

facing  
menopause?

12 COMMON  
(AND NOT-SO-COMMON)

# MYTHS

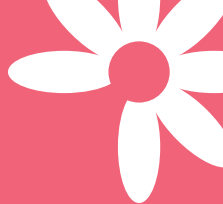
about menopause  
explained

Because

i am

unique





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# TO OUR READERS

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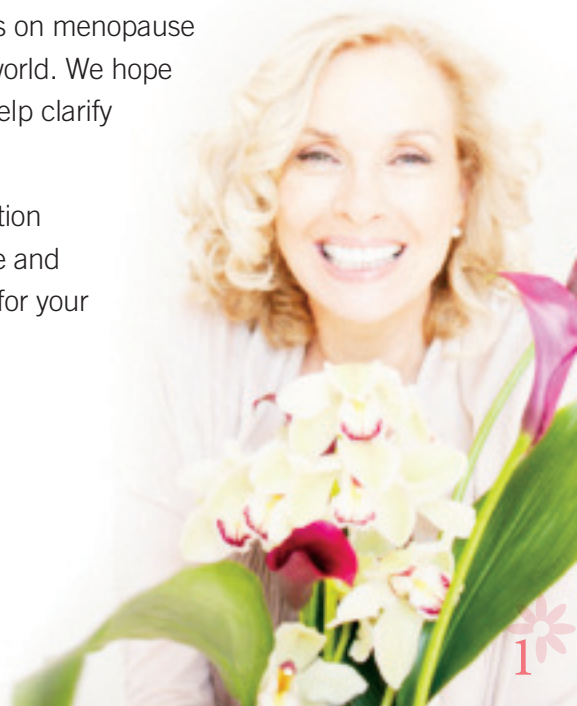
**Menopause.** For every woman, the word and the experience of menopause bring about so many different emotions, thoughts – and perhaps most of all – misinformation. And in this supersaturated information age we currently live in, it is difficult to identify what counts as fact and what as fiction. In this short booklet, we address some of the myths, common and uncommon, surrounding menopause. It is our hope to clarify a few of these myths in a way that is direct, clear, and understandable.

Like no generation before, women entering menopause today have many plans to fulfill and so much more life to live. In order to do this, women need clear and simple answers to some of the most frequently misunderstood myths related to menopause. While talking to friends and family is certainly a start, following the advice of your physician will ensure you get the best and most accurate information possible.

There are vast conversations on menopause happening throughout the world. We hope these myths and facts will help clarify some of these issues.

And remember, the information provided is general in nature and not considered a substitute for your personal physician's advice.

***Because you are unique.***



# MYTH 01

## ONCE YOU TURN 50, MENOPAUSE TAKES OVER

### Myth explained:

Menopause can occur at various ages, but the age range that most women experience menopause is between ages 45 and 55, with the average age around 51. Early menopause occurs between ages 40 and 45 and late menopause between ages 55 and 60. 1-2% of women develop premature menopause (before age 40). The time at which a woman reaches menopause depends on a number of factors. Smokers reach menopause on average 2 years earlier than nonsmokers. The best predictor of menopause age is the age at which mothers and sisters reach menopause.

**Natural menopause** is a spontaneous ending of menstruation not caused by disease or intervention. With increased life expectancy, most North American women now live at least one third of their lives after menopause.

**Surgical menopause.** Menopause occurs immediately if both ovaries are surgically removed (bilateral oophorectomy). Surgery to remove the uterus (hysterectomy) does not cause menopause if the ovaries are left in place, although menses will stop. Women who have had hysterectomy on average will start menopause 2 to 3 years earlier than women who have not. Chemotherapy and pelvic radiation therapy may predispose a woman to have an earlier menopause. But in some of these instances, cessation of menses is temporary.

**Premature menopause,** whether natural or induced, occurs before age 40. The major cause (40%) is unknown. 30% of cases are autoimmune with antibodies destroying ovarian egg cells. Investigations for coexisting autoimmune conditions (thyroiditis, rheumatoid arthritis, lupus, etc.) should be done. Less common causes include destruction of ovarian tissues secondary to surgery, radiation, and chemotherapy. Rare causes include genetics and chromosomal abnormalities. Terminology for this condition includes premature menopause, premature ovarian failure (POF), and premature ovarian insufficiency.

