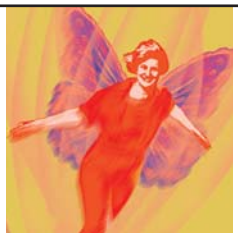

# Assessment of women in midlife

**BACKGROUND** Midlife is much more than menopause. At the time of their life when women may be experiencing symptoms relating to decreased ovarian function, they are also confronted with a range of physical and psychosocial issues that may affect their wellbeing.

**OBJECTIVE** This article outlines the range of clinical presentations of women in midlife and discusses assessment of these presentations in the context of the individual woman's life.

**DISCUSSION** Women in midlife present to doctors for a variety of reasons including information and preventive health, vasomotor or other symptoms of oestrogen deficiency, menstrual disorders, breast disorders, sexual difficulty, relationship and family issues, or mood disorders. Forming an effective doctor-patient partnership to address these issues requires time, empathy, good interpersonal skills, comprehensive and sensitive history taking and examination skills, and a good knowledge of relevant research.

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Why do women in midlife present to their general practitioner for advice at this particular time of their lives? Is the multitude of physical and psychological changes they may be experiencing simply explained by hormonal changes? Is this menopause? How do women seek information about these changes confronting them in midlife? What is the role of the GP?

Many women, their partners and their doctors are searching for a single, simple explanation – 'hormones' – for the physical and psychological symptoms they are experiencing at midlife. If only it were that simple! Menopause is a label defining the level of ovarian activity at a particular time in a woman's life; usually midlife. This decline in ovarian function will, in turn, create a state of 'hormonal chaos' which may or may not cause a multitude of physical and psychological symptoms varying considerably in severity, nature, frequency and persistence.

In addition to these internal biological factors, there is potentially a myriad of external factors that will interplay with the hormonal environment experienced by women in midlife. These may include family and relationship issues, socioeconomic concerns, cultural variations, general health and wellbeing, and the ability to adapt to changes associated with aging (see the article *Is this menopause?* by Amanda Deeks page 889 this issue).

Importantly, it is often these factors that will determine a woman's tolerance to the symptoms she may be experiencing with the hormonal changes of her menopause. As such, the thorough assessment of a woman in midlife must include specific questioning relating not only to her hormonal status, but also to her social and emotional wellbeing. An understanding of these external stressors is integral to the success of her overall management plan.

With increased life expectancy resulting from improved health, nutrition, and medical intervention, the major health issues facing western society today

relate to an aging population. Women can expect to spend half their adult lives in the postmenopause in a state of ovarian failure and relative hormone deficiency.

Despite this phenomenon, women continue to find it difficult to obtain accurate information about menopause. Frequent sources of information include women's magazines, newspapers, the internet, television, radio, and a vast array of advertising material. Unfortunately these sources vary considerably in accuracy and motive. Well meaning words of wisdom from friends and family will then be added to the conglomeration of information.

Some women do not even experience a mild flush and 'cannot see what all the fuss is about'. Others experience symptoms, but have the internal and external resources to cope without assistance. Some women are made to feel guilty because they have succumbed to their symptoms and sought help. It is important to recognise that every woman's experience throughout menopause and midlife is unique, and information must be specific to her situation and based on a thorough assessment of all interplaying factors.

## Doctor-patient partnership

General practitioners are the primary point of contact within the health care system for women seeking advice about menopause – and may be the sole source of information for women in rural and remote areas. Other sources include naturopaths, psychologists, nurses, pharmacists and other health practitioners.

As such, there is an expectation that GPs and allied health professionals will be informed about management options based on the latest research. General practitioner must be confident to deliver accurate advice in this area, or be able and prepared to refer appropriately. Specific skills that may be required of the GP include:

- empathy and interpersonal skills
- understanding of the range of health issues facing women at midlife
- knowledge of latest research to be able to provide evidence based information
- gentle but thorough breast examination
- sensitive pelvic examination
- prescribe, titrate and monitor hormone therapy (HT) regimens, and
- insertion of hormone implants.

