OAND

Menopausal Hormone Therapy

IN THE CONTEXT OF EXCELLENT NATUROPATHIC PRACTICE

OAND SPRING CONFERENCE 2024

Dr. Kara Dionisio, B.Sc, M.Sc, ND (She/Her)
Menopause Society Certified Practicioner

"Doubt is not a pleasant condition, but certainty is absurd."

Voltaire

Naturopathic Doctors are leaders in Menopause Practice

30% of menopause society certified practitioners in Canada are Naturopathic Doctors

Hello.

I'm Dr. Kara

Dr. Kara Dionisio

B.Sc, M.Sc, ND, MSCP

- Naturopathic Doctor
- Co-Founder of Menoverse
- Menopause Society Certified Practitioner (since 2020)
- B.Sc Nutrition & Nutraceutical Science (Guelph)
- M.Sc Human Nutrition & Metabolism (Aberdeen, Scotland)
- Pelvic Health Physiotherapy - Level 1
- The Confident Clinician- Faculty & Menopause Fellowship Facilitator
- Canadian College of Naturopathic Medicine- Menopause Curriculum

Dr Kara ND & ASSOCIATES

MENOVERSE

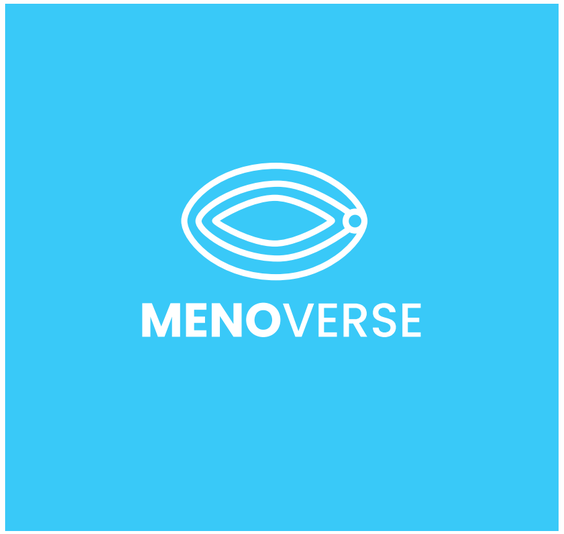
www.drkarand.com @drkarand @themenoverse

Conflicts of Interest

- **Dr. Kara & Associates**
  - Menopause Focused Clinic in Owen Sound, ON

- **Menoverse**
  - Co-Pilot of The Menoverse, a Menopause Education & Community

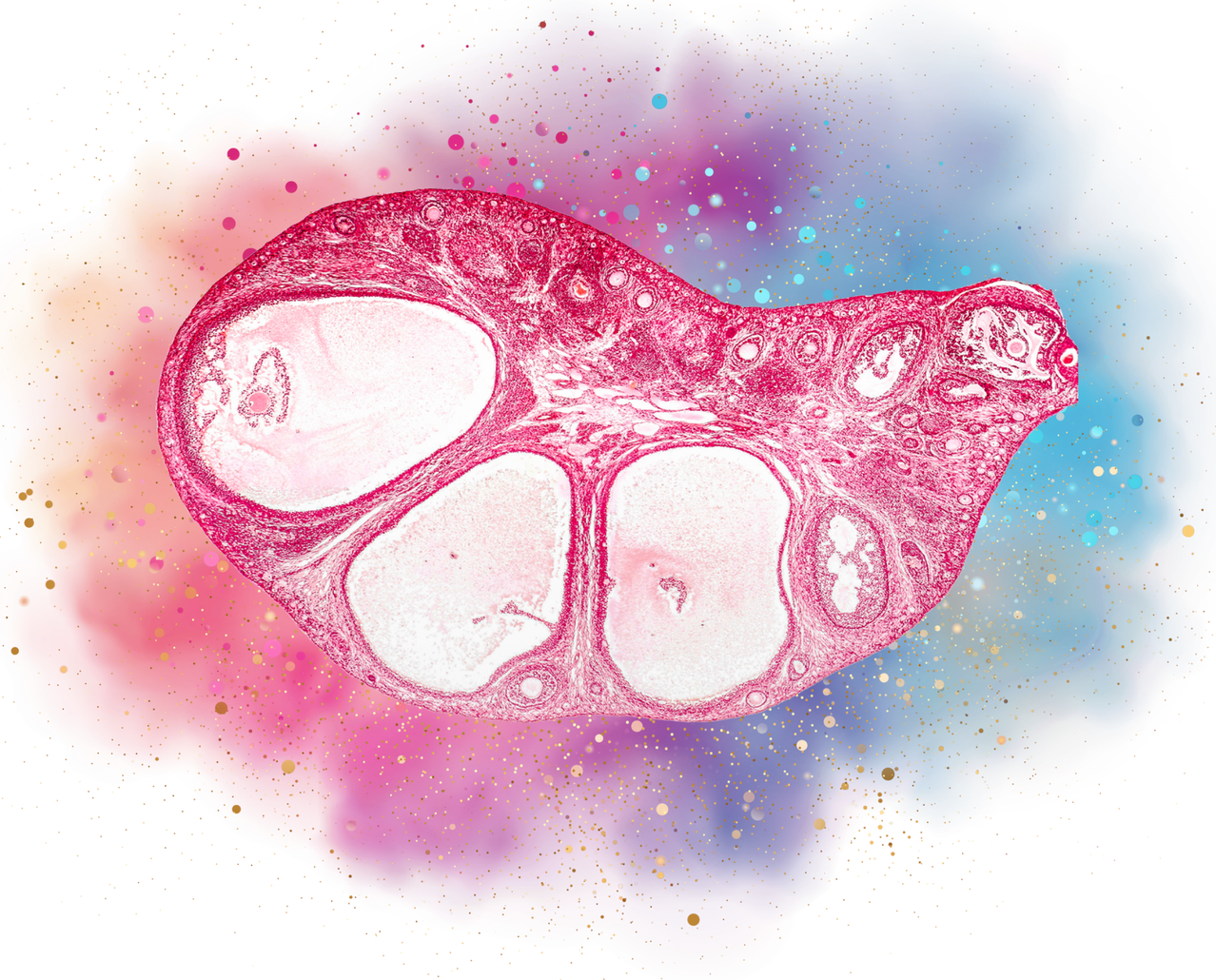
- **The Confident Clinician**
  - Faculty
  - Expert Clinician
  - Facillitator of The Menopause Fellowship
  - Paid course- Advanced Practice MHT



OAND SPRING CON MENO-Group

WhatsApp group

Menopause happens to **PEOPLE**.



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1. MHT Matters

From Controversy to Centre Stage

2. MHT Benefits & Risks

Highlighting Key Benefits & Risks of Menopausal Hormone Therapy

3. MHT Prescribing

Introductory Anatomy of a MHT RX
Elements of Excellence in Naturopathic Prescribing

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My mission today is to demonstrate how Midlife and Menopause healthcare, focusing on MHT, can exemplify the potential of naturopathic medicine in today's healthcare.

Dr. Kara Dionisio, ND


MAX
SKILL


HELLO
MY NAME IS
HRT


HELLO
MY NAME IS
HT


HELLO
MY NAME IS
MHT

College of Naturopaths of Ontario

Naturopathy Act, 2007, S.O. 2007, c. 10, Sched. P
O. Reg. 168/15, Table 3; O. Reg. 94/23, s. 2

Estrogen (bioidentical)	Only if prescribed in topical or suppository form.	This always requires a prescription and may only be prescribed in a topical or suppository form.
Progesterone (bioidentical form)	Only if prescribed in a topical or suppository form.	Progesterone requires a prescription and may only be prescribed in topical or suppository form.

Husbands, too, like "Premarin"®

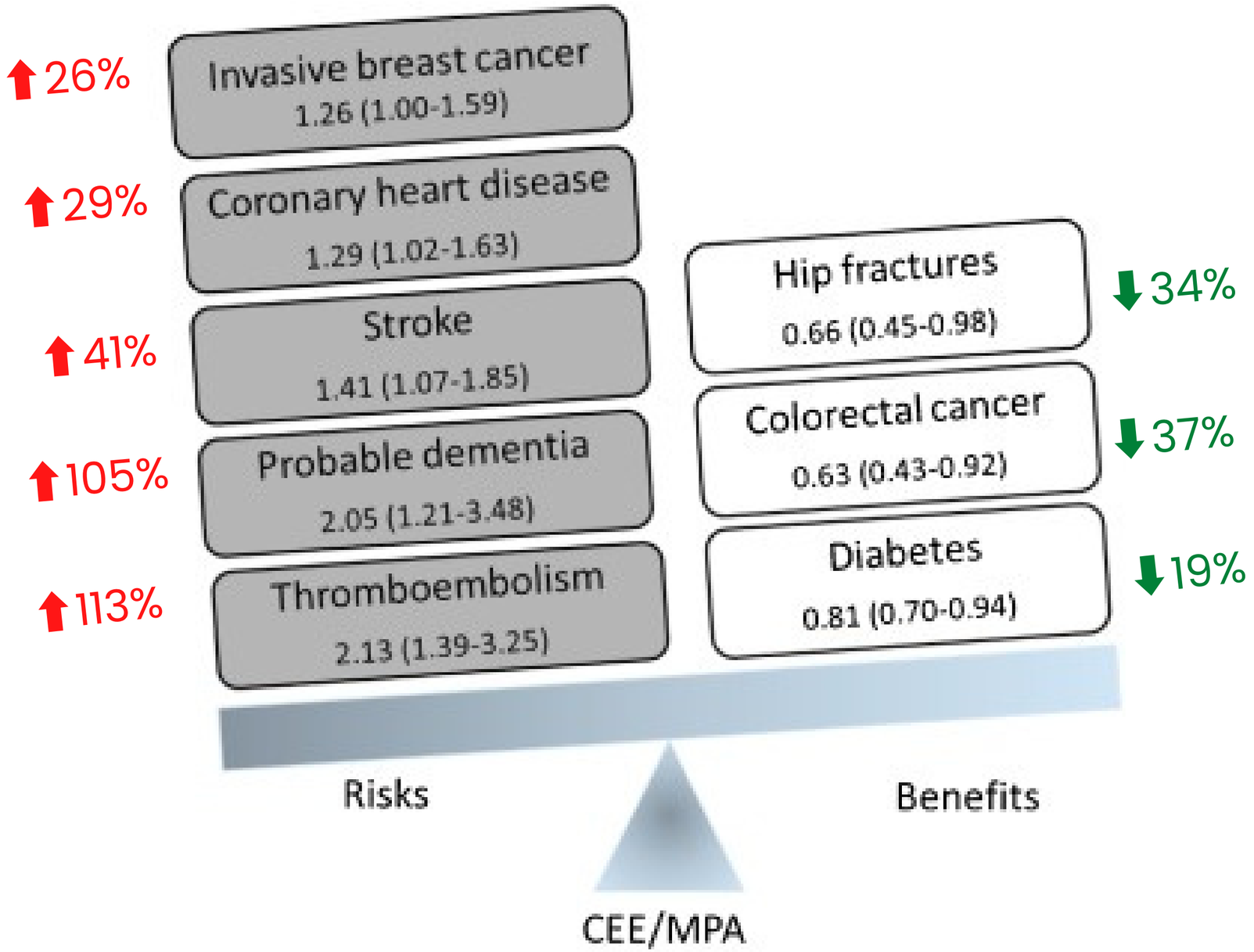
THE physician who puts a woman on "Premarin" when she is suffering in the menopause usually makes her pleasant to live with once again. It is no easy thing for a man to take the stings and barbs of business life, then to come home to the turmoil of a woman "going through the change of life." If she is not on "Premarin," that is.

But have her begin estrogen replacement therapy with "Premarin" and it makes all the difference in the world. She experiences relief of physical distress and also that very real thing called a "sense of well-being" returns. She is a happy woman again — something for which husbands are grateful.

"Premarin," conjugated estrogens (equine), a complete natural estrogen complex, is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

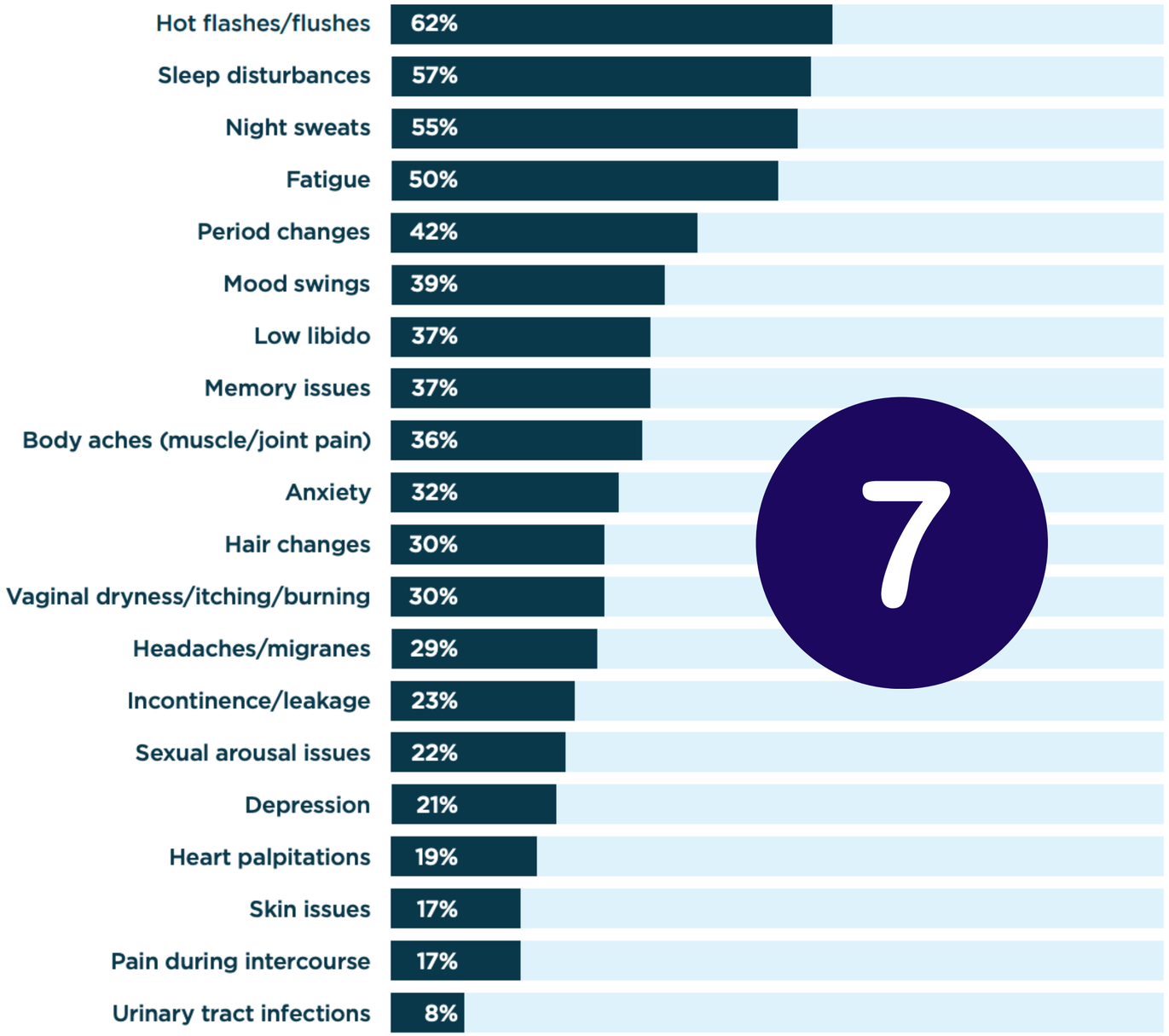
WHI Estrogen + Progestin



(Rossouw, 2002)
(Image: Zaw, 2018)

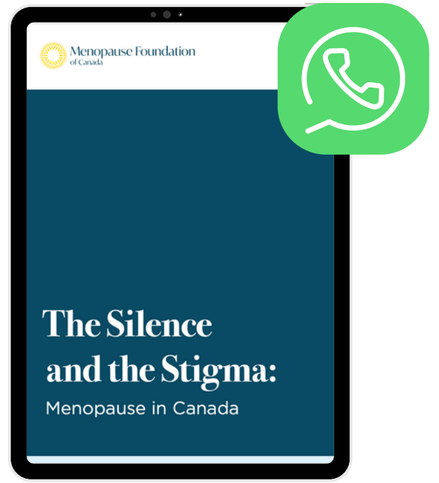
THE NEWS THAT CHANGED WOMEN'S HEALTH FOR DECADES


Tired of being NORMAL?
Bioidentical Hormones
For Men & Women
enlighten
LASER COSMETICS
294-9999
92
SOM



4 *in* 10

Four in 10 women sought medical advice, but 72% found it to be not helpful or only somewhat helpful. Four in 10 (38%) felt their symptoms were undertreated.