# MYTH 02

## MENOPAUSE MEANS DEPRESSION, ANXIETY, MOOD SWINGS, AND MEMORY LOSS

### Myth explained:

Many women often experience irritability, tearfulness, anxiety, difficulty concentrating, lack of energy, poor concentration, and mood swings as they go through menopause. But, are all of these things caused by menopause?

**Mood swings vs. depression.** Mood swings related to menopause and depression are two separate things. Menopause does not cause depression nor are there higher rates of depression among menopausal women. But sleep disorders and hot flashes are common, and these can contribute to feeling irritable and moody.

**Memory and menopause.** What about memory problems? Many women report difficulties with their memory and with concentration during the transition to menopause. Studies that attempted to measure memory changes in women going through menopause all tend to be quite small in size, and the memory tests that are used in these studies may not reflect the kinds of memory-related tasks women do in real life. Many authors also point out that the way we see ourselves (“I have a poor memory!”) does not always match with objective tests that demonstrate our abilities (e.g. you scored well on a memory recall test, or you could remember all the words to a song you just heard). Given these shortcomings, it is difficult to assess whether menopause and memory loss are correlated.

**Menopause is just one of many challenges that women face.** Mood and stress can affect how we feel about our memory and our emotions – and mid-life is full of stressors that impact our mental health. Whether it's dealing with adolescent children or facing an empty nest, increased career demands, financial challenges, or aging parents, women in their 50s today have many things to think about and take care of. And when menopause arrives, this only compounds the stress a woman feels. As well, sleep disturbances, made worse by hot flashes, help contribute to a poorly functioning memory.

**The Takeaway Message:** Try to relieve the important factors in daily life that are likely contributing to changes in mood and stress. And talk to your doctor if you are concerned about your mental health.

# MYTH 03

## SEX AFTER 50 IS JUST NOT THE SAME

### Myth explained:

While it may seem that menopause and sexual dysfunction coincide, the truth is that sexual dysfunction for women can happen at any age – from adolescence to late postmenopause. In two widely quoted studies, 43% of women – ranging from age 18 to postmenopause – complained of some type of sexual dysfunction.

For some women, menopause **does affect their sex life**. Here are a few common conditions:

- **Low sexual desire**, also known as hyposexual desire disorder (HSDD), includes the absence of sexual fantasies or desire for any form of sexual activity. This absence of desire co-exists with the presence of personal distress and/or interpersonal difficulties. Women who have had their ovaries surgically removed (i.e. have undergone surgical menopause) are more likely to experience HSDD than women who experience natural menopause.
- **Sexual pain disorders** are the result of the thinning of the vulva, vagina, and urinary tract over time. Known as vulvovaginal atrophy, or VVA for short, this thinning occurs with the loss of estrogen production during menopause. In addition, a loss of vaginal elasticity can make sexual intercourse uncomfortable and result in tears of delicate tissue. There is also an increased risk of vaginal infections and reactive contractions of vaginal muscle secondary to painful penetration (vaginismus). Simple solutions such as using vaginal lubricants and moisturizers can help; your doctor may prescribe estrogen creams, tablets, or rings in more severe cases. All patients with sexual pain disorders should be assessed for gynecological conditions.

There are also situations related to menopause that in turn affect sexual desire:

- Although not directly caused by menopause, depression is common in women. The average lifetime prevalence of major depression in women is approximately 20% and can dampen sex drive and affect the global sexual response cycle. Some antidepressants (particularly selective serotonin reuptake inhibitors [SSRIs]) can also lessen sexual desire and affect the ability to orgasm.
- **Relationship issues**. Menopause can be a challenging time; when a woman is unhappy, angry, or disappointed with her partner, her sex life may suffer too. Research has shown that relationship issues can be a factor in the lack of sexual desire, more so than hormone levels.

**The Takeaway Message:** Menopause does not signal the end of a healthy and active sex life! Do not be afraid to talk to your healthcare provider. With appropriate evaluation, possible treatment, counselling, and involvement of your partner, you can resolve many issues and continue to have an enjoyable sex life well beyond menopause.



# MYTH 04

## ALL WOMEN HAVE HOT FLASHES DURING MENOPAUSE

### Myth explained:

While hot flashes are fairly common, they are not universal. In North America, about 75% of women experience hot flashes as they go through menopause. Hot flashes start at menopause transition, and are most prominent in the first two years of menopause. While the cause of hot flashes is not fully understood, it is known that a decrease in estrogen levels plays an important role. Unlike vaginal dryness that worsens with time, hot flashes usually disappear after 7 years in 60% of menopausal women, although up to 15% of women still report hot flashes for 10 years or more.

