CHANGE OF LIFE, ALL RIGHT

Fifty years on from the contraceptive pill and the rise of feminism, why are thousands of Kiwi women suffering – unnecessarily – through menopause? Peta Carey reports.

For around a quarter of women hitting menopause, life is the pits. The hell ride doesn't last a few weeks, even a few months. The nightmare of no sleep, hot flushes, depression, joint aches, "brain funk" and fast-fading sex life can go on for years.

This is not simply *women's problems*; it can be a very real, often demoralising and dysfunctional-seeming near-end-of-life sentence. The real bugger is that for many of these women medical help is available, but since 2002, they've been scared away from it.

The symptoms for this group of menopausal women can bunch together to inflict a major blow to quality of life, relationships, professional life and income. Yet when some New Zealand women front up to their family doctor and ask for hormone replacement therapy (HRT), which relieves menopausal symptoms, their GP might shake his or her head, declining a prescription. The doctor may refer to research that made headlines in 2002. It was called the WHI (Women's Health Initiative) and suggested that a common oestrogen-progestogen combination of HRT was harmful, increasing the risk of breast cancer, heart attack and stroke.

Thirteen years on, a number of reputable studies have disproved the prematurely released WHI findings and indicated the relative safety of HRT, but many New Zealand doctors have clung to the sensationalist, and flawed, claims of the United States study.

For others willing to prescribe HRT, the subsidised options for women in this country are woefully inadequate. Despite there being no "one size fits all" solution to the varying shifts in women's hormones, Pharmac now funds fewer

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options of medication than it did before 2002, fewer subsidised options than for comparable male testosterone medications, and certainly nowhere near what's available across the Tasman.

Five decades on from the contraceptive pill and the rise of feminism, New Zealand is lagging pitifully behind the times when it comes to this critical area of women's health – menopause.

Dr Anna Fenton has been trying to set the record straight for the past 13 years. In her light-filled consulting rooms in Christchurch, overlooking the quake-embattled northern corridor of Bealey Ave, Fenton's frustration only just edges out her typical calm restraint. Dressed in tailored suit and heels, she epitomises professionalism, with a good dose of warmth and compassion.

Fenton, a gynaecological endocrinologist, is New Zealand's representative on the executive council of the Australasian Menopause Society and the organisation's president. She was the first New Zealand doctor to be certified by the North American Menopause Society as a specialist menopause practitioner, and is co-editor of *Climacteric*, the journal of the International Menopause Society. Just back from conferences in Europe, she divides her time between international collaboration, private and public clinics, and teaching.

In July 2002, Fenton was on a plane returning from Singapore when she saw the first headlines of the early release of the WHI results. "It was front page of the Singaporean daily the *Straits Times*. I was sitting in my seat thinking, 'Oh, my God.' By the time I got home, all hell had broken loose. I had thousands of calls from anxious patients and GPs."

The Women's Health Initiative was established in the United States in 1991. It was the biggest and boldest scientific study of its kind in the history of women's health, addressing various concerns for postmenopausal women and including the effects of hormone therapy. So how did a study – costing $US625 million and involving more than 161,000 women and a small army of scientists and physicians – misinterpret key data, leading to the media making basic mistakes about the increased risk of stroke, heart attack and cancer?

According to Fenton, "they asked the right questions, but of the wrong women. We knew there were benefits in younger women taking HRT, so the WHI was set up to see if these same benefits existed for much older women beginning HRT later in life."

"I'd sit in meetings among all these men, feeling myself burning up all the time, and then I'd get the sweats. It was humiliating."

The average age of menopause (the final menstrual period) for Western women is 50 to 52. The average age of the participants in the WHI study was 63, and the average time since menopause for those women in the study was more than 10 years.

Eyebrows were raised even in 2002 when the stats didn't stack up against a previous smaller-scale study called the Nurses Health Study. These nurses were women in their early 50s, bang on menopause, and the results – a relative decrease in coronary artery disease for those on HRT – were at odds with the WHI. It would take until 2007 and intense reanalysis of the WHI study for its investigators to admit the initial release of information was flawed.

It all came down to age, and the number of years since menopause had passed. It was later proven that the age of the woman (ideally in her late 40s to mid-50s) and the timing of the hormone treatment dramatically change the risks and benefits. Used within the first decade of menopause, HRT neither increases nor decreases the risk of coronary artery disease. However, for women in their 50s who begin HRT soon after menopause, the risk of coronary artery disease is reduced. And breast cancer? For some forms of HRT there is an increase in risk, although nowhere near the numbers that were suggested in 2002.