Medical Menopause Training

2019 Mayo Clinic Review of family medicine, internal medicine, and ObGyn Residents

- **25% had ZERO lectures, and 50% only had 1 lecture** on menopause management in their residencies
- **30-50%** of residents felt **"not at all" prepared to manage menopausal patients**

2023 Review of Of US ObGyn Residency Programs

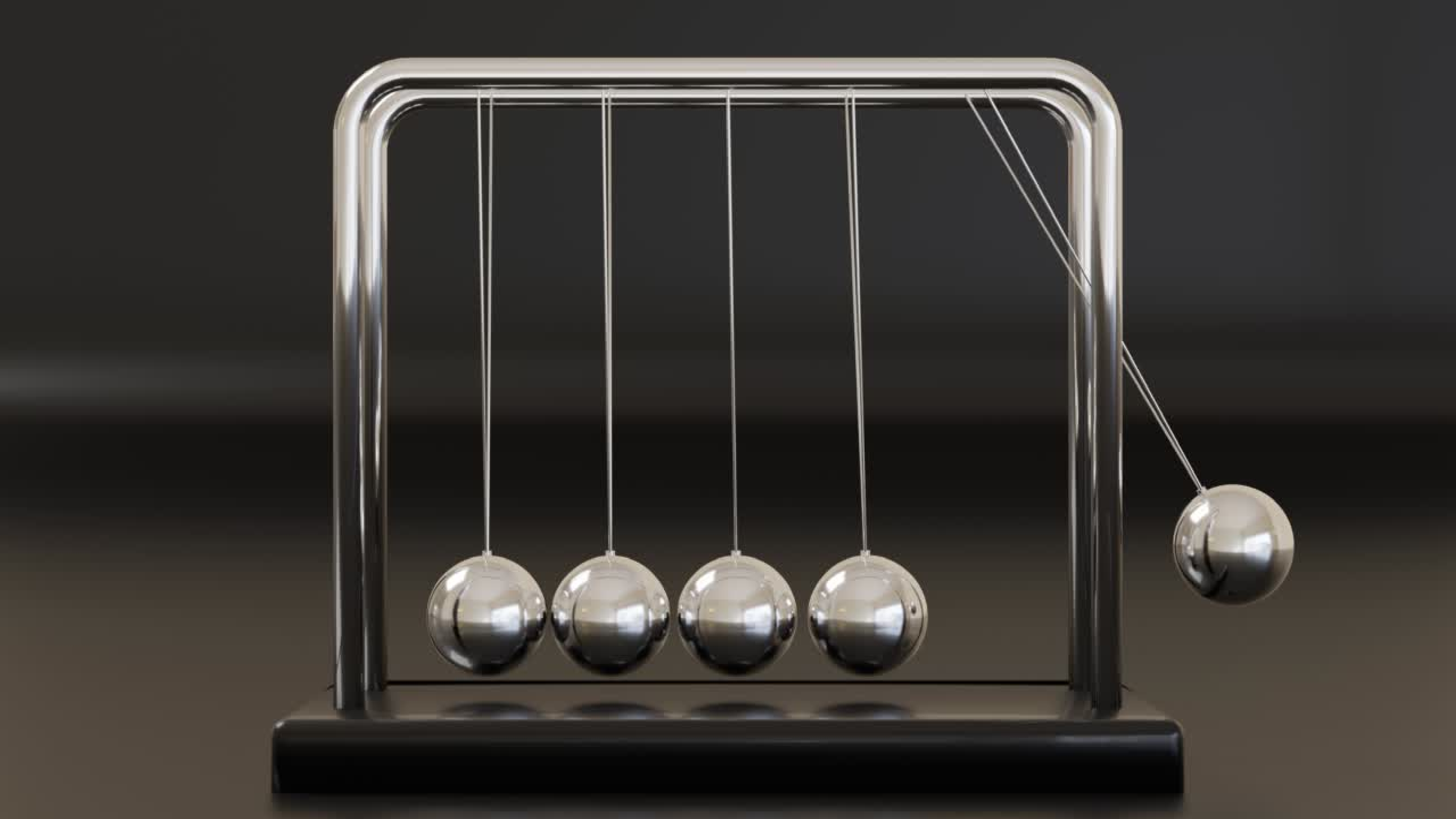
- **31% had a menopause curriculum**
- Of those that did, **70% had only 1-2 lectures**
- Only 30% had time in a dedicated menopause clinic

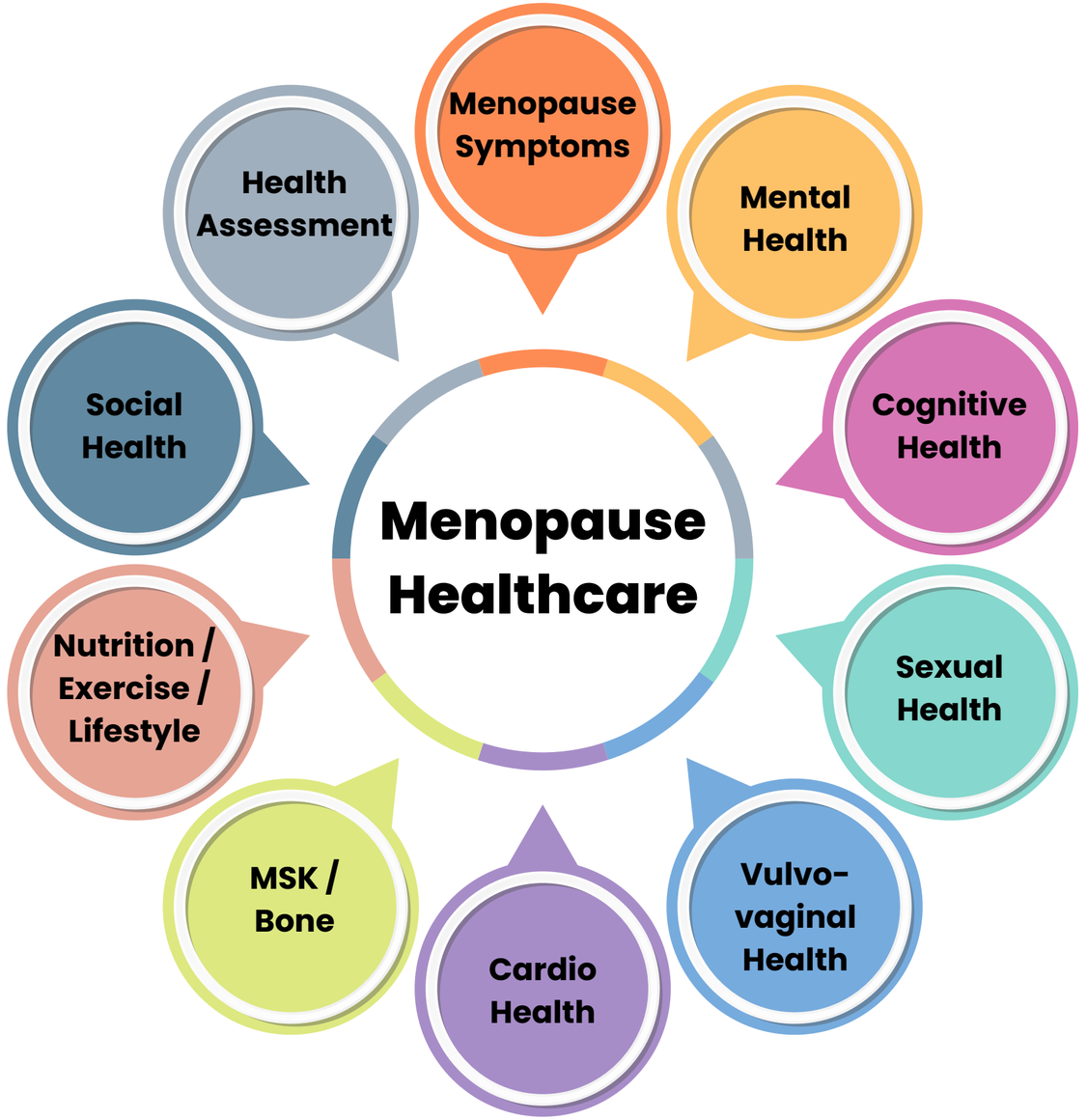
CCNM

- Two lectures

(Kling 2019, Allen 2023)


$600 billion
ONE A DAY women's
Menopause FORMULA
50 TABLETS
alloy M4
helps you understand your menopause journey[1]
Menopause Stage Indicator
EP 157
SURPRISING RESEARCH ON MENOPAUSE
With Dr. Mary Claire Haver
MEL ROBBINS PODCAST
What's your menopause type?
You Are Not Broken
Dr. Kelly Casperson
GENITOURINARY SYNDR OF MENOP
SAM & DR. JEN GUNTER TALK MENOPAUSE
FULL FRONTAL
Personalized Treatments, the Last Word on Hormones, and Remedies that Work
UNLOCK YOUR MENOPAU TYPE
Heather Hirsch, MD, MS, N
with Stacey Colino
NEW YORK TIMES BESTSELLER
THE MENOPAUSE BRAIN
LISA MOSCONI, PhD
Author of THE XX BRAIN
Mary Claire Haver, MD
The Guardian
HRT may cut risk of dementia in women
The medic who kick-started the menopause revolution
Your sex drive fades
Your memory fails
Your days are sweaty
Your nights are sleepless
Your bones can get brittle
You're depressed and anxious
But you feel you have to
KEEP CALM and CARRY ON
Global
Global News
FINALLY. IT'S OFFICIAL
HRT IS NOT A DANGER TO WOMEN





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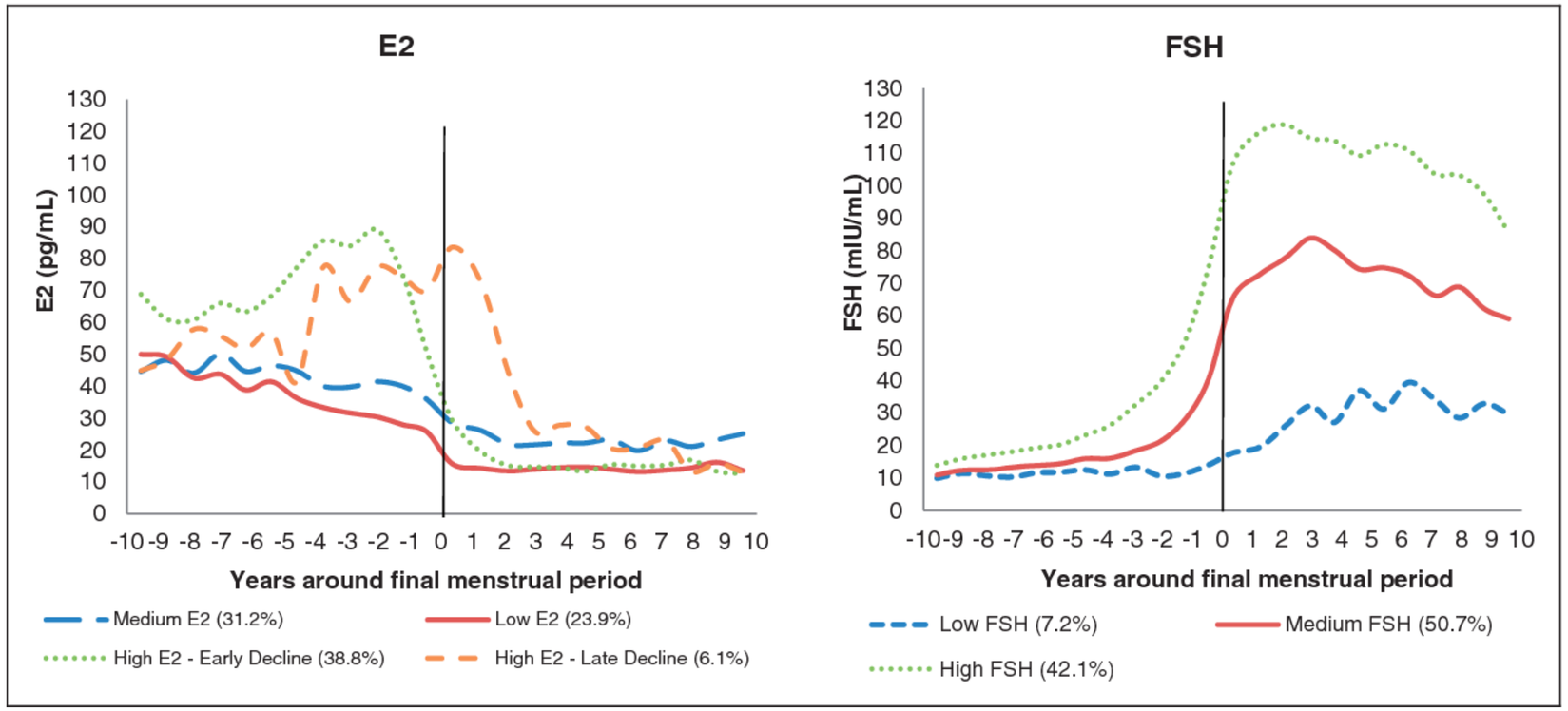
2. MHT Benefits & Risks

Highlighting Key Benefits & Risks of Menopausal Hormone Therapy

Menopause is a clinical diagnosis.