Most hot flashes are mild to moderate. Severe hot flashes that disrupt quality of life happen 9% of the time. Mild flashes can usually be managed with lifestyle modifications such as keeping yourself cool, regular exercise, weight control, smoking cessation, and avoidance of triggers (e.g. hot and spicy food, caffeinated beverages, and alcohol).

Hormone therapy (HT) remains the most effective treatment to relieve hot flashes in menopausal women. You can use progestin and low-dose birth control pills if you are still menstruating. If you are unable to use HT, your doctor can prescribe you a nonhormonal treatment. And if you are thinking of taking a complementary and alternative medicine, it's worth knowing that many of these treatments have been shown to have little benefit. What's more, most have no safety data.

***The Takeaway Message:*** Hot flashes are common but they are manageable, both with lifestyle modifications and with HT.



# MYTH 05

## HORMONE THERAPY CAUSES BREAST C

### Myth explained:

Research has shown a link between HT and breast cancer: it is uncertain whether estrogen causes breast cancer or promotes the growth of it in women. Current research points to estrogen as NOT causing breast cancer.

In 2002, the Women's Health Initiative (WHI), the largest study of women and HT, reported that increased estrogen and progesterone use in women with a uterus was associated with a small increased risk of breast cancer at 5 years.

In 2004, the WHI estrogen-only arm (women without a uterus) did not show an increased risk of breast cancer after 6.8 years.

Other studies have shown that the longer the use and the greater the dose of estrogen, the higher the risk of breast cancer. This is why many healthcare practitioners prescribe HT at "the lowest effective dose for the shortest time."

**So should I stop taking HT if there is a risk?** Studies suggest that HT may slightly increase the risk for breast cancer in late menopause after 4 or more years of continuous HT.

**The Takeaway Message:** Menopausal women (aged 50 to 60) who are suffering hot flashes should know that short-term use of HT will have very little effect on their personal breast cancer risk. If women are at a high risk, they need to discuss their personal benefit/risk situation with their physician to make a decision.

### KNOW YOUR PERSONAL RISKS OF DEVELOPING BREAST CANCER

**Major risk factors include:** Age (your risk increases significantly after age 55); family history; previous breast biopsy that showed abnormal cells; increased breast density on mammography; and/or never having children (or having first child after age 30).

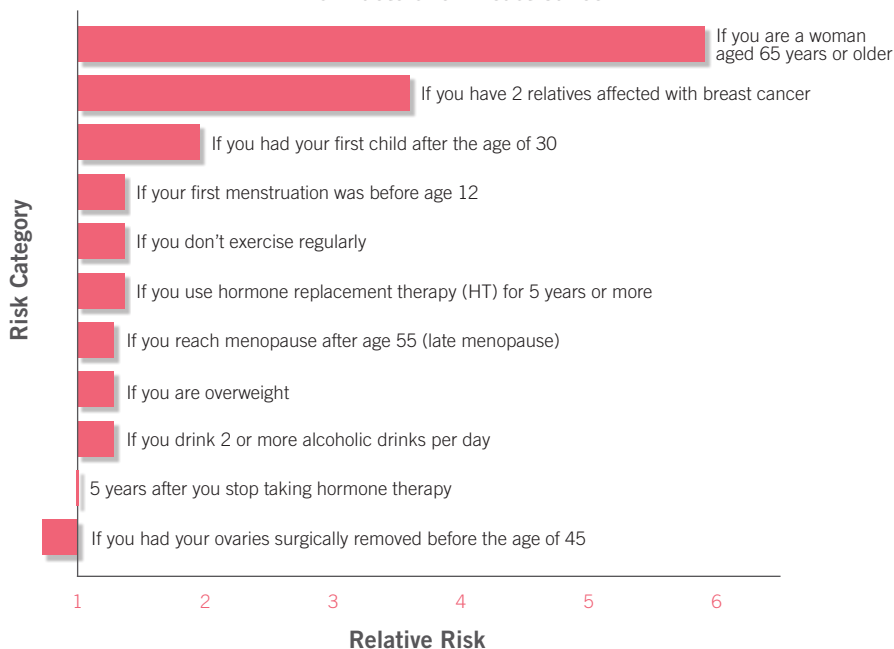
**Lifestyle choices that impact your risk include:** Lack of exercise; excessive alcohol intake; obesity and weight gain after menopause; smoking; and/or lack of breast-feeding after childbirth.





