen vaginally
- Without systemic estrogen effects (non estrogen)
- Commercial medication available soon

Archer DF. DHEA vaginal for VVA .J Steroid Biochem Mol Biol. 2015 Jan;145:139-43. doi: 10.1016/j.jsbmb.2014.09.003. Epub 2014 Sep 6. Review.

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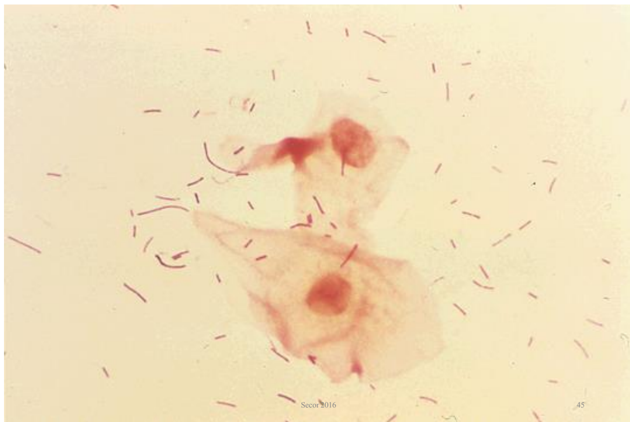

Sexual Counseling: FUN Complex, Individual, Time-consuming

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Sexual Counseling: Complex, Individualized

- Regular SEX, Sleep, Lifestyle!
- Lubricants: Poise, Sliquid
- Pelvic physical therapy (PT)
- Vibrators: Middlesex.MD
- Dilators
- Romance!
- Orgasm before intercourse

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Low Libido and Testosterone New Research 2014

- Only **supra-physiologic** levels increased libido!
- Investigators randomized post-hysterectomy menopausal women (mean total and free testosterone levels, 13.0 ng/dL and 2.2 pg/mL, respectively [below the range for healthy premenopausal women]) to 12 weeks of transdermal estradiol (0.05 mg daily) followed by 24 weekly intramuscular injections of placebo or testosterone enanthate at doses of 3.0 mg, 6.0mg, 12.5mg, or **25.0 mg** while continuing transdermal estrogen. N=62
- Need long term safety data!
- MEANWHILE: Encourage SLEEP, healthy lifestyle

Huang G et al. Testosterone dose-response relationships in hysterectomized women with or without oophorectomy: Effects on sexual function, body composition, muscle performance and physical function in a randomized trial. Menopause 2014 Jun; 21:612. (http://dx.doi.org/10.1097/GME.0000000000000093) - See more at: http://www.jwatch.org/na35167/2014/07/14/exogenous-testosterones-effects-menopausal-women-matter?query=etoc_jwwomen#sthash.8hQ05kqb.dpuf

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NEW: Flibanserin Female "Viagra?"

- FDA approved Sept. 2015
- Centrally mediating
- Taken daily
- 10% more effective than placebo (modest effect)
- Does NOT help all women (no magic bullet)
- Controversial
- NO ETOH

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Abnormal Vaginal Bleeding

- For ANY vaginal bleeding 12 months after FMP
- FMP = final menstrual period
- If after intercourse
- Or just random
- **Even if only spotting, 1 time, or 1 drop blood!**

MUST ORDER:

- Transvaginal ultrasound (Must do with EMB)
- Endometrial biopsy (EMB): > 5 mm Endom. Stripe

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Resources: Hot Off the Press!

- Ap for handheld devices

"Menopro"

2015 Clinical Practice Guidelines for the Management of Menopausal Women

North American Menopause Society (NAMS).

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References

- Freeman, EW, et al. (2011). Duration of VMS and associated risks. *Obstet Gynecol, 117* (5),1085-1104.
- Honjo, H., et al. (2009). Low-dose estradiol for climacteric symptoms in Japanese women: A randomized controlled trial. Climacteric, 12(4), 319-328.
- Laliberte, F, et al. (2011). Does route of administration for ET impact risk of VTE? *Menopause,18* (10), 1052-1059.
- NAMS. (2013). Position statement: Management of symptomatic VVA. *Menopause, 20 (*9), 888-902.
- Roach, RE. et al. (2013). The risk of VTE in Women over 50 using oral contraception or postmenopausal hormone therapy. *J Thromb Haemost, 11* (1), 124-131.
- Scarabin, PY, et al. (2003). ESTER study group: Oral vs transdermal ET and VTE. *Lancet, 362* (9382), 428-432.

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References

- Alexander, I. M. & Andrist, L. C. (2013). Menopause. In K. D. Schuiling & F. E. Likis (Eds.). *Women's Gynecologic Health* (2nd ed.) (pp 285-328). Burlington, MA: Jones & Bartlett Learning.
- De Villiers,T. J., Gass, M. L. S., Haines, C. J., Hall, J. E., Lobo, R. A., Pierroz, D. D., & Rees, M. (2013). Global consensus statement on menopausal hormone therapy. *Climacteric. 16*, 203–204.
- Freeman, et al. (2011). Duration of menopausal hot flushes and associated risk factors. *Obstet Gynecol, 117* (5), 1095-1104.
- North American Menopause Society (NAMS). (2010). *Menopause practice: A clinician's guide* (4th ed.). Cleveland. OH: Author.
- North American Menopause Society (NAMS). (2013). Management of symptomatic vulvovaginal atrophy: 2013 position statement of The North American Menopause Society. *Menopause: The Journal of The North American Menopause Society*, 20(9), 888-902.
- Stuenkel, C. A., Gass, M. L. S., Manson, J. E., Lobo, R. A., Pal, L., Rebar, R. W., & Hall, J. E. (2012). A decade after the Women's Health Initiative-The experts do agree. Menopause*: The Journal of The North American Menopause Society, 19*(8).

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Menopause Update: Summary

- Describe epidemiology of menopause, Vasomotor Symptoms (VMS) and Vulvovaginal Atrophy (VVA)
  15 minutes
- Discuss diagnosis of VMS and Vulvovaginal Atrophy
  45 minutes
- Explain options for treatment of VMS and VVA
  30 minutes

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Thank You and Good Luck!
Questions Welcome

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