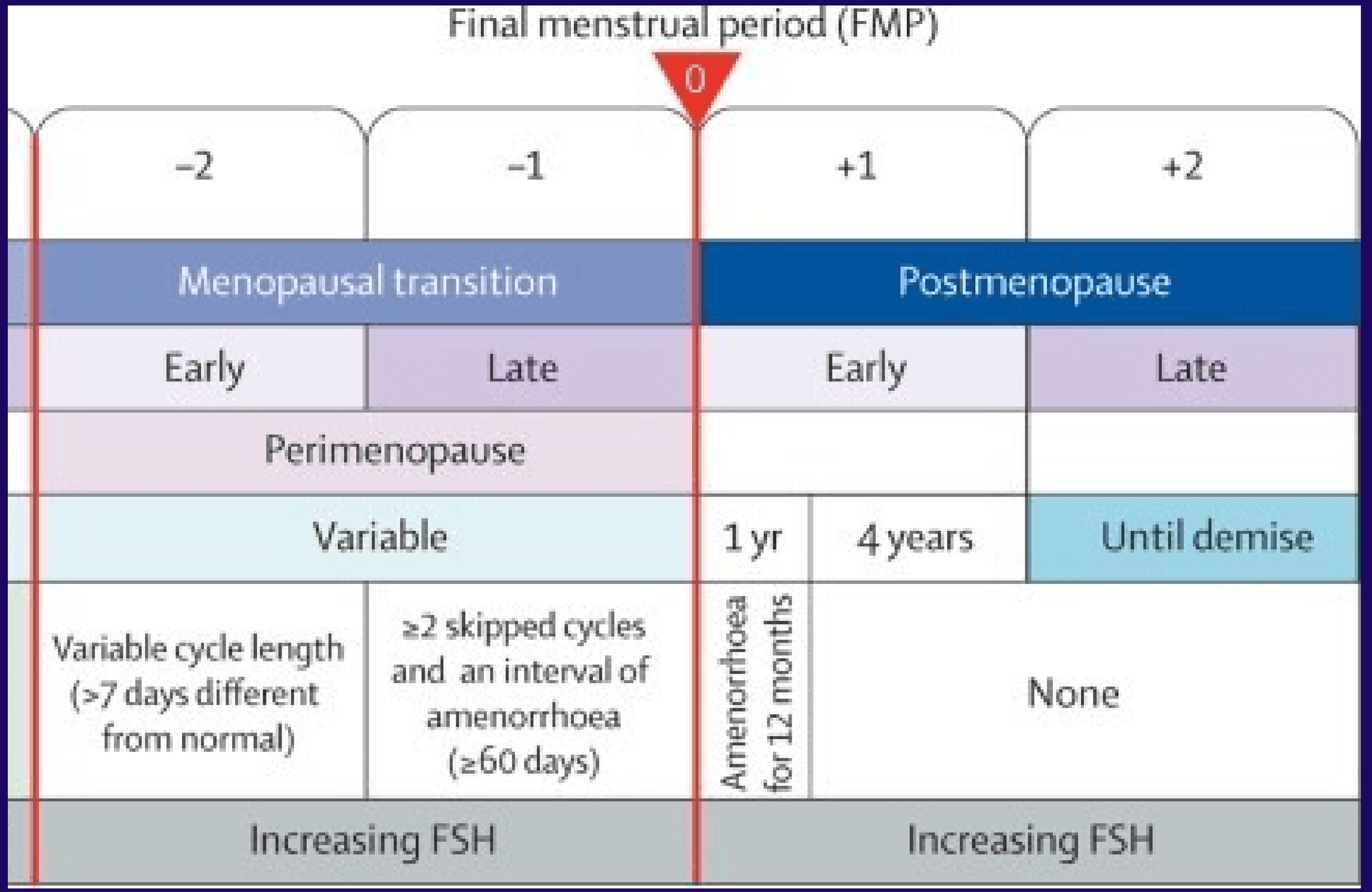
Patients over 45 years do not need an FSH measurement

The diagnosis of menopause in symptomatic patients should be based on age, symptoms, and menstrual cyclically



(NICE GUIDELINES- Lumsden, 2016)
(CMAJ- Lega, 2023)

STRAW CRITERIA STAGES OF REPRODUCTIVE AGING



(STRAW 10+: Harlow, 2012)

What do you need to know?

Full assessment recommended for midlife women

Medical History

Relevant gynae facts:

- Bleeding pattern or LMP
- Past surgery eg hysterectomy/oophorectomy
- Current use of any exogenous hormones
- +/- contraceptive needs

Major medical illnesses – ask about:

- DVT/PE
- Breast cancer/endometrial cancer
- Thyroid disease
- Cardio/cerebrovascular disease including HT
- Osteoporosis
- Diabetes
- Depression/anxiety/postnatal depression
- Recurrent UTI's
- Liver disease

Family History:

- Cardio/cerebro vascular disease
- Osteoporosis/fractures
- Dementia
- Cancer

Smoking/alcohol use

Current medication including non prescription medications

Social history

Sexual wellbeing

Examination

- Height and weight
- Blood pressure
- Breast exam (not required if recent breast imaging/ breast checks)

Investigations for menopause diagnosis

≥ 45 years old

- Diagnosis symptom based; measure FSH and E only if atypical presentation

< 45 years old

- Measure FSH and E – Of no value in women on COCP
- **Prog/LH/AMH** levels of no diagnostic value

Midlife women general health assessment:

- Cervical screen test
- Mammogram (if available)
- Lipid profile
- FBG
- TSH
- Renal and liver function
- FBE/ferritin
- FOBT
- Vit D in at risk women

(Davis, 2023)

Benefits

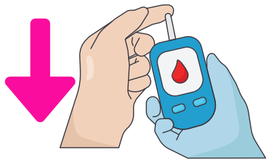
The Menopause Society Approved Indications for Hormone Therapy

- Moderate to Severe **Vasomotor Symptoms**
- Prevention of **Osteoporosis** in Postmenopausal Women
- **Premature Ovarian Insufficiency**
- Treatment of Moderate to Severe **Vulvovaginal Symptoms** (use vaginal estrogen if none of the above)

Adapted from NAMS Menopause Practice 6th edition

NAMS Position Statement

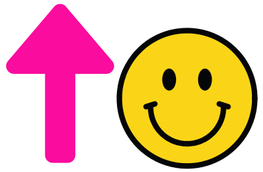
The 2022 hormone therapy position statement of The North American Menopause Society



Diabetes

Key points

- Hormone therapy significantly reduces the diagnosis of new-onset type 2 DM, but it is not government approved for this indication. (Level I)

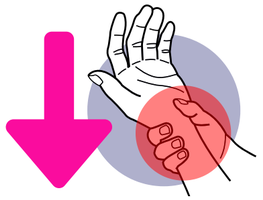


Depression

- There is some evidence that ET has antidepressant effects of similar magnitude to that observed with antidepressant agents when administered to depressed perimenopausal women with or without concomitant VMS. (Level II)

Skin

- Estrogen therapy appears to have beneficial effects on skin thickness and elasticity and collagen when given at menopause. (Level II)

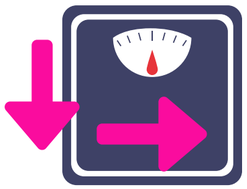


Joint Pain

- Women in the WHI and other studies have less joint pain or stiffness with hormone therapy compared with placebo. (Level I)

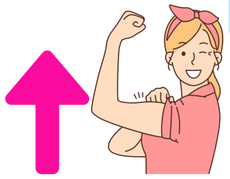
Sexual Function

- Both systemic hormone therapy and low-dose vaginal ET increase lubrication, blood flow, and sensation of vaginal tissues. (Level I)



Abdominal Weight Gain

- Although hormone therapy may help attenuate abdominal adipose accumulation and weight gain associated with the menopause transition, the effect is small. (Level II)



Muscle Mass

- Preclinical studies suggest a possible benefit of ET when combined with exercise to prevent the loss of muscle mass, strength, and performance, but this has not been shown in clinical trials. (Level II)

Sleep

- During the menopause transition, women with VMS are more likely to report disrupted sleep. (Level I)
- Hormone therapy improves sleep in women with bothersome nighttime VMS by reducing nighttime awakenings. Estrogen may have some effect on sleep, independent of VMS. (Level II)

(The Hormone Therapy Position Statement of NAMS, 2022)

VASOMOTOR SYMPTOMS (VMS)

VASOMOTOR SYMPTOMS

Up to 80% report VMS in the menopause transtion

10% of have more than 7 VMS per day

Most VMS are rated as moderate to severe

Median duration of VMS is 7.4 years

55% report VMS before the onset of menstrual irregularity

- 25% have VMS >5 years
- 33% have VMS >10 years
- 8% have VMS >20 years!

(Avis, 2015, Bansal 2019, Tepper 2016, Santoro 2016))

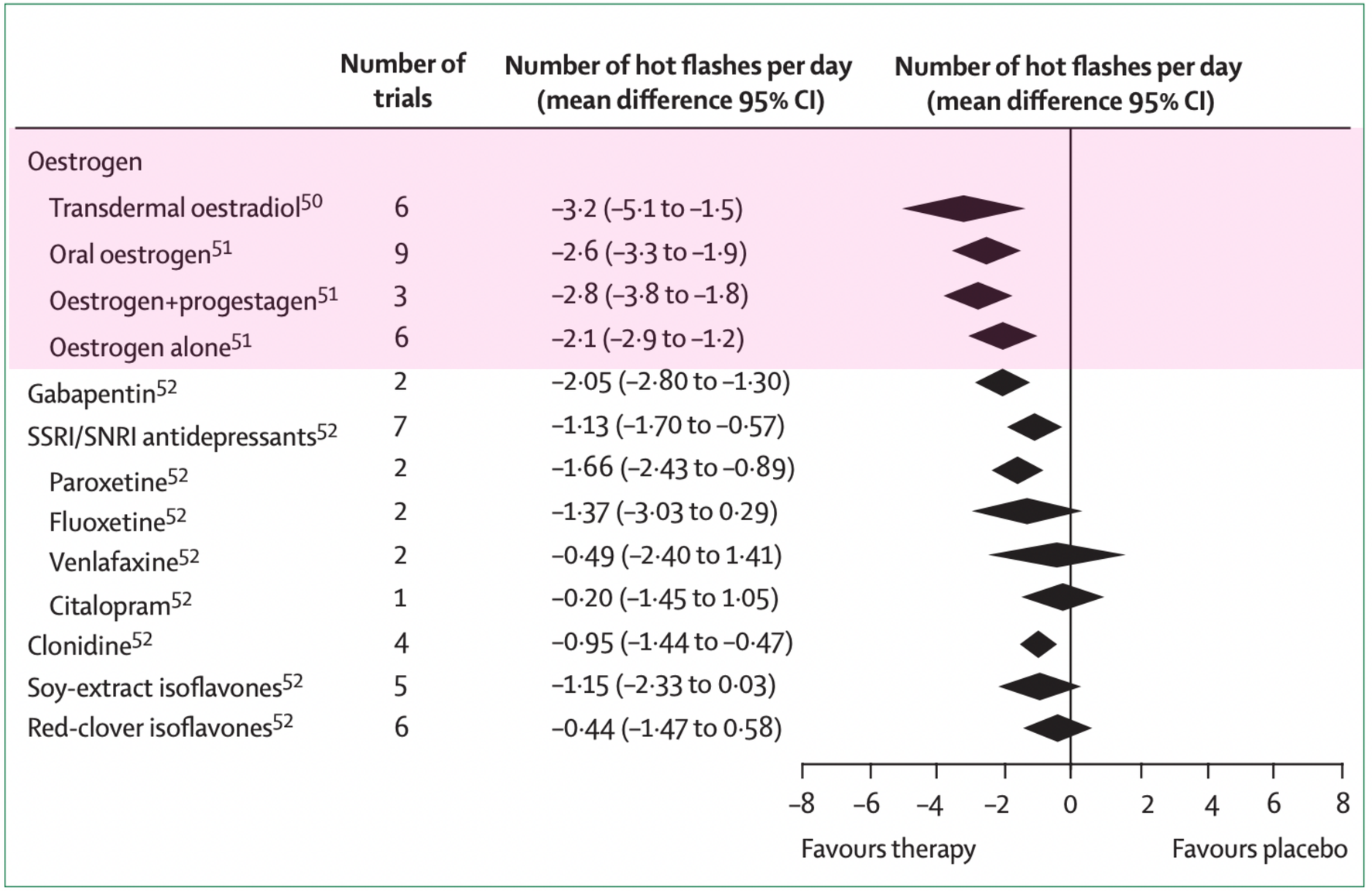
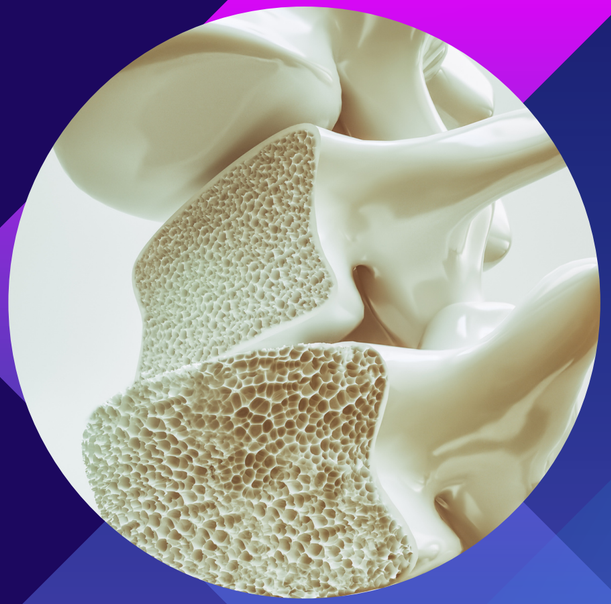