Did you know? Early diagnosis of breast cancer has been shown to reduce mortality risk by approximately one third in women aged 50 to 69. At present, the only proven strategy to reduce breast cancer deaths is early detection through mammography in women over 50.

## Risk Factors for Breast Cancer



It may surprise you, but lifestyle factors such as lack of exercise, alcohol intake, and weight gain after menopause also have an impact on your risk of developing breast cancer similar to the use of HT.

**The Takeaway Message:** When postmenopausal women (age 50 to 60) experience distressing vasomotor symptoms (hot flashes), they should know that SHORT-TERM USE of HT will have little effect on their personal breast cancer risk, yet will afford them excellent symptom control and quality of life. Longer use of HT DOES increase breast cancer risk, similar to lifestyle risks.

# MYTH 06

## HORMONE THERAPY CAUSES HEART AT

### Myth explained:

While heart disease is the number two killer of women in Canada, it should be noted that HT alone does NOT increase the risk of a heart attack. The single most important factor for heart disease is AGE and MENOPAUSAL STATUS: i.e. being premenopausal is protective and the risk is low, but after menopause, as the woman grows older, the risks of heart disease increase.

The seven major factors that explain 94% of the risks of heart attacks have been identified. These are **smoking, abnormal lipid profile, hypertension, abdominal obesity, poor diet, excess alcohol, and stress**. The really good news is that each of these is modifiable – meaning you can do something about them.

In the landmark 2002 WHI study, women between 50 and 80 years of age were started on menopausal hormones, and the study results raised concerns about the relationship between hormonal therapy and heart attacks.

**However, there's more to the story you may not know:** The initial results were reported by popular media as causing 26% more heart attacks in postmenopausal women (50 to 80 years old) taking estrogen plus progestin (vs. those not taking HT) but failed to clarify that this meant less than one additional event per 1,000 hormone-taking women overall. More importantly, this risk is even smaller if the group of women is aged 60 or less. In fact, those who started HT between 50 and 59 years of age were less likely to die (one less death per 1,000 HT users) from coronary artery disease than those NOT on HT.

In a re-analysis of the WHI data and other studies, a clear outcome emerged: risks associated with postmenopausal hormonal therapy (estrogen/estrogen-progestin) are **age related**. That is, even prior to giving treatment with any HT, women in their 50s have half the cardiovascular risk of women in their 60s, and one quarter the risk of women in their 70s.



Thus, a physician needs to consider the age of a patient before prescribing HT, because there is good evidence that, not only are women who start HT between 50 and 59 years of age **not** at increased risk of cardiovascular disease, they may indeed experience **cardiovascular benefits** as a result of taking HT.

**The Takeaway Message:** Women in the 50- to 59-year-old age group should feel reassured that taking HT is not harmful to their heart health and if symptomatic, they should not hesitate to take HT for relief of their symptoms. However, caution is advised if HT is being considered for the older postmenopausal woman, as it could have adverse effects.



**THE FACTS:  
USED AT THE RIGHT  
AGE, HT CAN BE GOOD  
FOR YOUR HEART.**

Studies have shown that starting HT in early menopause is safe, and may actually protect the heart and promote heart health. Currently the Society of Obstetricians and Gynaecologists of Canada (SOGC), the North American Menopause Society (NAMS), and the International Menopause Society (IMS) recommend that HT should be used for the management of moderate to severe menopausal symptoms, and should not be prescribed solely to prevent heart disease.

**Myth explained:**

The relationship between HT and ischemic strokes (a clogged blood vessel obstructing blood flow to the brain) is fraught with misinformation and fear.

In Canada, in both men and women, strokes are not uncommon. They occur in one in five Canadian women, and are the third leading cause of death. Although the incidence of stroke increases with age (unlike heart disease), being premenopausal does not give any protection. However, the good news is that the major risk factors for strokes (hypertension, obesity, smoking, excessive alcohol, lack of exercise, diabetes, migraine headaches [with visual aura], and too little/too much sleep) are all modifiable – meaning you can do something about them.