The other problem with the WHI study was these results went to press before any peer review from the scientific community or other physicians. There was protest from scientists, but the damage had already been done.

Fenton recalls: "In just two weeks, the media story was so entrenched it was impossible to come back from that. We've had five formal reviews of the data thereafter, and of course the risk statistics decreased dramatically over time, but the media would not take up the story."

As with all facets of medicine, the risks are never absolute and need to be weighed against the benefits. But the recommendation from several respected organisations (among them the Endocrine Society and North American Menopause Society) in the past 10 years suggest the benefits for relatively young, healthy women suffering menopausal symptoms outweigh the risks. In 2013, the major menopause societies released a "global consensus statement" that said: "...for most women, the potential benefits of HRT... are many and the risks are few when initiated within a few years of menopause" and "the absolute risks known to date for use of HRT in healthy women ages 50 to 59 years are low".

The effect of the WHI study was dramatic. Following the release of its preliminary findings, women who had previously taken HRT to relieve menopausal symptoms dropped the medication overnight. GPs put a line through prescriptions. High-profile women's advocates such as Sandra Coney suggested women were, yet again, being taken advantage of by irresponsible pharmaceutical companies.

Fenton, alongside colleagues all over the world, battled to recapture the media's attention for years. "As late as 2012, the International Menopause Society issued a press release re-emphasising the revised analyses. It was picked up by 300 media outlets around the world, but not one in New Zealand. I was told, 'We're not interested.'"

Fenton's restraint was tested. "We spoke to many journalists, trying to get some balance. But it becomes very difficult; you don't want to be seen as a zealot." Her major concern? "There were so many women, and still are, suffering unnecessarily out there. And it's not that HRT is the only option."

She says a drug used originally to treat epilepsy and nerve pain can sometimes control flushes and sweats; mild symptoms can be suppressed using an antihistamine or hypertension medication; there's even an injectible nerve block procedure that's proved useful for treating flushes and other symptoms. "But this whole area of medicine became a black hole for women."

One of those women in the black hole was Sally Chambers. She well remembers the headlines in the *New Zealand Woman's Weekly* in 2002, declaring the dramatic risks of developing breast cancer with HRT.

Chambers (not her real name) suffered peri-menopausal (leading up to menopause) symptoms and then post-menopausal symptoms for 12 years. "My recollections from my 40s into my 50s are unbelievable tiredness, disturbed sleep, hot flushes, increasing malaise, and everything was grey. I had a burning pain in my hips. I felt like an old woman."

Working in the male-dominated construction industry was an added difficulty. "I'd sit in meetings among all these men, feeling myself burning up all the time, and then I'd get the sweats. It was humiliating." But because of what she'd read about HRT as a result of the WHI study she was determined "to deal with it myself. I was of the generation that when you got your period you simply got yourself a hot water bottle, sucked it up and got on with it. So I was going to go herbal, dance around the fire, do whatever it took."

Chambers' mother was similarly staunch. She told her: "It's a fact of life, dear. You simply have to put up with it."

And Chambers did put up with it for those 12 years. She went through hell in her relationship and her work. Not once did her GP – whom she went to regularly – suggest HRT. It was only when she saw a dermatologist on an unrelated matter that the specialist picked up on her symptoms and suggested she contact Anna Fenton.

Her life changed overnight. "Within three to four days, I felt unbelievable," she says. "I curse myself that I was so naive for so long – that I didn't have the time to really research it. Yet even my mother was still grilling me about it."

Chambers' experience is repeated by women all over New Zealand. The effect of the WHI study on their quality of life has been considerable. And if there are health risks associated with HRT, there are also risks, including stroke, for women who experience early menopause. Worse, thousands have put their lives at risk by taking so-called natural alternatives – unregulated and unchecked by health professionals. (See the story on bio-identical hormones on page 78.)

Christchurch gynaecological endocrinologist Dr Anna Fenton says the whole area of menopause medicine has become a "black hole" for women.

JOHN COLLIE

Fenton is still concerned by the lack of up-to-date menopause knowledge among some New Zealand physicians and spends significant time educating junior doctors and GPs. So, too, does Wellington-based Associate Professor Beverley Lawton, author of *Menopause: A New Zealand Guide* and a past president of the Australasian Menopause Society.