Regardless of our personal views and anxieties, we must respect the rights of women to be given the opportunity to consider all treatment options. When answers are inconclusive or not evidence based, women prefer honesty and open discussion, enabling them to make informed decisions and take control of their own lives and health management. This ability to be a partner with their GP in decision making rather than being told dogmatically what to do is therapeutic in itself.

An open, two-way doctor-patient relationship is essential, as sensitive information will only be obtained with trust and good communication skills. Some women will have difficulty communicating certain issues such as loss of libido with their usual family doctor. By seeking help elsewhere, they can feel guilty because they are 'betraying' their trust in their doctor. We need to be able to see issues, without bias, from a woman's point of view. For some women, it is also important that their partners are aware and sympathetic to the issues they are facing.

Most importantly, the thorough assessment of a menopausal woman requires time. Often midlife is the first time a woman has actually sought assistance and advice for herself alone. She may have been the nurturer, homemaker, taxi, often the breadwinner; looking after everybody else's needs above her own. Besides the physical and psychological symptoms of menopause, she may have a multitude of equally important external issues to discuss and resolve. Time is essential to assess total wellbeing – to simply talk

**Table 1. Presentations in midlife**

| |
|---|
| Abnormal vaginal bleeding |
| Breast lumps |
| Contraceptive advice |
| Hirsutism |
| Information about menopause |
| Mood disturbance |
| Osteoporosis management |
| Pelvic pain |
| Premenstrual syndrome |
| Preventive health |
| Relationship and family issues (partner, children and/or elderly parents) |
| Sexual dysfunction/loss of libido |
| Urinary incontinence |
| Vasomotor symptoms |
| Well woman's check |
| Weight gain/body image concerns |

and tease out the stressors that may be impacting on her symptoms. Unfortunately, our current health system does not encourage this philosophy.

## Why does a woman present to the GP at midlife?

There are a variety of reasons why a woman presents for advice at midlife (*Table 1*), but often the actual purpose will only be revealed with careful and sensitive history taking (*Table 2*).

Many women present for management of specific symptoms, either directly associated with menopause (eg. relief of hot flushes) or related to other medical disorders occurring coincidentally with menopause (eg. concern about a breast lump). This includes psychological symptoms such as depression, anxiety, tiredness, irritability, insomnia, loss of concentration and memory loss. These symptoms may be perceived to be menopause related, but they may also be intertwined with various major life stressors requiring 'crisis support' or counselling.

Asymptomatic women often present at midlife for a 'well woman's check'. These motivated women are seeking information and assessment of their potential risk factors for issues such – cancer, cardiovascular disease, or osteoporosis – thereby reassuring themselves that they are doing everything within their power to eliminate or reduce these risks. Some are simply seeking accurate information after reading about or hearing advice from others.

Women who have been prescribed HT may wish to update their medication or seek advice for management of side effects. Following the premature release of the initial Women's Health Initiative trial results in the media, many women either sought reassurance and advice regarding whether they should continue their HT or, after abruptly stopping their HT, required ongoing management of disabling symptoms.

When assessing a woman who has presented in midlife for whatever reason, health professionals must be aware and sensitive to many factors that may influence her presentation. While menopause and aging are normal biological events, there is an enormous variation in prior experiences and expectations. These factors may include:

- age – different concerns and issues relating to a woman 40 years of age compared to a woman of 65 years
- cultural background – awareness of differences in customs and attitude to menopause and aging, language expertise
- menopausal status – different issues affecting women experiencing a premature sudden surgical or chemical menopause, possibly secondary to cancer treatments
- intrinsic health and wellbeing
- pre-conceived fears about menopause/HT such as cancer, weight gain
- current controversies, misinformation and level/accuracy of information accrued from other sources