**What about the use of menopausal HT?** The results of studies looking at whether use of menopausal HT increases strokes are conflicting: many have shown no effect, some found a decrease, while others have shown an increase of strokes with HT. The large WHI study did find an increased incidence of stroke overall, **except in those women who exercised regularly!** However, in women 50 to 59 years old who were taking HT, there was **not** a significant increase in stroke risk. Other studies have shown that lower doses of estrogen, the addition of progestin/progesterone and most recently, the use of transdermal preparations (i.e. estrogen patches or gels), appear not to be associated with increased stroke risk.

**The Takeaway Message:** The key to reducing stroke risk – regardless of whether or not you are on HT – is a healthy lifestyle. This should include an active exercise program, controlling blood pressure as well as weight and diabetes (if relevant), stopping smoking, and limiting alcohol intake.

# MYTH 08

## I'M TOO YOUNG TO WORRY ABOUT SOMETHING LIKE OSTEOPOROSIS

### Myth explained:

With the onset of menopause and lower estrogen levels, a woman's risk for health conditions such as heart disease, diabetes, osteoporosis, and cancer increases.

In the case of osteoporosis, the decrease in estrogen levels associated with menopause affects a woman's bone density and strength. And this is why it is important for women to pay close attention to their bone health during menopause.

**Risk factors for osteoporosis.** Do you know if you are at higher risk for osteoporosis? Knowing your risk factors can help you determine what preventative measures you can take to reduce your risk of osteoporosis and fracture. You can take an online test for fracture risk developed by the World Health Organization called FRAX.

**You could be at higher risk of developing osteoporosis if any of the following apply to you:**

- Have suffered a previous fragility fracture
- Experienced loss of 1.5 inches or 3 cm in height
- Low body mass index
- Smoking, consumption of more than two alcoholic drinks per day
- History of corticosteroid use
- Family history of osteoporosis

One of the largest clinical studies of postmenopausal women – the WHI – demonstrated that even in a population of older postmenopausal women **not** at increased risk for fracture, the risk of hip fractures were reduced\* by postmenopausal estrogen use. Women with menopausal symptoms requiring estrogen may be reassured that this therapy will also slow bone loss.

**The Takeaway Message:** Menopause can put you at increased risk of developing osteoporosis – so talk to your doctor about what steps you should take to monitor and/or prevent bone loss. There are some HT treatments that are indicated for the prevention of osteoporosis – you and your doctor can decide if this treatment is right for you.

\*(Relative risk=0.64, 95% confidence interval=0.41-1.00).

# MYTH 09

## AT THIS AGE, I'M PROBABLY AT INCREASED RISK FOR COLON CANCER

### Myth explained:

Menopause does not increase risk for CRC, but growing older does. In fact, 93% of CRC cases occur in people over 50 years. Although it is not as well known as breast or ovarian cancer, CRC is the third most common cancer and affects both men and women equally. Screening for this cancer should be offered to all adults aged 50 to 74.

You can determine your risk for CRC using the table below:

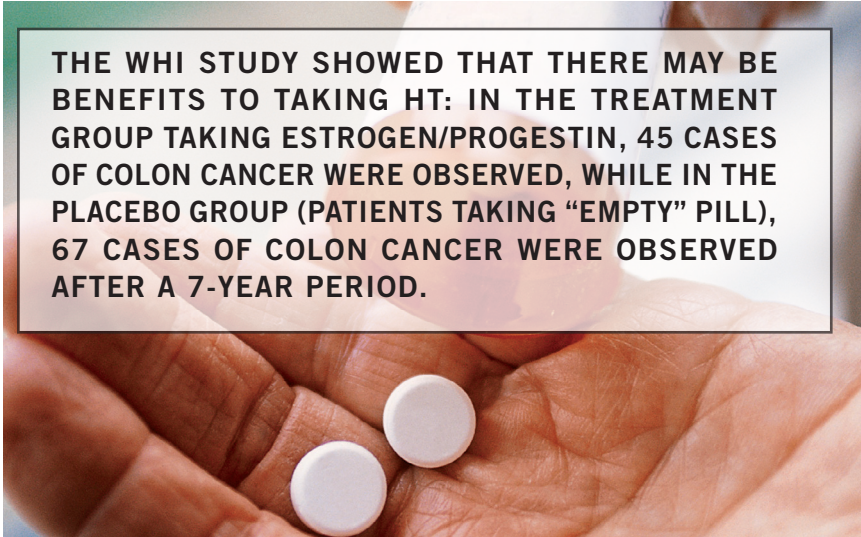
Your history	Your risk	Your action plan
<b>Over 50 years old</b> <ul style="list-style-type: none"><li>• Showing no symptoms of CRC</li><li>• No family or personal history of CRC or polyps</li></ul>	Average	Talk to your doctor about getting a fecal occult blood test (FOBT) done every 2 years
<b>Over 50 years old</b> <ul style="list-style-type: none"><li>• Have two first-degree relatives (e.g. mother, sibling) with CRC or precancerous polyps at any age</li></ul> <b>OR:</b> <ul style="list-style-type: none"><li>• Have one first-degree relative with CRC or precancerous polyps BEFORE the age of 60</li></ul>	Above average	Talk to your doctor about getting a regularly scheduled colonoscopy
<b>Over 50 years old</b> <ul style="list-style-type: none"><li>• Have a personal history of CRC, precancerous polyps, or inflammatory bowel disease</li></ul>	High risk	Ensure your doctor monitors your health regularly, as well as scheduling ongoing surveillance with colonoscopy