Lawton – of Ngati Porou, and made an officer of the New Zealand Order of Merit in 2004 for services to women's health – was well ahead of her time in regard to menopausal health care. She and colleagues Dr Jill Shepherd and Professor John Hutton opened the Wellington Menopause Clinic in 1994. Like Fenton, she spends a great deal of her time up-skilling GPs.

"I still get women coming to me whose GP has refused them treatment. The woman who comes to see me usually has moderate to severe symptoms. She's tried everything else. And that's what's so noticeable – prior to 2002, she would have come in earlier."

How many women would truly benefit from HRT? "Once you approach menopause, you've got a 50 per cent chance of mild to moderate symptoms, perhaps treatable simply by lifestyle changes. Another 25 per cent of women will breeze through. But there's 20 to 25 per cent who will suffer, for quite some time. Those are the women we see here.

"'Quality of life' is a term we throw around. But if you don't sleep at night, if you're continually sweating, you can't perform in your job and you're losing

NICOLA EDMONDS

Wellington-based Associate Professor Beverley Lawton, author of *Menopause: A New Zealand Guide*, spends a great deal of her time upskilling GPs. "HRT is not the Holy Grail. But women need the correct information in order to decide for themselves."

your partner, it's devastating. Sleep deprivation alone is torture.

"It's simple. A woman with severe symptoms should have a choice. HRT is not the Holy Grail. But women need the correct information in order to decide for themselves."

Dr Denise Nicholson of Christchurch is one of the key authors of HealthPathways, a website for Canterbury health practitioners advising on best practice in key areas of medicine, including menopause. She says the menopause guidelines are often ignored and women asking for help from their GP have been refused.

The result? A burgeoning waiting list of six months or more in Christchurch to see Fenton and her colleagues through the public system – for many, the cost to go private is out of reach. The majority of these cases could easily be dealt with by the family doctor, says Nicholson, yet women with particularly complex symptoms are left waiting and suffering.

Nicholson, who's in the midst of establishing a GP practice specialising in women's health, suggests menopause "specialist" GPs could get referrals from other family doctors, as happens now for GPs who have become specialists in treating skin conditions and who perform simple surgeries and procedures.

"The first appointment can be time-consuming," she says. "We have to do tests, follow-ups. First, you have to determine what the real reasons for the symptoms are. And then there are women who can't use HRT and we have to find alternative treatments. And even if they are aware of the recent research, a lot of GPs struggle with tailor-making the hormonal combinations that are necessary."

Hormone replacement therapy – what is it? The first critical ingredient is oestrogen (or estrogen in the US). It's a woman's wonder hormone, which she produces during the reproductive cycle. It's also the hormone that contributes to the regulatory health of the heart, brain, blood vessels, liver, urinary tract and digestive system. At menopause, however, oestrogen drops off dramatically, often resulting in hot flushes (or vasomotor symptoms), joint and muscle aches, mood swings and vaginal dryness. One of the most overlooked symptoms is invisible: loss of bone density.

"Oestrogen is one of the main protectors of our bones," says Fenton, who is also accredited as a bone density specialist. "Once you get to menopause, the brakes are taken off that process. In four to five years, women can lose up 10 per cent of their skeleton." The oestrogen in HRT ensures bones stay strong for as long as a woman takes HRT.

Oestrogen replacement therapy (ERT) alone is prescribed for women who no longer have a uterus. Others who still have an intact uterus need "combination therapy" – oestrogen combined with progestogens (the umbrella group of hormones that include progesterone). Progestogens offset the tendency of oestrogen, if unchecked, to cause a build-up of tissue in the uterus, the precursor of uterine or endometrial cancer.

There are pills, gels and patches. Patches, or transdermal medication, are advisable for those women with obesity, high blood pressure, cardiovascular disease (particularly any risk of clotting), mild liver dysfunction and significant sexual dysfunction. The exact combination – a mix of hormones in various forms – is tailored to each woman.

The two broad arms of HRT – oestrogen therapy alone and combination oestrogen/progestogen therapy – are studied independently, the "risk profile" being very different for each. And those risks? "Key is to give each patient the correct information and leave them to make their decision," says Lawton.

Breast cancer is the risk foremost in women's minds. Oestrogen-alone ERT treatment is associated with a *lower* risk of breast cancer. For every 1000 women on the combination HRT, an additional four to five may present with breast cancer after using it for more than five years. But compare that to the risk associated with obesity or alcohol consumption. Overweight women who drink more than 1.5 standard drinks a day are far more likely to get breast cancer than those on HRT who are otherwise of normal weight and not excessive drinkers.