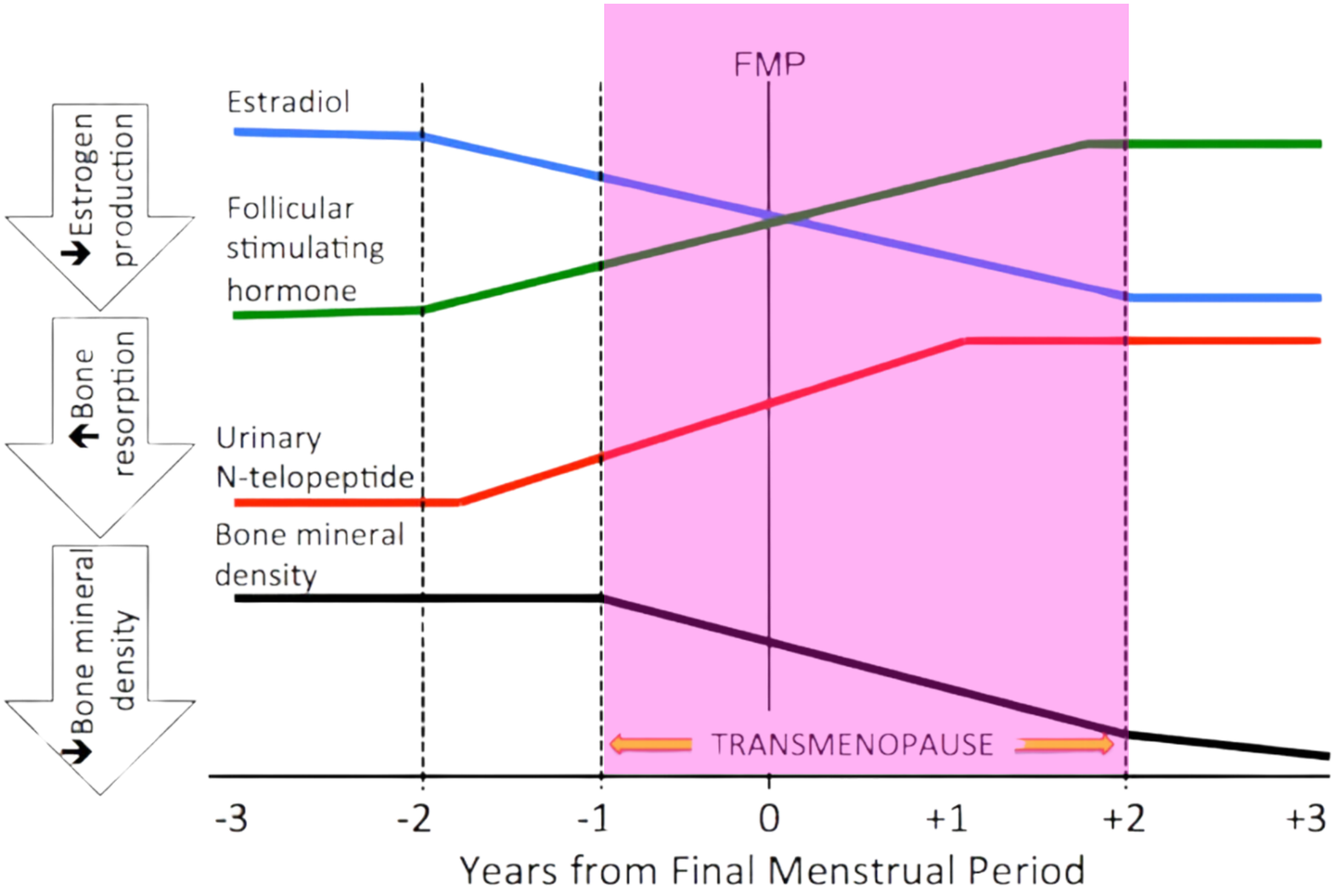
***Figure 3*: Results of trials of therapies for hot flashes**

Hot flashes were reduced by two to three flashes per day with oestrogen, two with gabapentin, about one with paroxetine, and one with clonidine in double-blind, randomised, placebo-controlled trials. Isoflavones had slight or no effect.

(Nelson, 2008)

OSTEOPOROSIS





	Lumbar Spine BMD Loss	Femoral Neck BMD Loss
10 Year Loss	-10.6%	-9.1%
Trans-Menopause	-7.4%	-5.8%

(SWAN Study - Greendale, 2012)
(Karlamangla, 2021)

MHT reduces the risk of fracture regardless of falls risk or baseline FRAX probability

The WHI Estrogen Plus Progestin Trial reported a 24% reduction in osteoporotic fractures

Total hip bone mineral density increased by 3.7% over 3 years

MHT was effective in reducing fracture risk compared to placebo, irrespective of the baseline FRAX probability and falls history

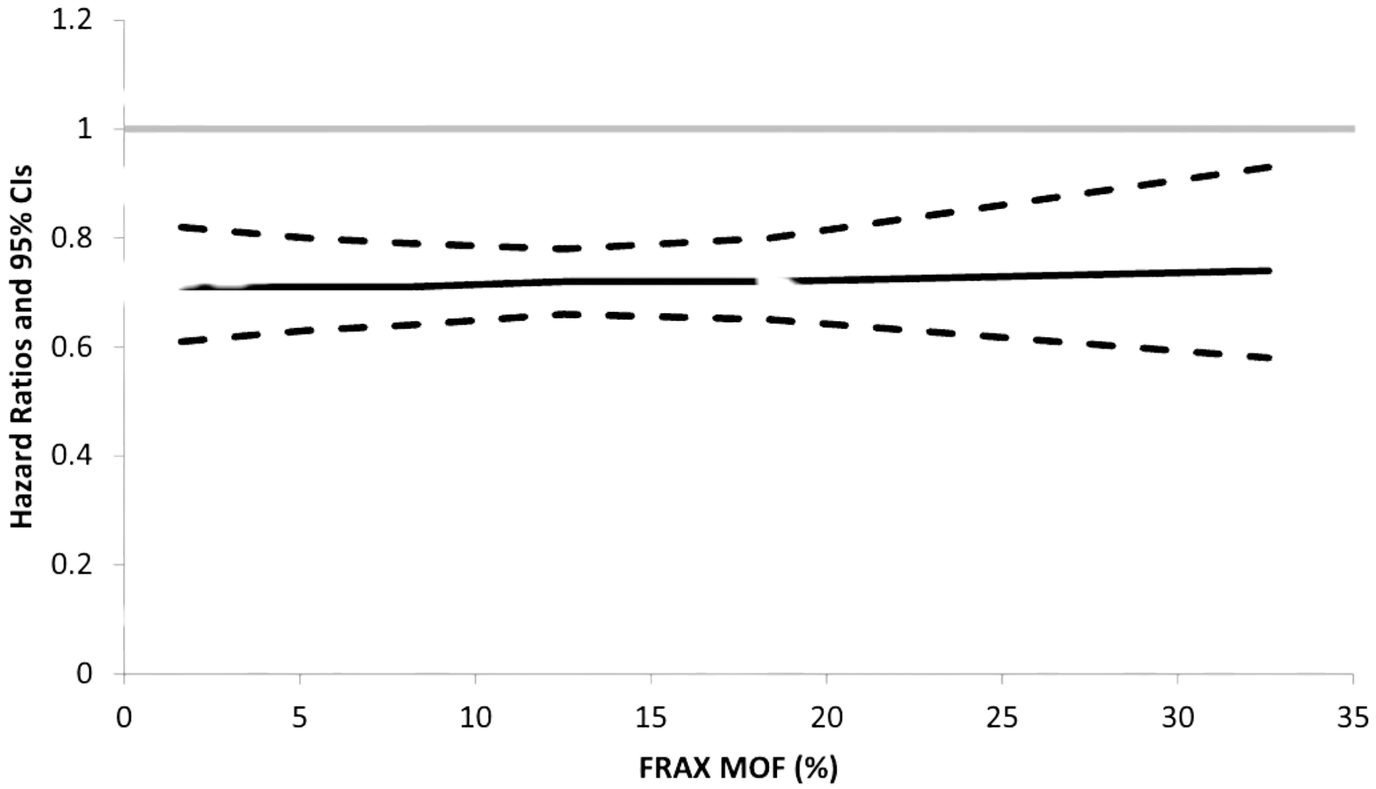


Fig. 1 Effect of menopausal hormone therapy on risk of any fracture according to baseline FRAX major osteoporotic fracture probability

(Weiss 1999)
(Lorentzon, 2022))

Transdermal Estrogen & Bone Density

CLIAMARA PATCH

Lumbar Spine BMD↑ 2.3-4.7%

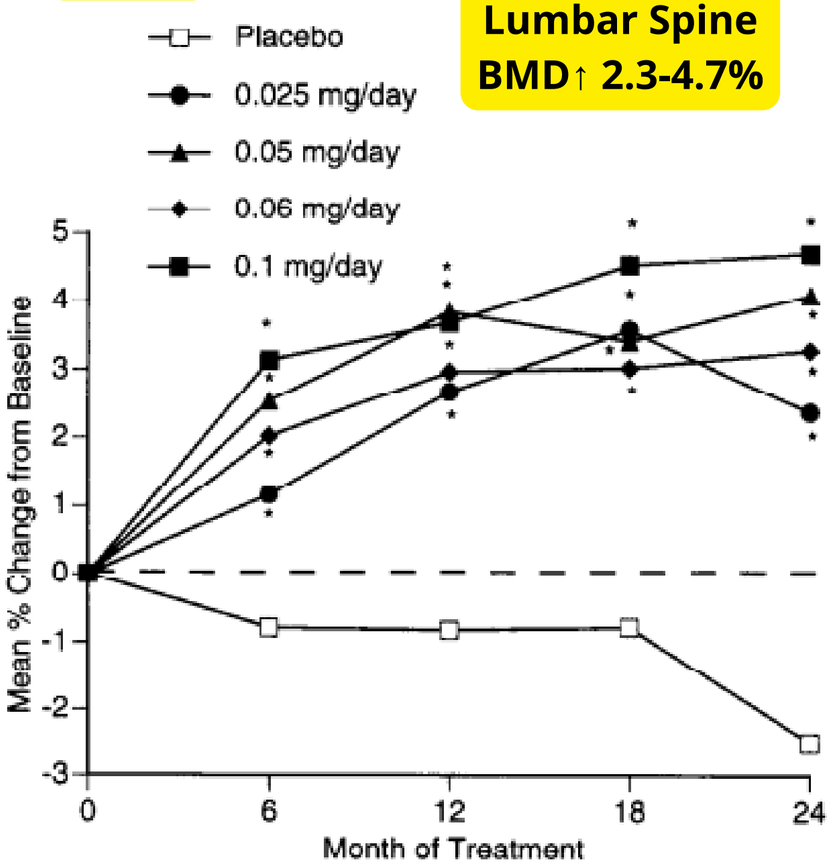


Figure 1. Mean percentage change from baseline for bone mineral density of the lumbar spine with active treatment and placebo. *$P < .05$ versus placebo.

Total Hip BMD ↑ 0.2-2.0-%

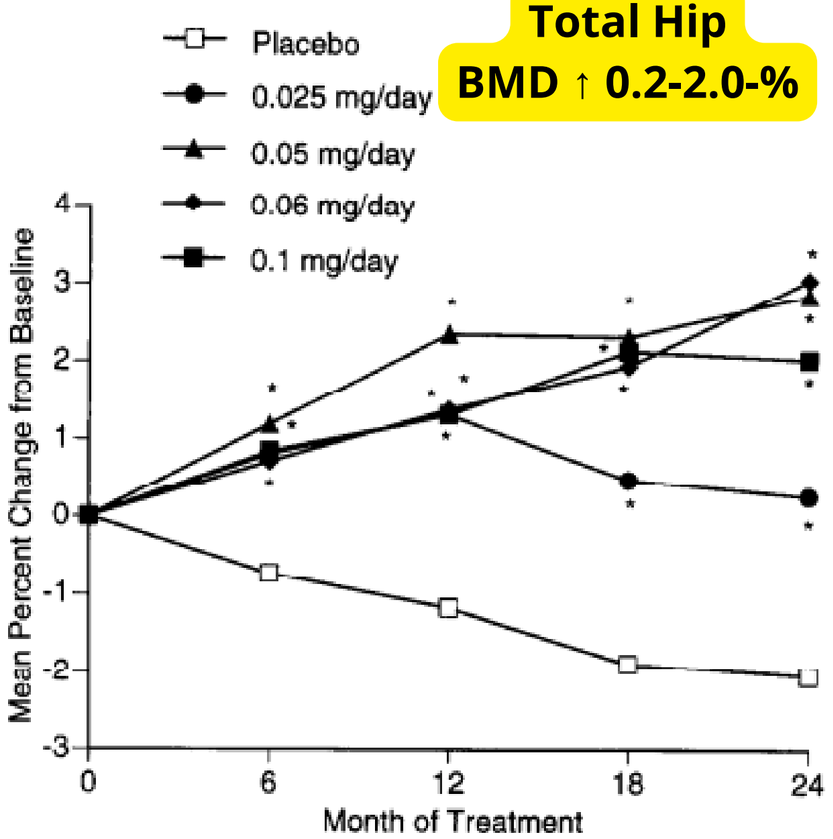
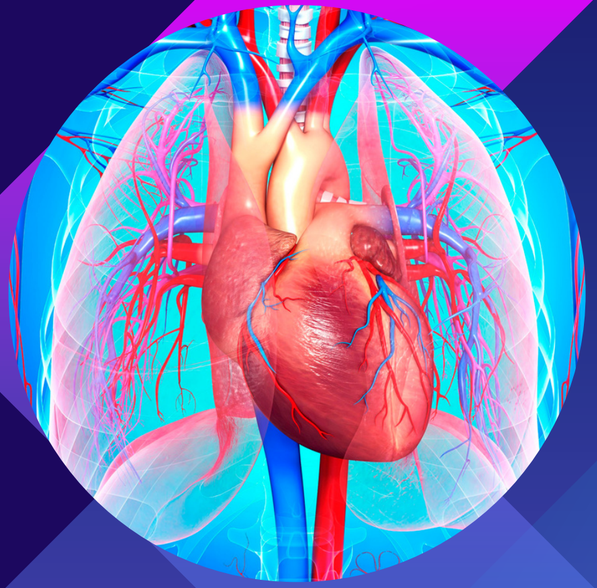


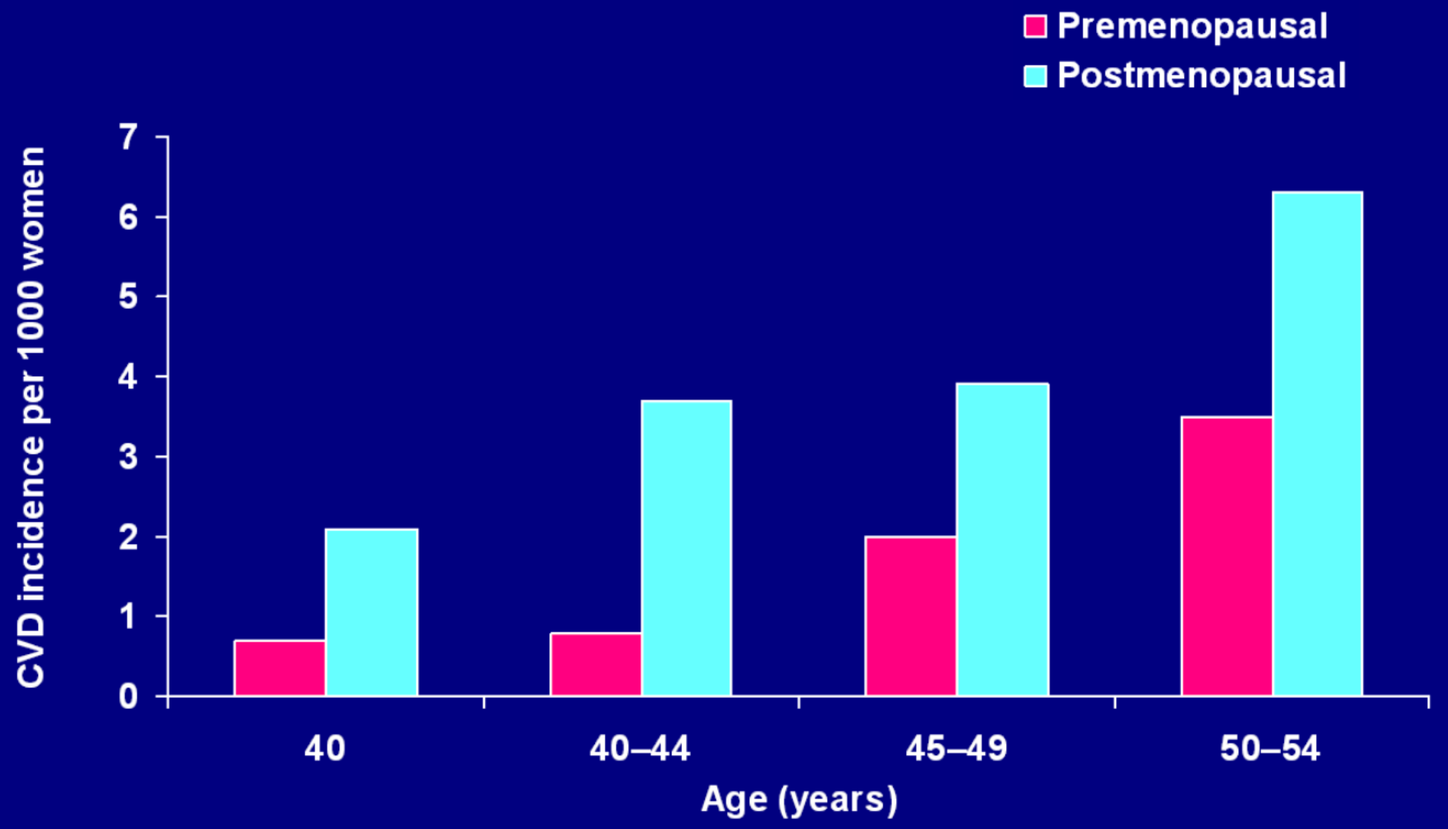
Figure 2. Mean percentage change from baseline for bone mineral density of the total hip with active treatment and placebo. *$P < .05$ versus placebo.