## SED RISK FOR COLORECTAL CANCER (CRC)

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This table is a simplified version of risk factors, so if you want to learn more about CRC and your risk, talk to your family doctor.

It should be noted that several studies (most notably the WHI and the Heart and Estrogen Replacement Study [HERS]) seemed to suggest that postmenopausal women who used combined HT (i.e. estrogen and progestin together) were *slightly less likely* to get CRC over the course of the study compared to women who did not use these hormones. This small protective effect was not seen in women who used estrogen-only HT. To put these findings in perspective, one author wrote that the results are not strong enough to warrant women to start taking estrogen plus progestin instead of estrogen alone.



**THE WHI STUDY SHOWED THAT THERE MAY BE BENEFITS TO TAKING HT: IN THE TREATMENT GROUP TAKING ESTROGEN/PROGESTIN, 45 CASES OF COLON CANCER WERE OBSERVED, WHILE IN THE PLACEBO GROUP (PATIENTS TAKING “EMPTY” PILL), 67 CASES OF COLON CANCER WERE OBSERVED AFTER A 7-YEAR PERIOD.**

**The Takeaway Message:** It's a good idea to talk to your doctor about your own personal risk of developing CRC.

# MYTH 10

## I SHOULDN'T TAKE HORMONE THERAPY BECAUSE I'LL GET BLOOD CLOTS

### Myth explained:

The majority of women taking HT do not experience blood clots (venous thromboembolism [VTE] and pulmonary embolism [PE]). However, some women are at an increased risk of developing blood clots. Based on a very large study of menopausal women (WHI), oral estrogen (Premarin® 0.625 mg) and progesterone (Provera® 2.5 mg) increased VTE two-fold. With estrogen alone (Premarin 0.625 mg), the VTE risk increased only slightly.

Recent data have suggested that with respect to HT and VTE, the risk is greatest in the first 3 months of therapy, but then the risk decreases. Some data indicate that transdermal and lower-dose HT result in reduced risk.

**Know your risk.** All women should know their personal risk for VTE before considering HT:

- Age (risk increases with age)
- Weight (obesity and being overweight contribute to higher risk)
- Having a prior case of VTE
- Family history
- Smoking
- Pregnancy
- Being immobile (due to major surgery, especially bone and joint, abdominal, or pelvic surgery; or from suffering a fracture)
- Illness
- Injury or trauma
- Using oral contraceptives or HT

**The Takeaway Message:** If you are considering HT, assess your risk of developing VTE and talk to your healthcare professional. You may also want to consider reducing your risk of VTE using the following strategies:

- Use a low dose of HT
- Use a transdermal (“patch on the skin”) form of HT
- Discontinue risky habits, such as smoking
- Keep an active lifestyle and practise weight control
- If you have a strong family history of VTEs or strokes, ask your doctor if you are a candidate for special tests for inherited risks for thrombophilia (i.e. a predisposition for blood clots)



# MYTH 11

## BIOIDENTICAL HORMONES ARE NATURAL AND SAFER THAN THE STANDARD HORMONE THERAPIES

### Myth explained:

**Bioidentical hormones** is a name used to describe hormones that are molecularly identical to those occurring naturally in the body. Another term – **bioidentical hormone therapy (BHT) or compounded bioidentical hormone therapy (cBHT)** – was coined later, and refers to “hormone recipes made by a compounding pharmacist from a physician’s prescription.” But don’t be fooled: even though BHTs are only available by prescription, they are not classified as drugs, and are not regulated by the government.