Do women accept these risks? "It's a calculated risk I readily accept," says Chambers. "There are other reasons for breast cancer: alcohol, hereditary markers, obesity. It's something I can manage myself, having regular mammograms. For me, it's about quality of life, not quantity. God forbid, I don't want breast cancer, but my quality of life has improved significantly."

And then there's the heart. "Cardiovascular disease is the number-one killer of women," says Fenton. "Of all stroke deaths in New Zealand, women account for 62 per cent. Nearly three times as many women die from heart disease as from breast cancer."

At this point, most women would throw their hands up in resignation. If a woman's lot – menstruation, premenstrual tension, childbirth complications and the joy-sapping symptoms of menopause – isn't enough, we then learn our bones are crumbling away and our arteries are building up with plaque, the precursor of a stroke or a heart attack. How on earth do we survive past 60 at all?

Fenton is not one to be captured by hype and will not give false hope. "HRT, oestrogen-only, reduces the risk of coronary artery disease [when taken soon after the onset of menopause]. Combined HRT is looking likely [from observational studies of younger menopausal women] to also reduce the risk. A recent review by the [global] Cochrane Collaboration of all published studies has shown a 48 per cent decrease in heart disease in women in their 50s taking HRT and a 30 per cent decrease in deaths from all causes."

> Sally Chambers says HRT changed her life overnight. "It's a calculated risk I readily accept. For me, it's about quality of life, not quantity."

A Danish HRT randomised study of more than 1000 healthy women aged 45-58 that ran for more than 10 years – and was reported in the *British Medical Journal* – also found starting HRT therapy early after menopause reduced the risk of heart attack, and did not result in any increased risk of breast cancer or stroke. (However, for the small number of women still suffering severe symptoms who start HRT more than 10 years after their periods stop, studies do show an increased risk for heart attack, stroke, breast cancer and other complications.)

Not that HRT should be seen as a panacea for middle-aged women's health problems, says Fenton. "We advise prescribing HRT only to relieve the extreme symptoms of menopause. Yes, there are health benefits, but these are not the main driver. All benefits need to be weighed against the risks, as in all areas of medicine."

She points out that when a woman no longer needs HRT and eases off the drugs, any concomitant health benefits can also fall away. But there are other medications available if needed at that time – for cardiovascular disease and bone density, in particular.

Risk versus benefits is one consideration. The other biggie is the cost. And here's where New Zealand continues to lag far behind the rest of the Western world.

"I spend over $180 for three months of patches," says Sally Chambers, "and for the next few weeks eat baked beans." Yes, she can afford it – just – by making a few sacrifices along the way. But there are other women who can't afford the part or full payments for what they require.

At the time of writing, Pharmac fully funds only one oestrogen medication, and only in pill form. Compare what's available here to that freely prescribed in Australia: several oestrogen pills, patches and gels, and a number of oestrogen and progestogen combination medications. Again, Fenton's calm is being tested. She's on the endocrinology sub-committee of Pharmac's Pharmacology and Therapeutics Advisory Committee. The sub-committee's advice, strongly advocating for a wider choice of HRT medication options, has not yet been heeded.

She writes: "International consensus states that transdermal oestrogen [the patch] is the treatment of choice in overweight women, those with hypertension or diabetes, those at risk of cardiovascular disease, migraine sufferers and young women with premature ovarian insufficiency [menopause under 40]. In addition, [the patch] is the oestrogen of choice in women with sexual dysfunction."

When oestrogen is absorbed through the skin via a patch, the risk of blood clotting is eliminated. The slight increase in stroke and thrombosis associated with HRT, as for the contraceptive pill, is the result of it being taken orally.

Fenton and Lawton also point out that it's very difficult to titrate (manipulate the dose of) the one oestrogen pill that's fully funded and adjust it for women with varying needs.

Pharmac medical director Dr John Wyeth repeatedly suggests that the lack of available medication is simply due to cost (it comes down to funding in bulk from pharmaceutical suppliers) and priority. "Any consideration of funding oestrogen transdermal patches would need to be considered alongside the health needs of other New Zealanders seeking funded pharmaceuticals, and ranked accordingly," he writes.

"Oestrogen transdermal patches were included in the 2014-2015 invitation to tender. Pharmac has not yet completed assessment of all products tendered in this process."

Fenton argues that the real cost of the

NATURALLY NOT SO GOOD

The risks of bio-identical therapies for menopause.