(Weiss 1999)

CARDIOVASCULAR

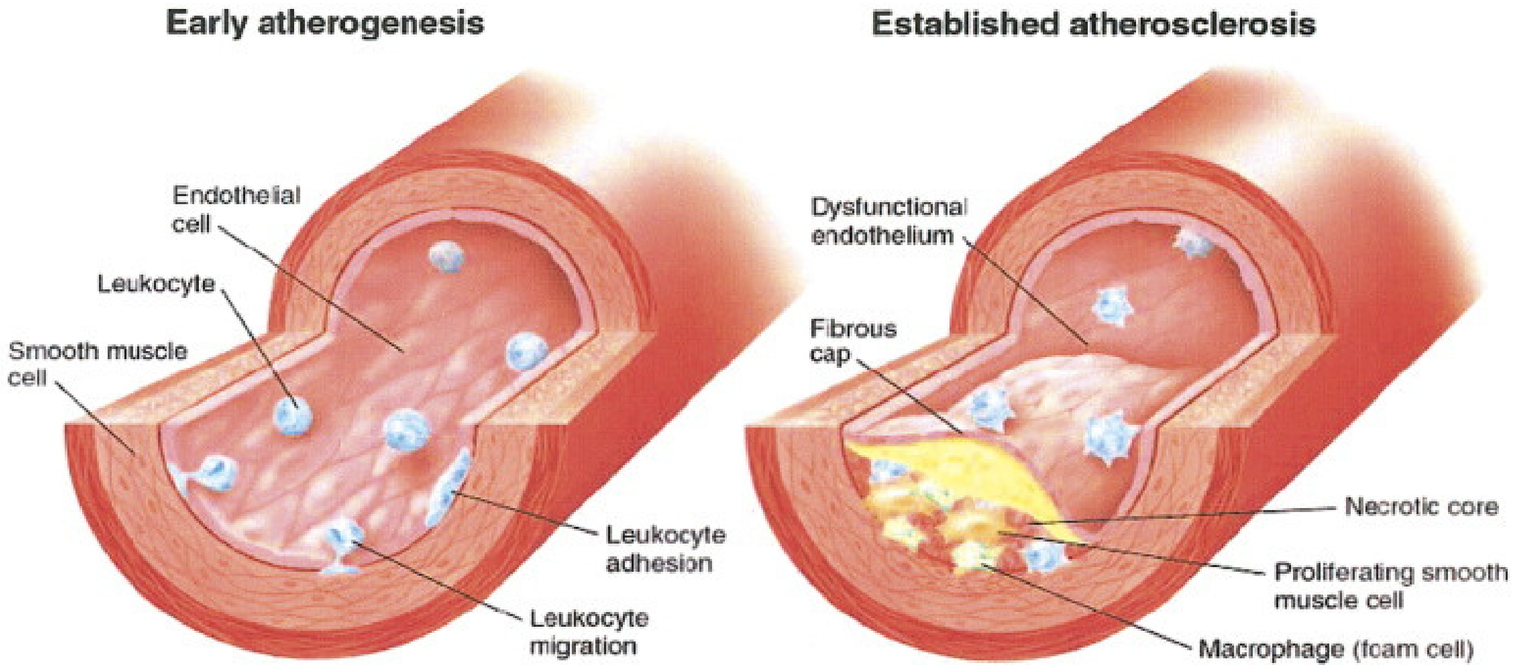


CVD and menopausal status



Adapted from the Framingham Study, DHEW No 74, 1974

(Kannel, 1976)



Beneficial effects of HRT

- ↑ Vasodilation
  - ↑ Nitric oxide
  - ↓ Endothelin
  - ↑ Cox-2
- ↓ Inflammatory activation
  - ↑ Nitric oxide
  - ↓ CAMs
  - ↓ MCP-1, TNF-α
- ↓ Lesion progression
  - ↑ Nitric oxide
  - ↓ Inflammatory cell adhesion
  - ↓ LDL oxidation/binding
  - ↓ Platelet activation
  - ↓ VSMC proliferation

Altered biology of HRT

- ↓ ER expression, function
- ↓ Vasodilation
- ↑ Inflammatory activation
- ↑ Plaque instability
  - ↑ MMP
  - ↑ Neovascularization

(Ouyang, 2006)

The “Window of Opportunity”

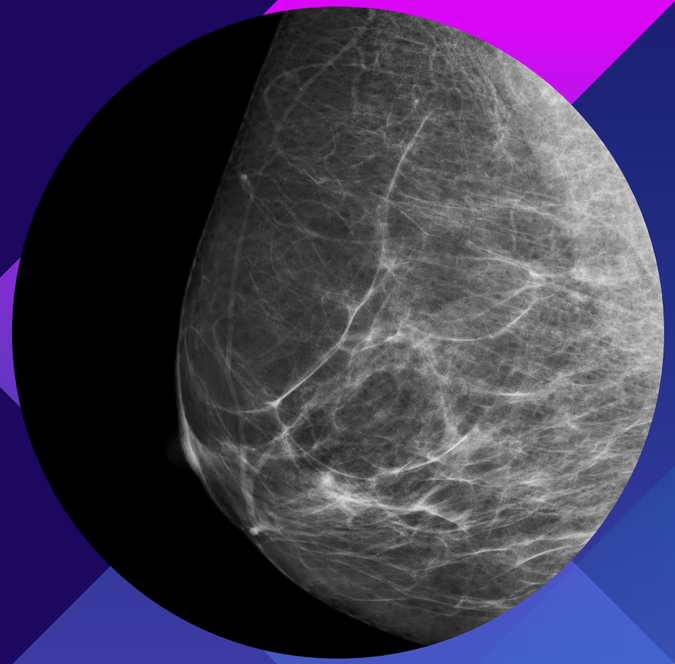
“For women aged younger than 60 years or who are within 10 years of menopause onset and have no contraindications, the benefit-risk ratio is favorable for treatment of bothersome VMS and prevention of bone loss.

For women who initiate hormone therapy more than 10 years from menopause onset or who are aged older than 60 years, the benefit-risk ratio appears less favorable because of the greater absolute risks of coronary heart disease, stroke, venous thromboembolism, and dementia.”

-The Menopause Society- 2022 Hormone Therapy Position Statement


Manage Your Risk

BREAST CANCER



Hormone therapy causes cancer we don’t use that anymore

“My friend took estrogen and she got breast cancer”

Bioidentical is a marketing term

Lowest dose for shortest amount of time

Hormone therapy does not cause cancer

Bioidentical hormones are safer

“The Women's Health Initiative was a bad study i’ts been debunked”

Estrogen alone in women with prior hysterectomy significantly reduce breast cancer incidence and breast cancer deaths.

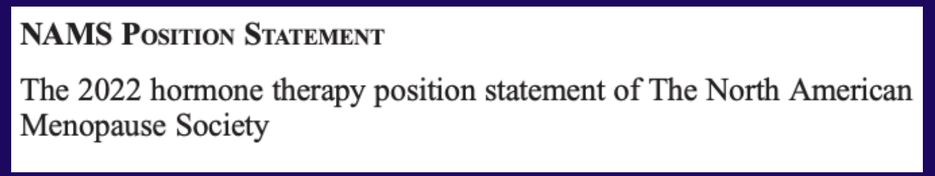
NAMS Position Statement

The 2022 hormone therapy position statement of The North American Menopause Society

The risk of breast cancer related to Estrogen + Progestogen hormone therapy is low, with estimates indicating a rare occurence

- **< 1 additional case per 1000 women per year of hormone therapy use, or**
- **3 additional cases per 1,000 women when used for 5 years**

(Level 1 Evidence)



+1/1000/yr

Difference in breast cancer incidence per 1,000 women aged 50–59 over 5 years

23 cases of breast cancer diagnosed in the UK general population

An additional four cases in women on combined hormone replacement therapy (HRT)

Four fewer cases in women on oestrogen only Hormone Replacement Therapy (HRT)

An additional four cases in women on combined hormonal contraceptives (the pill)

An additional five cases in women who drink 2 or more units of alcohol per day

Three additional cases in women who are current smokers

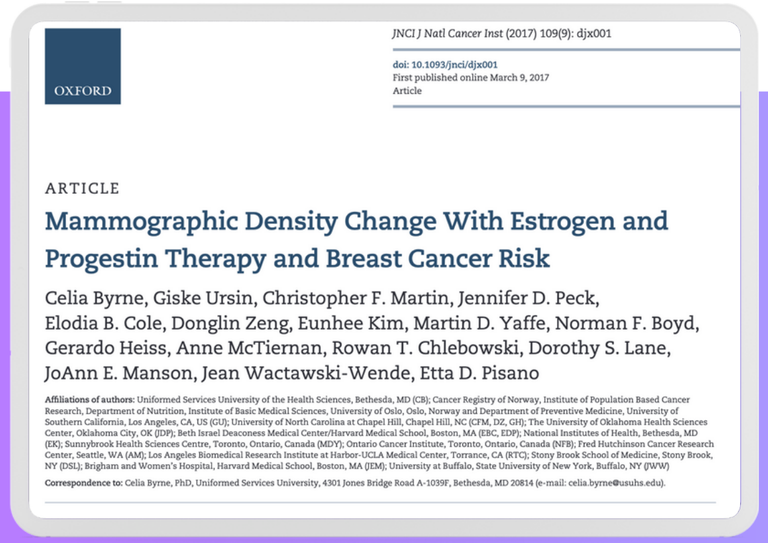
An additional 24 cases in women who are overweight or obese (BMI equal or greater than 30)

Seven fewer cases in women who take at least2½ hours moderate exercise per week

BMS British Menopause Society

Different hormone therapy regimens may be associated with **increased breast density,** which may obscure mammographic interpretation, leading to more mammograms or more breast biopsies and a postential delay in breast cancer diagnosis.

NAMS Position Statement 2022



OXFORD

JNCI J Natl Cancer Inst (2017) 109(9): djx001

doi: 10.1093/jnci/djx001
First published online March 9, 2017
Article

ARTICLE

Mammographic Density Change With Estrogen and Progestin Therapy and Breast Cancer Risk

Celia Byrne, Giske Ursin, Christopher F. Martin, Jennifer D. Peck, Elodia B. Cole, Donglin Zeng, Eunhee Kim, Martin D. Yaffe, Norman F. Boyd, Gerardo Heiss, Anne McTiernan, Rowan T. Chlebowski, Dorothy S. Lane, JoAnn E. Manson, Jean Wactawski-Wende, Etta D. Pisano

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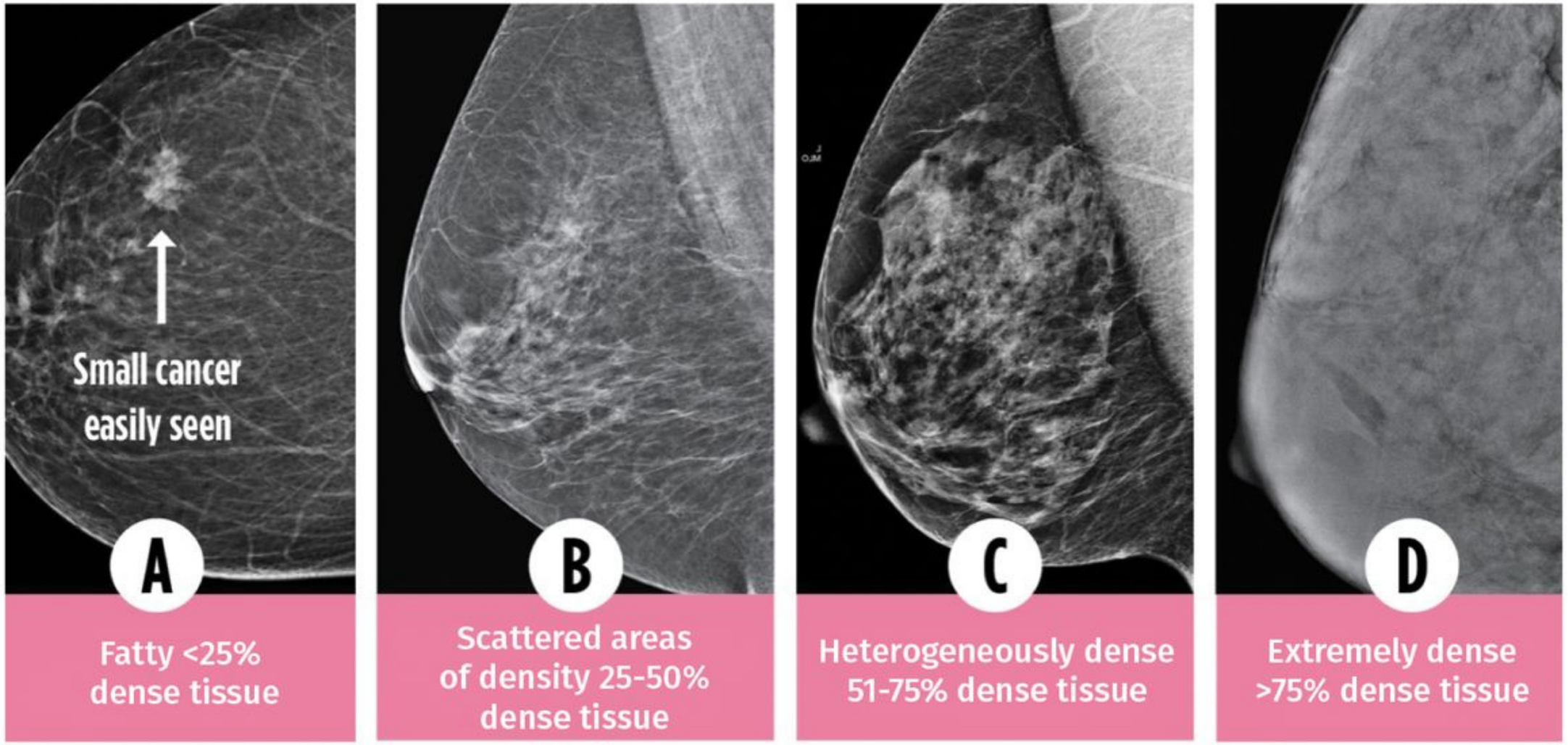
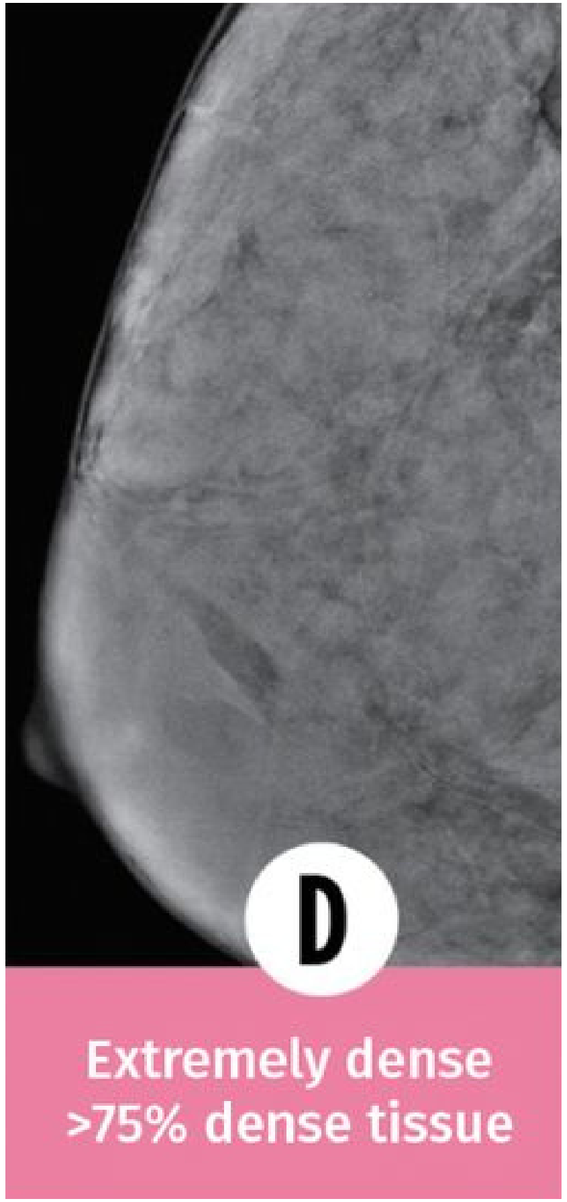
(Bryne 2017)