**But if they are identical to the hormones in my body, aren’t they safe and more effective?** There is no scientific evidence to back up the manufacturer’s claims that bioidenticals are effective or safe. In fact, because the production of BHTs is not regulated, and uniform standards for making these compounded products do not exist, it is even more difficult to know whether you are getting a product that has the correct amount or a pure amount of hormonal product needed to fulfill these claims.

**The Takeaway Message:** Similar to complementary therapies or natural remedies, it’s “buyer beware”: be careful when you decide to use a treatment that doesn’t have important safety and dosing information, and makes promises that seem too good to be true. And remember, if you want to take a BHT there are a number of commercially available and approved pharmaceutical hormonal products that are bioidentical (including skin patches, gels, and oral pills) and that have been widely tested for safety and effectiveness. Talk to your doctor about these options to see if they are appropriate for you personally.

# MYTH 12

## COMPLEMENTARY (OR ALTERNATIVE) THERAPIES ARE EFFECTIVE FOR MANAGING MENOPAUSE

### Myth explained:

The thought of treating menopause “naturally” using herbal remedies is appealing to many women. Perhaps this is because many of us associate natural with harmless. Unfortunately, natural products are not always safe, and what's more, they are not necessarily as effective as advertised, when it comes to relieving menopause symptoms.

**(Hot) flash-in-the-pan remedies.** Many of the herbal remedy products currently on the market have been shown to have limited efficacy in relieving hot flashes.

- A systematic review of 25 studies that involved some 2,348 women found that in most of the studies, there was no significant difference between soy-derived isoflavones and placebo (i.e. a dose that looks like the medicine being tested, but with no medicinal ingredients).
- Black cohosh did not significantly impact hot flashes compared to placebo and has potential gastrointestinal side effects. Liver toxicity/hepatitis is a significant concern.
- Similarly, studies on dong quai, ginko biloba, ginseng, and vitamin E have not shown any impact on hot flashes that is greater than the use of placebos.
- In a recent review, it was pointed out that although individual trials might suggest benefits from certain therapies, there is not enough conclusive evidence to show that complementary and alternative therapies are truly effective in managing menopausal symptoms. As well, without long-term safety and efficacy data, we cannot be sure that there is no harm. Side effects and drug interactions are not well known, but do occur.

**The Takeaway Message:** Again, it's “buyer beware” when it comes to buying natural remedies. Up until 2004, there were no limitations on product claims, leading many women to believe and buy products that promised more than they were able to deliver. This has been borne out of numerous consumer reports that have highlighted problems with inaccurate or false labelling. In the end, it is best to be wary of any herbal remedy product that promises relief from menopause symptoms.





## Who is SIGMA?

SIGMA (Special Interest Group on Menopause and Aging) is the Canadian Menopause Society. We are a multidisciplinary group of family physicians, specialists, and healthcare professionals who are interested in menopausal health. Our mission is to advance the health of women at and beyond the menopause transition through education initiatives and knowledge transfer.

SIGMA is a hub of menopausal knowledge with the ability to transfer information on a wide range of issues. It will network with menopause clinic(s) and menopause practitioners across Canada to share knowledge; to act as advocate(s) for menopausal health in Canada; and to provide up to date knowledge to our patients. SIGMA strives to have one voice in Canada that speaks for the women in Canada.

SIGMA is linked internationally to the North American Menopause Society (NAMS) and to the International Menopause Society (IMS). SIGMA members also liaise with the SOGC (Society of Obstetricians and Gynecologists of Canada), CCFP (Canadian College of Family Practice), OC (Osteoporosis Canada) and FMWC (Federation of Medical Women of Canada).

For references and additional information, please visit us at [www.sigmamenopause.com](http://www.sigmamenopause.com).

## SPECIAL THANKS TO THE FOLLOWING PHYSICIANS FOR THEIR CONTRIBUTIONS TO THIS BOOKLET:

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