The marketing of so-called "bio-identical" natural therapy for menopause symptoms is clever, seductive and convincing, says reproductive endocrinologist Dr Stella Milsom of Auckland's Fertility Associates and the Auckland District Health Board's National Women's Health services.

"I'm seeing one new patient a week who is unwell because they've gone to one of these so-called menopause clinics and are taking unregulated hormones. These are often well-educated, sensible women," she says. "Some are in their late 40s or 50s, glamorous, or might have a younger partner so feel a degree of anxiety about ageing. They become easy prey to such clever marketing."

Alternatively, these are women suffering from serious post-menopausal symptoms but scared off HRT because of the 2002 WHI results, and believe they're getting something more natural. "The marketing of bio-identical therapy has played against those WHI fears very successfully," says Milsom.

The reality is bio-identicals are exactly the same hormones as those used in many forms of HRT (and chemically identical to the hormones the body produces naturally), but a great deal more expensive. Worse, the bio-identical compounds women are prescribed – drugs, lozenges or creams – are unregulated, unchecked and nowhere near the standard of regulated pharmaceutical-grade drugs, running the risk of indeterminate dose and contamination. There have been three cases of endometrial cancer (of the uterus) associated with bio-identical therapy in Australia, and 55 fatalities in the United States from contamination of the drugs by fungal meningitis.

Milsom and Christchurch gynaecological endocrinologist Dr Anna Fenton are also seeing a number of women who are presenting with "virilisation" – developing male attributes including acne, facial hair growth and deepening voices. The hormone responsible? Testosterone, usually in the form of a cream or lozenge, prescribed in the hope of boosting libido.

"Because it's perceived as natural, women are using it in huge quantities," says Fenton. "It's the only product I've seen that can give rise to testosterone levels in the male range." While acne and hair growth can be alleviated when women cease using the cream, the baritone voice is there to stay."

Perhaps of greater concern are the risks of bio-identical treatment with regard to cancer. For women who still have a uterus, taking oestrogen without a progestogen can result in uterine or endometrial cancer. But both Fenton and Milsom are seeing cases of women who have been prescribed bio-identicals with insufficient progestogen to offset the risk.

"Often they're given only a progesterone cream," says Fenton, "which is not readily absorbed and is not opposing the effects of the oestrogen on the lining of the uterus."

For women with a history of breast cancer, standard HRT is not recommended; the risk is unacceptable. Yet women who have had breast cancer are being prescribed the equivalent of HRT under the guise of so-called "natural bio-identical therapy".

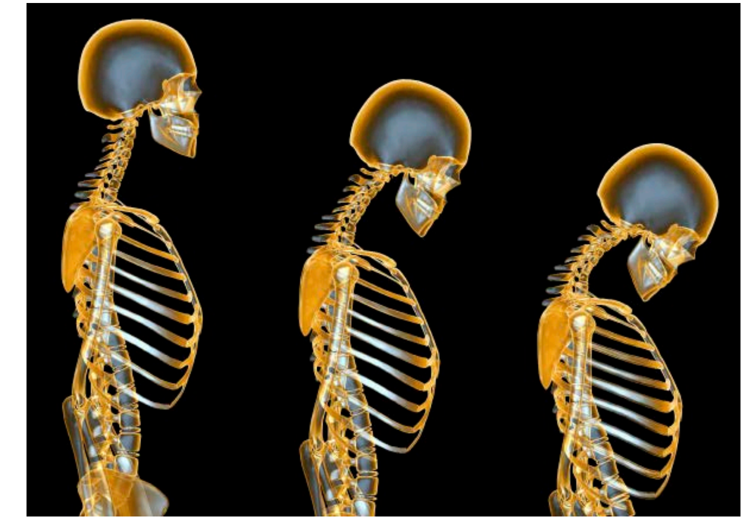
The irony is that a GP has to write out the prescription. "Often," says Fenton, "the women are convinced by the marketing from these companies, then take the recommendation of these bio-identicals off to their doctor, who is then pressured to write out the prescription for non-registered drugs."

Milsom is trying to warn GPs of their responsibility towards patients, and that legal ramifications could be significant. "The government is trying to close this loophole. It's a huge industry, a big money spinner. Other countries have started to litigate against it – Australia, North America. It's just a matter of time.

"Doctors need to think seriously about the legal consequences if they write out the scripts. They must fully inform women that these therapies are unproven and there may be risks. Moreover, prescribers should advise that regulated hormone therapy is available as an alternative."