“All of the increased risk from estrogen plus progestin use was mediated through mammographic density change.”



From Dense Breasts Canada - www.densebreastscanada.ca



Risk of Breast (Chest) Density

- **Extremely dense breasts (Category “D”)** have a risk of breast cancer that is **greater than that of having a 1st degree relative with breast cancer.**
- Those with Category “D” density have a risk of up to **4 to 6 times higher** than for patients whose breasts are mostly low density
- **Mammograms are less sensitive with dense breasts**
  - 98% with Category “A”
  - 50% with Category “D” density
- Category D dense breasts are **5 to 13 times more likely to present with interval cancers.** And these cancers generally have a poorer prognosis.

(Yong-Hing, 2022)

NEW Ontario Changes

- As of **July 2023, the Government of Ontario has mandated** that all patients who have a routine mammogram are **notified of their breast density in their OBSP normal result letter**

- **Category D patients are recalled for screening in 1 year instead of 2**

- **Supplemental Screening is not current policy**

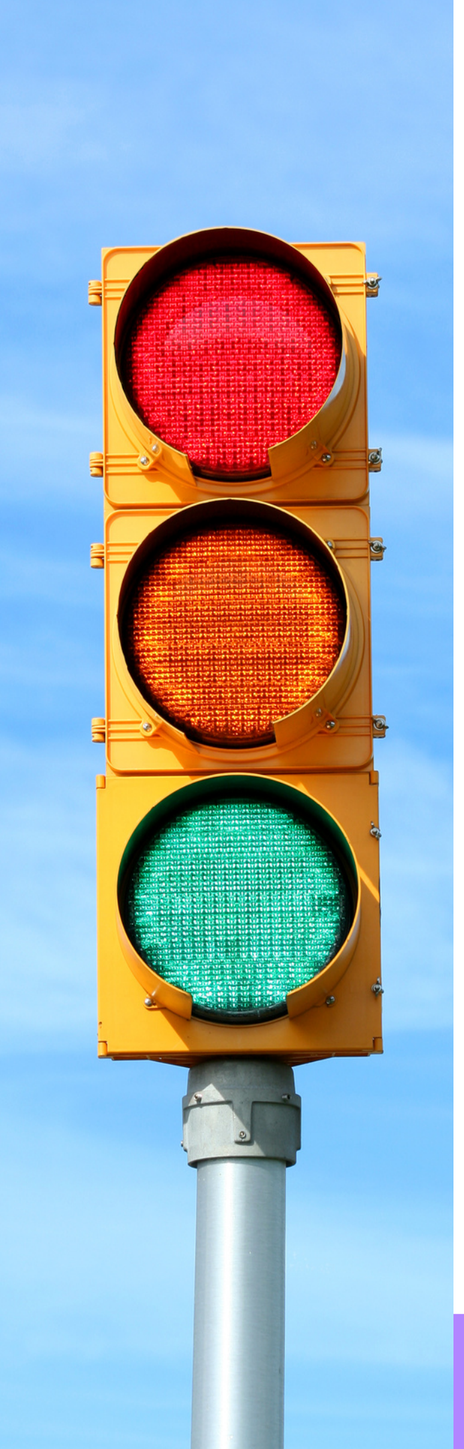
    - Supplemental **MRI** detects **16 additional cancers per 1000** screens after normal mammograms in dense breasts

    - Supplemental **Ultrasound** finds **2-3 additional cancers per 1000 women** with dense breasts after normal mammograms.

NEW Ontario Changes

- Starting in **fall 2024**, patients can self-refer for mammograms beginning at age 40

- Patients will not need a doctor or nurse practitioner’s referral and the service is covered by OHIP.



Contraindications for Estrogen Therapy or Estrogen Progestogen Therapy (NAMS)

- Undiagnosed abnormal genital bleeding
- Known or suspected estrogen-dependent cancer
- History of blood clot
- Active or recent (within past year) stroke or heart attack
- Liver dysfunction or disease
- Known or suspected pregnancy
- Known hypersensitivity to estrogen or progesterone

MHT Likely Safe (Benefits > Risks)

- **No Contraindications**
- **No major health issues**
- **Normal weight, blood pressure, cholesterol**
- **Within 10 years of menopause**
- **Low 10-year cardiovascular risk (Framingham or ASCVD Calculator)**

Adapted from NAMS Menopause Practice 6th edition

American College of Cardiology- Lundberg, 2019

OAND SPRING CONFERENCE 2024

3. MHT Prescribing

Introductory Anatomy of a MHT RX
ND Prescribing- Beyond the Prescription Pad

College of Naturopaths of Ontario

Naturopathy Act, 2007, S.O. 2007, c. 10, Sched. P
O. Reg. 168/15, Table 3; O. Reg. 94/23, s. 2

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Progesterone (bioidentical form)	Only if prescribed in a topical or suppository form.	Progesterone requires a prescription and may only be prescribed in topical or suppository form.

Compounded Hormone Therapy

BIO-IDENTICAL

Pharmaceutical Grade Hormone Therapy

ORAL ESTROGEN VS TOPICAL ESTROGEN

	ORAL ESTROGEN	TOPICAL ESTROGEN
Inflammation Markers	↑	Neutral
Blood Pressure	↑	↓
Cholesterol Levels	↓	Neutral
Triglyceride Levels	↑	↓
Overall Sexual Function	Neutral	↑
Blood Clots	↑	Neutral
Blood Estrogen Levels	Peaks & troughs	Relatively constant

(Sood, 2014)

Estriol

**"Tri-est and bi-est are frequently promoted as posing less risk of breast or endometrial
cancer than FDA-approved agents, although there is no research to back up this claim.**

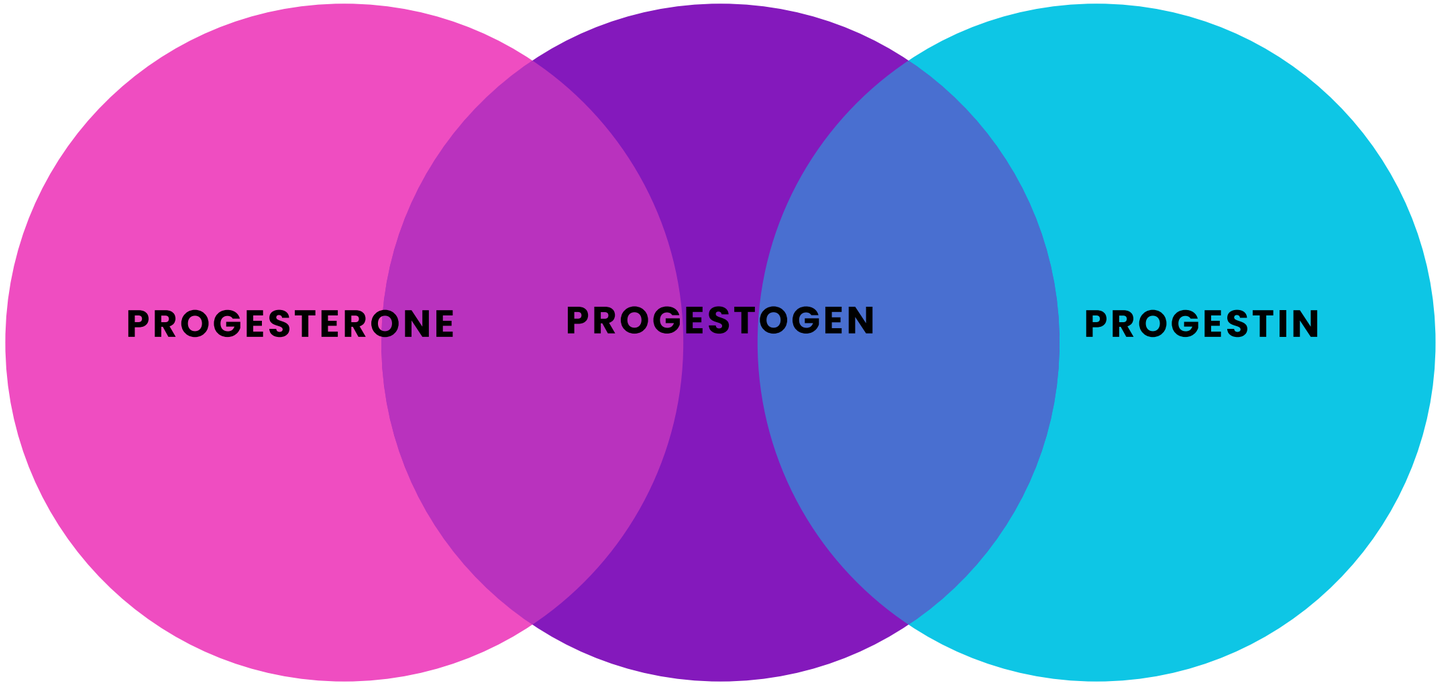
In fact, estriol may have a stimulatory effect on the breast."

(Pattimakiel, 2011)

- **LOTS of research**
  - Vaginal Estriol for GSM :)
- **SOME but MINIMAL RESEARCH**
  - Multiple Sclerosus- ORAL Estriol
  - VMS and Insomnia post-menopause- ORAL Estriol
  - Reduce bone resorption- ORAL Estriol
  - Estriol stimulates breast cancer cells in vitro
- **ZERO CLINICAL TRIALS**
  - CHD- No studies
  - BREAST- no studies

(Ali 2007)

"PROGESTOGENS" = PROGESERONE + PROGESTIN



AKA

- “bioidentical” progesterone
- Micronized Progesterone
- Oral Micronized Progesterone (OMP)

EXAMPLES

- Medroxyprogesterone Acetate (MPA)
- Norethindrone (NET)
- Levonorgestrel (LNG)

Purpose of Progesterone in MHT

01

UTERINE PROTECTION

When using Estrogen Therapy

02

SLEEP

Hypnotic & Sedative Effects

03

BONE

Stimulates Osteoblasts

04

VMS

May improve hot flashes and night sweats independent of Estrogen

TOPICAL Progesterone DOES NOT provide Endometrial Protection With Estrogen therapy

BJOG: an International Journal of Obstetrics and Gynaecology
October 2005, Vol. 112, pp. 1402–1406

Transdermal Progesterone & The Endometrium

Setting: Tertiary referral London teaching hospital
Design: Open Label
Population: Nationally recruited women, at least two years postmenopausal.

Treatment
1 mg Transdermal Estradiol Gel applied daily.
+40 mg Transdermal Progesterone Cream applied daily

	BASELINE	24 WEEKS	28 WEEKS	48 WEEKS
MEAN ENDOMETRIAL THICKNESS	3.3 mm	5.3 mm		5.5 mm
HISTOLOGY (ENDOMETRIAL BIOPSY)	100% ATROPHIC			

<u>48 Week Biopsy</u>

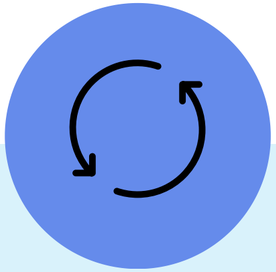
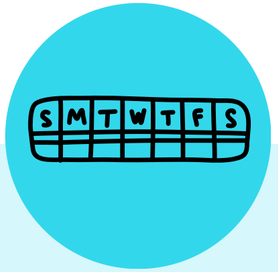
32% Inadequate Endometrial Opposition
27% Endometrial Proliferation
5% Complex Hyperplasia
1 non-atypical, 1 atypical