**Table 2. Taking a history**

- Current specific symptoms (vasomoter, urogenital, mood, sexual)
- Menstrual status/cycle/vaginal bleeding
- Medications
  - prescription and nonprescription medications including herbal therapies
  - use of oral contractive pill, corticosteroids (relevant to osteoporosis)
  - prior use of HT: positive or negative experiences, side effects
- Family history
  - familial cancers: breast, ovary, uterus, bowel
  - mood disorders
  - osteoporosis
  - cardiovascular disease, diabetes, hypertension, hyperlipidaemia
  - thromboembolic disorders (factor V Leiden, prothrombin gene mutations)
- Past personal history
  - obstetric and gynaecological history: menstrual cycle, contraception, miscarriage
  - mood disorders: depression/anxiety, premenstrual syndrome, postnatal depression
  - previous cancer
  - general surgical and medical history
  - thromboembolism (spontaneous/related to surgery, immobility, pregnancies)
- Preventive health
  - cardiovascular risk factors: diabetes, hyperlipidaemia, IHD, hypertension
  - osteoporosis risk factors including previous fractures
  - current screening status (Pap test, mammogram, DEXA)
  - need for contraception
  - lifestyle factors: smoking, alcohol and other drugs, nutrition, exercise
- Midlife social issues
  - partner, marital status, relationship issues, health of partner
  - sexual problems
  - children: 'empty nest', 'full nest' or 'revolving door'
  - elderly parents: health, dependence, carer
  - employment status
  - financial position
  - attitude to aging

- doctor's own knowledge, beliefs and prejudices about management of women of menopausal age, and
- previous experiences with other health professionals, both positive and negative.

## History

The aim of taking a thorough and sensitive history is to elicit the actual reason for presentation of a woman NOW, at this particular time in her life. Besides her 'hormonal symptoms', other issues that may be impacting on her symptoms must be defined, particularly psychosocial factors. Finally, an awareness of potential risk factors impacting on her short and long term health is essential (*Table 2*).

**Table 3. Investigations according to individual need**

- Pap test
- Mammogram +/- ultrasound (screening or diagnostic)
- Cardiovascular risk profile: fasting lipids (including HDL, LDL), glucose
- FBE, iron studies, TFT (consider if tiredness, menorrhagia or mood disturbance)
- DEXA (particularly if family history of osteoporosis, history of secondary amenorrhoea, spontaneous fracture, thyroid disease or corticosteroid use)
- If osteoporosis is present: TFT, LFT, ESR, U&E, calcium, phosphate, vitamin D, (if ESR is increased, check serum and urine protein electrophoresis)
- Vaginal ultrasound (if pelvic pathology or abnormal bleeding)
- Referral for hysteroscopy +/- endometrial biopsy (abnormal bleeding)
- Coagulation studies: INR/APTT, APCR, prothrombin gene mutation, lupus anticoagulant, homocysteine; for those at high risk add antithrombin III, protein C & S
- Hormone levels (rarely required), FSH, oestradiol, sensitive testosterone, SHBG
- Urodynamics assessment (if stress/urge incontinence, particularly if not responsive to pelvic floor exercises)

**Table 4. Referrals (where appropriate)**

- Dietician
- Pelvic floor physiotherapist
- Alternative therapists
- Psychologist
- Psychiatrist
- Breast surgeon
- Urogynaecologist
- Gynaecologist
- Weight management specialist
- Endocrinologist
- Sex counsellor/relationship counsellor
- Community support services

## Examination

The extent of the physical examination will depend upon the nature of the presenting symptoms, risk factor assessment and current screening status. Asymptomatic women presenting for a 'well woman check' require routine preventive health examinations such as a Pap test, breast examination and cardiovascular check (where not current).

Women presenting with a breast lump, a family history of breast cancer, or contemplating HT will require a thorough breast examination as will those who have not had a routine breast examination in the past 12 months. The extent of a gynaecological examination will depend on factors such as time lapsed since previous Pap test, past history of abnormal Pap test, the presence of abnormal bleeding or pelvic pain, or family history of ovarian cancer. Women who have had a hysterectomy with ovarian conservation will require a bimanual examination for ovarian pathology and vaginal vault smear with a past history of abnormal Pap test.

## Investigations

Investigations should be chosen judiciously depending on the outcomes of the history, examination and current routine screening status (*Table 3*). Pap tests should be taken every 2 years until the age of 70 years, including vaginal vault smears following hysterectomy in those with a past history of an abnormal Pap test. However, women with vaginal bleeding which is unexpected, persistent or considered abnormal for the individual situation may require an earlier Pap test and/or a transvaginal ultrasound to assess endometrial thickness and pelvic pathology and/or hysteroscopy with biopsy.