HRT medication is small, certainly compared to chemotherapy drugs, for example. "While I wouldn't begin to take away the availability of chemotherapy drugs to people, the ramifications of not funding a relatively cheap HRT to New Zealand women are significant." She points to the cost to the New Zealand taxpayer of managing osteoporosis – in excess of $1.3 billion a year.

"As a result of funding restraints, we are forced to prescribe old-fashioned oestrogen therapy that is less than ideal for a great number of women."



Computer artwork of a female skeleton degenerating due to osteoporosis – a condition where loss of bone mass causes a reduction in the bone density. It is most common in women after menopause because they no longer produce oestrogen, which helps to retain bone mass.

More than 50 years since the pill was approved and the rise of women's liberation, why has it taken so long for menopause to be taken seriously as a health issue?

"Only a century ago, a woman's life expectancy was not much more than 50 years," says Fenton. "Now, with much longer lifespans, we're having children later and many women are at the peak of their professional life when they go through menopause."

Here's where menopause hits the economy. With women comprising a significant proportion of the workforce, often in full-time employment in their 40s, 50s and well into their 60s, menopause can affect work output. The one country in the world to recognise this and begin to address concerns is the United Kingdom.

There, trade unions are pivotal, encouraging anti-discrimination practices in the workplace – to support older women – and highlighting menopause issues to management, ensuring a female manager is available to liaise with if there are problems; even recommending better ventilation and fresh drinking water for women workers with hot flushes... the list goes on.

PC gone mad? Ask Sally Chambers. "Menopause affecting my work?" She laughs. "Enormous. Sleep was the killer. You'd turn up to meetings and your brain couldn't function. Credibility is all-important, particularly in a male-dominated industry. My sense of self-worth went out the window. Somehow it's okay for men to be old, grey and fat, because they still have credibility. But the way I felt, and my inability to focus, forever perspiring... I came that close to giving up."

It's an area of major concern to Fenton. She applauds the work being done in the UK and suggests health-care professionals have an important role to "promote greater workplace support for women at menopause and to educate women about the options they have to manage their symptoms".

Both Lawton and Fenton highlight the importance of diet and exercise in managing symptoms. Fenton also says yoga, hypnosis and acupuncture can help some women. She's less enthusiastic about herbs. "There is no scientific evidence for most herbal therapies," she says. "It's not that there haven't been studies. There have, but the results show that many alternative remedies are no more effective than a sugar pill."

She reiterates that although lifestyle changes may ease mild to moderate menopausal symptoms, they are less likely to make any difference for women with severe symptoms.

Lawton suggests the late-20th century obsessions of natural healing and childbirth have their downsides. Women who buy into the "if it's not natural, it's no good" mantra may suffer needlessly. "Women are generally pretty hard on themselves. They say, 'I've failed because I've had a caesarean.' If it weren't for medical intervention they mightn't have had a baby at all."

She suggests we shouldn't underestimate the symptoms of menopause and what medication can offer to help relieve those symptoms. "Not so long ago, women with menopause went into mental health institutions, diagnosed with hysteria."

On the scale alongside sleep deprivation, quality of life, ability to earn a living and all those pesky health concerns, how does sex rate? Fenton: "Sexual dysfunction is just not taken seriously. It takes a lot of guts for a woman to say to her doctor that there's an issue there – usually vaginal dryness, painful intercourse and low libido. And the flipside is the doctor is often too embarrassed to ask.

"I routinely ask all the women I see. Once you ask, you see a look of relief on their face. 'God, it's been terrible,' they might say, or they push it away saying, 'It's really only important for my husband,' knowing that sometimes spells the end of a relationship. It makes me very sad."

Lubricants and vaginal moisturisers are helpful, Fenton says. She lists the funded creams and pessaries (messy), but suggests the gem of the treatments, Vagifem (oestrogen vaginal tablets), is out of reach financially for most. And while women might be open about suffering from hot flushes, she believes they're still less comfortable discussing the impact of other menopausal symptoms on their sex life.

Looking ahead, however, she's optimistic. "Women are exceptionally good at talking to one another, saying, 'My life has just been turned around,' and they tell other women, and word gets out there that it's not the big scary thing we think," she says. "There are options."

Sally Chambers agrees. "Women need to talk about it more. They don't say to each other, 'Hi, how's your menopause today?' It usually takes a couple of wines to bring it out. Let's ask." +