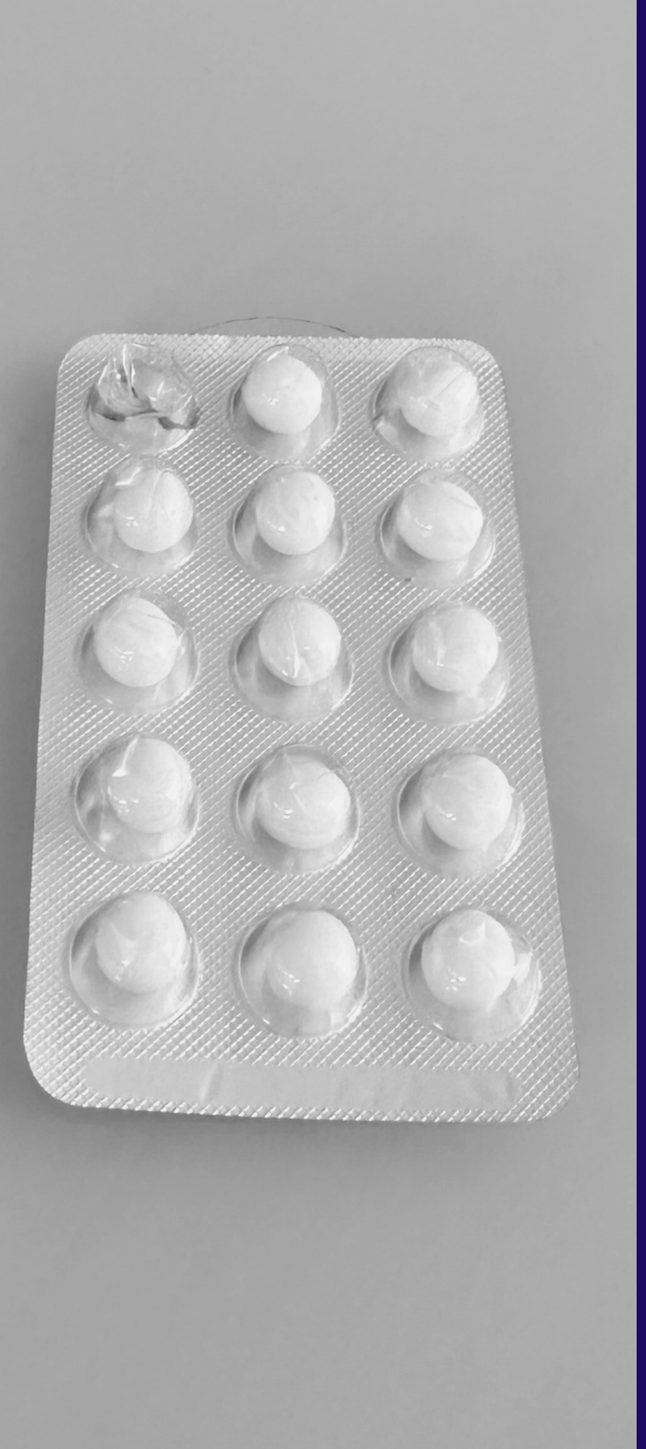
(Vashisht , 2005)

BJOG: an International Journal of Obstetrics and Gynaecology
October 2005, Vol. 112, pp. 1402–1406

Standard of Care RX

PROGESTOGEN MINIMUM REQUIREMENTS FOR ENDOMETRIAL PROTECTION WITH STANDARD ESTROGEN DOSING

PROGESTOGEN	 **CYCLIC** 12-14 d/mo	 **CONTINUOUS** Daily
Medroxyprogesterone Acetate (MPA)	5 mg	2.5 mg
ORAL Micronized Progesterone (MP)	200 mg	100 mg
LNG-IUS (e.g. Mirena)	Up to 5 years for this purpose	

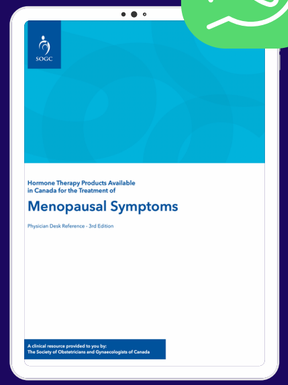


Progestogens – Oral

ACTIVE INGREDIENT(S)	PRODUCT / MANUFACTURER	DOSAGE FORM / STRENGTH	SCHEDULE
Norethindrone acetate	**NORLUTATE** Erfa Canada Inc.	**Tablet** 5 mg	Daily
Micronized progesterone B	**PROMETRIUM** Merck Canada Inc.	**Tablet** 100 mg	Daily
Medroxypro-gesterone acetate	**PROVERA** Pfizer Canada Inc.	**Tablet** 2.5 mg 5 mg 10 mg	Daily

Progestogens – Intrauterine

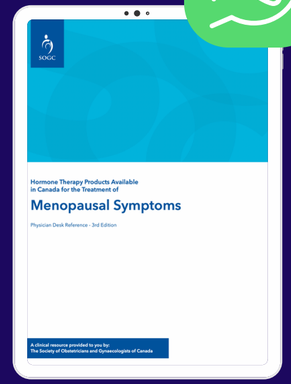
ACTIVE INGREDIENT(S)	PRODUCT / MANUFACTURER	DOSAGE FORM / STRENGTH	SCHEDULE
Levonorgestrel	**MIRENA** Bayer Inc.	**Intrauterine** 52 mg	5 years



Estrogens – Transdermal

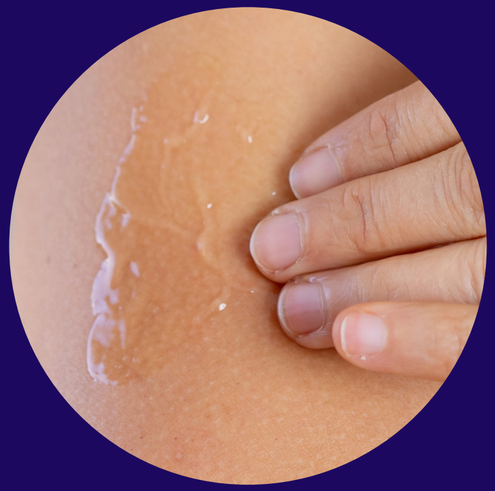
ACTIVE INGREDIENT(S)	PRODUCT / MANUFACTURER	DOSAGE FORM / STRENGTH	SCHEDULE
17ß-estradiol B	**CLIMARA** Bayer Inc.	**Patch** 0.025 mg 0.05 mg 0.075 mg 0.1 mg	Once weekly
17ß-estradiol B	**ESTRADOT** Novartis Pharmaceuticals Canada Inc.	**Patch** 0.025 mg 0.0375 mg 0.05 mg 0.075 mg 0.1 mg	Twice weekly

ACTIVE INGREDIENT(S)	PRODUCT / MANUFACTURER	DOSAGE FORM / STRENGTH	SCHEDULE
17ß-estradiol B	**DIVIGEL** Teva Canada Ltd.	**Gel** 0.1% 0.25 mg 0.5 mg 1 mg	Daily
17ß-estradiol B	**ESTROGEL** Merck Canada Inc.	**Gel** 0.06% 2 pumps (1.5 mg E_2)	Daily



Patients with a Uterine Hysterectomy

OR



Transdermal Estrogen
Patch
1-2 Times Weekly

Transdermal Estrogen
Gel
Daily

Only if clinically relevant

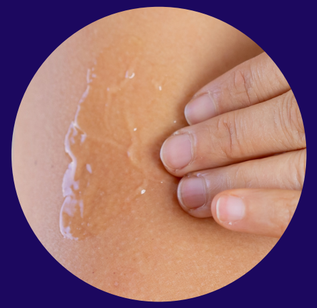
Patients with a Uterus

Transdermal Estradiol

PATCH

1-2 Times Weekly

OR

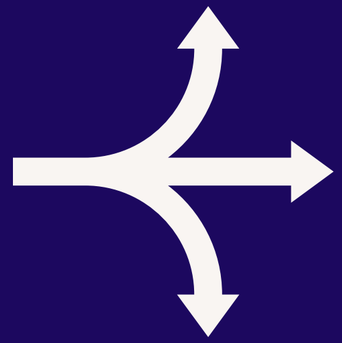


Transdermal Estradiol

GEL

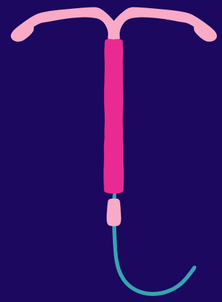
Daily

+



OMP
200mg
12-14 days
per month

OMP
100mg
DAILY



52mcg LNG-IUD
5 years

College of Naturopaths of Ontario

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Collaborate

For Menopausal People without a Uterus

- Estrogen only therapy is safe, and within our scope of practice
- It does not require collaboration, but it does require communication

For Menopausal People with a Uterus in Which Estrogen + Adequate Progestogen is Necessary:

- Referral to patients Primary Care Provider or Gynecologist to consider MHT Rx

- Consider IUD, which can serve as the Progesterone component of MHT for 5 years

- **REFERRAL (not delegate)** to a a private prescribing clinician, such as a nurse practitioner, to prescribe oral progesterone and co-manage MHT

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4. Naturopathic Prescribing

Beyond the Prescription Pad

Tests to Monitor MHT

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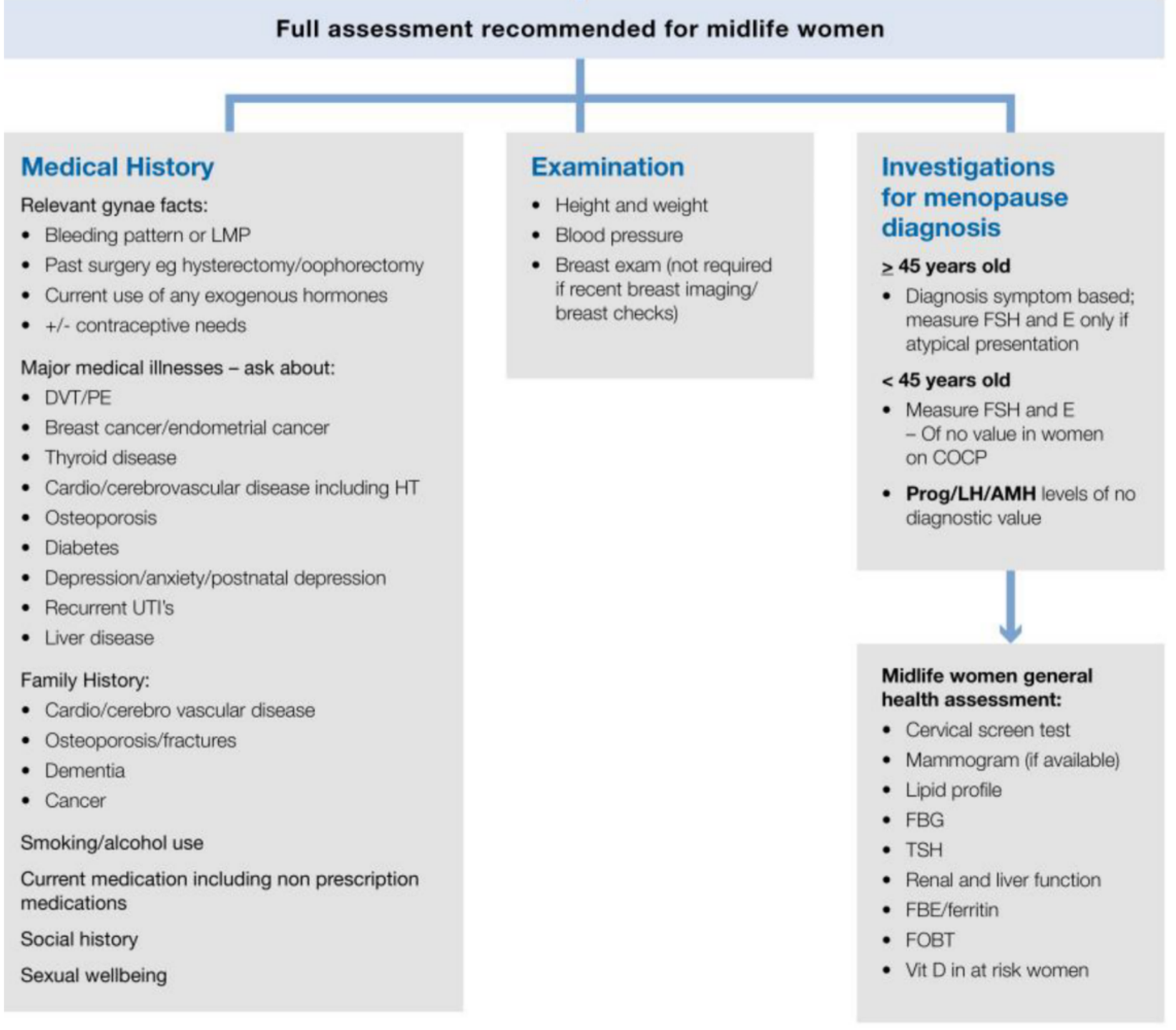
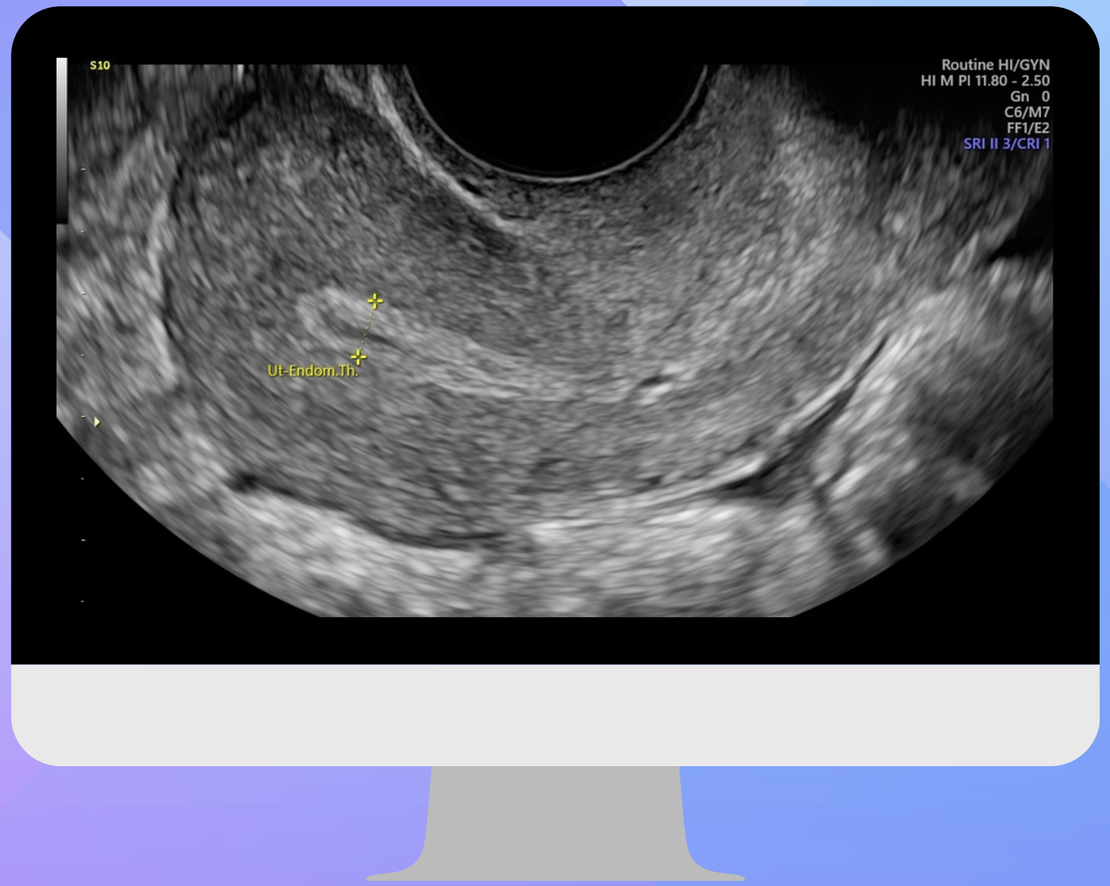