A mammogram should be performed every 2 years in women over 40 years of age (free of charge at Breastscreen). Women over 50 years of age are routinely recalled every 2 years. However, with any breast abnormality found on examination, a diagnostic mammogram and ultrasound should be obtained. This should include comparison with previous films which will involve organising copies of films from Breastscreen (at a small cost to the patient).

Cardiovascular risk profile including fasting lipids and glucose should be updated every 2 years, particularly where other cardiovascular risk factors are present.

Hormone levels are rarely required. Follicle stimulating hormone (FSH) and oestradiol have limited use in the diagnosis of symptoms due to the day-to-day variability of levels in a natural cycle or with the 'hormonal chaos' of the menopausal transition. Oestradiol levels cannot be used to monitor oral HT doses, but may assist where absorption from a patch or gel is an issue or when monitoring implant therapy and tachyphylaxis. Follicle stimulating hormone/oestradiol levels can assist with diagnosis after a hysterectomy where there is no menstrual marker, however, premenopausal levels do not exclude the menopausal transition. Follicle stimulating hormone may be useful to differentiate between premature menopause and secondary amenorrhoea in younger women.

Testosterone levels are generally of little use in women as the assay is not accurate enough at the lower end of the detection range (ie. levels found in women). It may be useful when monitoring therapy with implants or testosterone creams, however, it is preferable to measure 'sensitive' testosterone which is a more accurate assay than the routine testosterone assay. The sensitive testosterone level must then be adjusted according to the sex hormone binding globulin (SHBG) to evaluate the nonbound or available testosterone. We await results of recent research to clarify this area in the near future.

Many women choose to have their bone density measured as a preventive measure, particularly if they do not require HT for symptom relief. Dual energy X-ray absorptiometry (DEXA) is the most appropriate measure but is not covered by Medicare unless the woman is from a defined 'risk group'. Heel ultrasound measurements and plain X-ray are not accurate markers of osteoporosis.

Coagulation studies are indicated if there is a family history or past history of thromboembolism, particularly if spontaneous. Tests for the most common abnormalities (factor V Leiden and prothrombin mutation) have only been available in recent years and have generally not been tested in women with deep venous thrombus more than 7–8 years ago.

## Management plan

The final stage in the assessment of a woman at midlife is to define her problem list, which commonly falls into one or more of the following diagnostic categories:

- asymptomatic – seeking information or preventive health assessment only
- menopausal symptoms – oestrogen deficiency
- sexual dysfunction
- abnormal vaginal bleeding
- osteoporosis/osteopaenia/high fracture risk
- incontinence
- mood disturbance
- cardiovascular risks
- contraceptive advice
- breast lump, and
- psychosocial/relationship issues.

From this summary, a discussion with the patient of the available management options can occur (see *Algorithm* page 900 this issue). The management plan should always include reinforcement of lifestyle issues such as diet (iron, calcium, fat), exercise, stress management, smoking and alcohol use. Sometimes HT may be helpful and can be used where safe and appropriate. Some women will prefer to use complementary therapies instead of, or in addition to, prescribed medications. Medications may also be indicated for the management of specific conditions such as osteoporosis or hyperlipidaemia. Some women will require referral to other health professionals for specialised management of specific conditions (*Table 4*).

### Summary of important points

- Decline in ovarian function creates a state of 'hormonal chaos' which may or may not cause a multitude of physical and psychological symptoms varying considerably in severity, nature, frequency and persistence.
- External factors include family and relationship issues, socioeconomic concerns, cultural variations, general health and wellbeing, and the ability to adapt to changes associated with aging.
- A thorough assessment of a woman in midlife must include specific questioning relating not only to her hormonal status, but also to her social and emotional wellbeing.
- General practitioners should be informed about management options based on the latest research, and be confident to deliver accurate advice or be able and prepared to refer appropriately.

Conflict of interest: none declared.

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