Full assessment recommended for midlife women
Medical History
Relevant gynae facts:
• Bleeding pattern or LMP
• Past surgery eg hysterectomy/oophorectomy
• Current use of any exogenous hormones
• +/- contraceptive needs
Major medical illnesses – ask about:
• DVT/PE
• Breast cancer/endometrial cancer
• Thyroid disease
• Cardio/cerebrovascular disease including HT
• Osteoporosis
• Diabetes
• Depression/anxiety/postnatal depression
• Recurrent UTI's
• Liver disease
Family History:
• Cardio/cerebro vascular disease
• Osteoporosis/fractures
• Dementia
• Cancer
Smoking/alcohol use
Current medication including non prescription medications
Social history
Sexual wellbeing
Examination
• Height and weight
• Blood pressure
• Breast exam (not required if recent breast imaging/ breast checks)
Investigations for menopause diagnosis
≥ 45 years old
• Diagnosis symptom based; measure FSH and E only if atypical presentation
< 45 years old
• Measure FSH and E – Of no value in women on COCP
• Prog/LH/AMH levels of no diagnostic value
Midlife women general health assessment:
• Cervical screen test
• Mammogram (if available)
• Lipid profile
• FBG
• TSH
• Renal and liver function
• FBE/ferritin
• FOBT
• Vit D in at risk women

(Davis, 2023)



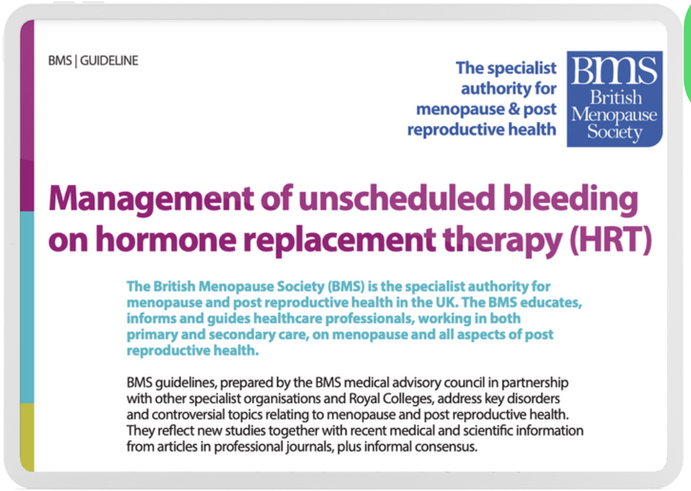
All Postmenopausal bleeding

AND

Unscheduled Bleeding on MHT

Requires Referral for:

Transvaginal ultrasound (TVUS) +/- uterine biopsy


BMS | GUIDELINE

The specialist authority for menopause & post reproductive health

BMS British Menopause Society

Management of unscheduled bleeding on hormone replacement therapy (HRT)

The British Menopause Society (BMS) is the specialist authority for menopause and post reproductive health in the UK. The BMS educates, informs and guides healthcare professionals, working in both primary and secondary care, on menopause and all aspects of post reproductive health.

BMS guidelines, prepared by the BMS medical advisory council in partnership with other specialist organisations and Royal Colleges, address key disorders and controversial topics relating to menopause and post reproductive health. They reflect new studies together with recent medical and scientific information from articles in professional journals, plus informal consensus.


Rx
PATIENT NAME:
ADDRESS:
Prescription:
Signature:
Date:

EDUCATE.

Risk/Benefit Decisions and Patient Education in MHT require a knowledgeable practitioner, an engaged patient, and sufficient time.

Repeatedly.

This cannot happen in 7 minutes.

College of Naturopaths of Ontario

Part II (Controlled Acts) of the General Regulation requires that a prescription contains the following:

- the name and address of the patient for whom the drug is prescribed;
- the name, strength (where applicable) and quantity of the prescribed drug;
- directions for use of the drug, including dose, frequency, route of administration and any special instructions;
- the name, signature, address, telephone number and College registration number of the Registrant issuing the instruction;
- the date the prescription was issued;
- the number of refills that the Registrant has authorised; and

Registrants must maintain a patient record for individuals prescribed a drug that includes:

- details of the reason for prescribing the drug;
- a copy of the prescription given to the patient;
- a record of the results of any laboratory or other tests that the Registrant considered in deciding to prescribe the drug; and
- the names and addresses of the patient's other health care providers who were notified, and how the notification was given.

PRESCRIPTION ADVISORY

Yes, this is a CONO Requirement

But it also makes you:

- A professional
- Collaborative
- Align wtih the patients best interest

And it makes your patients PCP

- Not blind sighted WHEN you have to ASK something of them

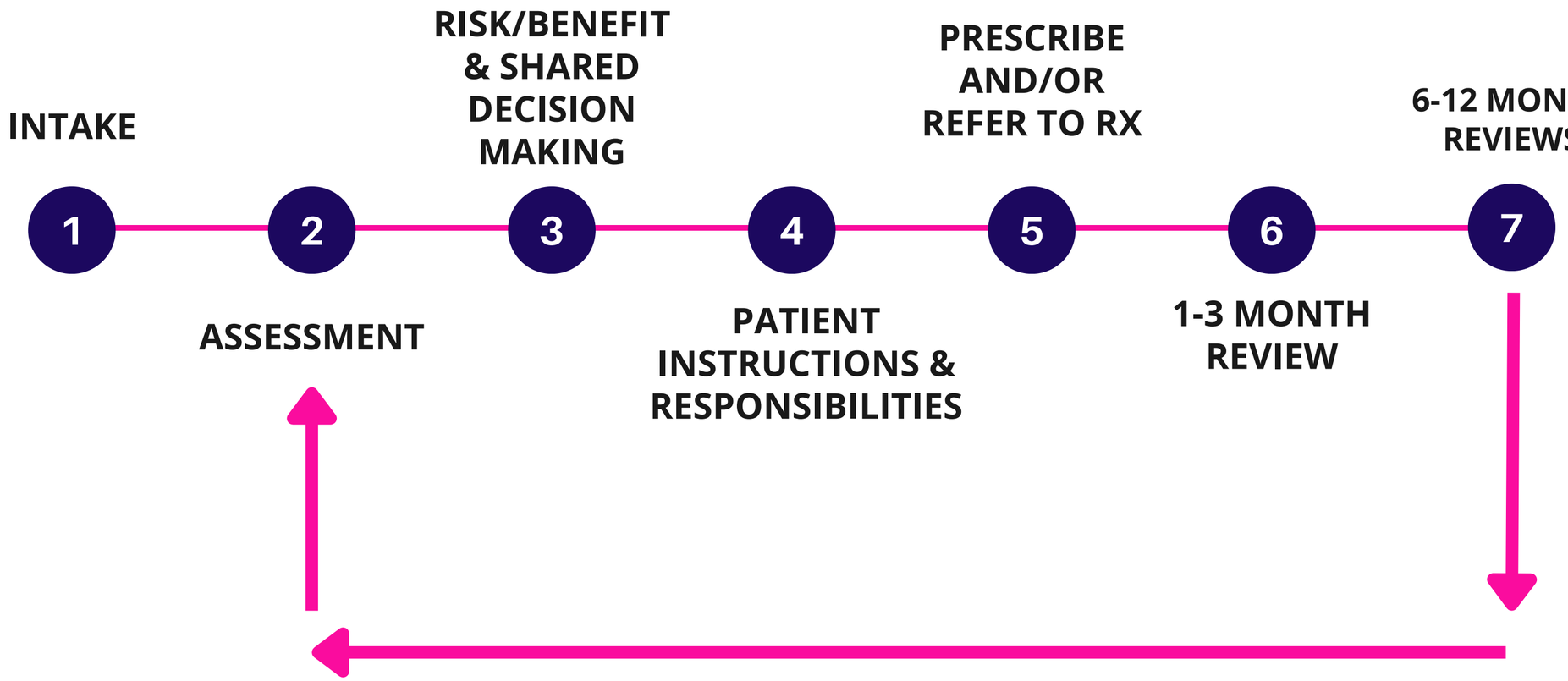
PATIENT INSTRUCTIONS & RESPONSIBILITIES

- **How do they apply their gel or patch?**
  - Where? How much? How often? What if it falls off?

- **What if they get vaginal bleeding?**

- **What do YOU Expect of them?**
  - **Screening**
  - **Followups**
  - **What they need to tell you...**

Clinic Systems & Administration



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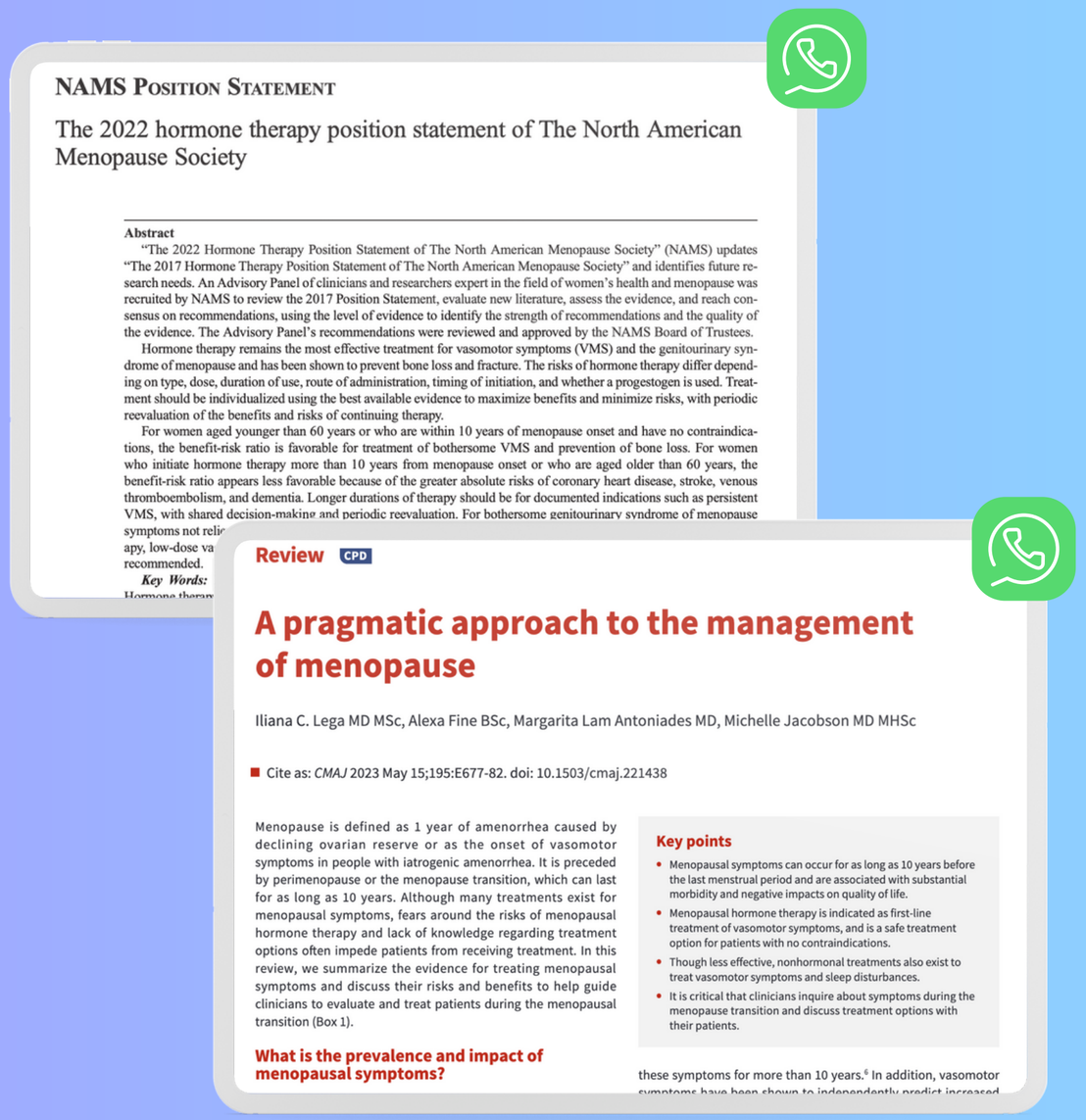

NAMS Position Statement

The 2022 hormone therapy position statement of The North American Menopause Society

Abstract

"The 2022 Hormone Therapy Position Statement of The North American Menopause Society" (NAMS) updates "The 2017 Hormone Therapy Position Statement of The North American Menopause Society" and identifies future research needs. An Advisory Panel of clinicians and researchers expert in the field of women's health and menopause was recruited by NAMS to review the 2017 Position Statement, evaluate new literature, assess the evidence, and reach consensus on recommendations, using the level of evidence to identify the strength of recommendations and the quality of the evidence. The Advisory Panel's recommendations were reviewed and approved by the NAMS Board of Trustees.

Hormone therapy remains the most effective treatment for vasomotor symptoms (VMS) and the genitourinary syndrome of menopause and has been shown to prevent bone loss and fracture. The risks of hormone therapy differ depending on type, dose, duration of use, route of administration, timing of initiation, and whether a progestogen is used. Treatment should be individualized using the best available evidence to maximize benefits and minimize risks, with periodic reevaluation of the benefits and risks of continuing therapy.

For women aged younger than 60 years or who are within 10 years of menopause onset and have no contraindications, the benefit-risk ratio is favorable for treatment of bothersome VMS and prevention of bone loss. For women who initiate hormone therapy more than 10 years from menopause onset or who are aged older than 60 years, the benefit-risk ratio appears less favorable because of the greater absolute risks of coronary heart disease, stroke, venous thromboembolism, and dementia. Longer durations of therapy should be for documented indications such as persistent VMS, with shared decision-making and periodic reevaluation. For bothersome genitourinary syndrome of menopause symptoms not reli
apy, low-dose va
recommended.

Key Words:

Review CPD

A pragmatic approach to the management of menopause

Iliana C. Lega MD MSc, Alexa Fine BSc, Margarita Lam Antoniades MD, Michelle Jacobson MD MHSc

Cite as: *CMAJ* 2023 May 15;195:E677-82. doi: 10.1503/cmaj.221438

Menopause is defined as 1 year of amenorrhea caused by declining ovarian reserve or as the onset of vasomotor symptoms in people with iatrogenic amenorrhea. It is preceded by perimenopause or the menopause transition, which can last for as long as 10 years. Although many treatments exist for menopausal symptoms, fears around the risks of menopausal hormone therapy and lack of knowledge regarding treatment options often impede patients from receiving treatment. In this review, we summarize the evidence for treating menopausal symptoms and discuss their risks and benefits to help guide clinicians to evaluate and treat patients during the menopausal transition (Box 1).

Key points

- Menopausal symptoms can occur for as long as 10 years before the last menstrual period and are associated with substantial morbidity and negative impacts on quality of life.
- Menopausal hormone therapy is indicated as first-line treatment of vasomotor symptoms, and is a safe treatment option for patients with no contraindications.
- Though less effective, nonhormonal treatments also exist to treat vasomotor symptoms and sleep disturbances.
- It is critical that clinicians inquire about symptoms during the menopause transition and discuss treatment options with their patients.

What is the prevalence and impact of menopausal symptoms?

these symptoms for more than 10 years.[6] In addition, vasomotor

readcube papers

REFERENCES

bit.ly/karaoandagm

Prescribing is a significant responsibility that demands the utmost due diligence— incorporating clinical judgment, evidence-based decision-making, patient education, informed consent, clinical systems, and interdisciplinary collaboration

For naturopathic doctors, **adopting a collaborative, respectful, and team-oriented approach—even amid reluctance** —is pivotal to earning our place as respected members of modern healthcare.

Dr. Kara Dionisio, ND