

LAPAROSCOPY NEWS

John P.A. George, MD, F.A.C.O.G.

MENOPAUSE—What is it all about?

Volume 1, Issue 4

March 2005,
Revised May 2010

Any woman who lives long enough will have to face menopause, either naturally or induced by surgery.

Menopause is associated with several changes in the body's physiology, and is by no means limited to hot flashes. And menopause is by no means over when hot flashes are gone.

Menopause influences the brain, the reproductive tract, the bony skeleton and more.

Coping with menopause begins with understanding what it is. Lifestyle changes, dietary supplements and exercise must all be part of the adjustment to this process.

Judicious use of hormonal and other drug therapy may become necessary to cope.

To understand menopause, one should review the menstrual cycle and the various bodily func-

tions that influence it. Most women have monthly, regular menstrual cycles beginning soon after the onset of menstruation, (menarche).

Regular menstrual cycles are dependent upon a complex hormonal interaction resulting in release of eggs from the ovary. Monthly production of estrogen, progesterone (and small amounts of the male hormone testosterone) from the ovary is dependent upon regular ovulation influenced by release of hormones called Follicle Stimulating Hormone, (FSH) and Luteinizing Hormone, (LH) from the pituitary gland located at the base of the brain. The production of FSH and LH is influenced by other hormones from the brain called releasing factors, Gonadotropin Releasing Hormones (GnRH). Estrogen influences the production of FSH, LH and GnRH. This entire process can be further

influenced by other hormones including those that are produced by the thyroid gland in the neck and the adrenal gland located over the kidneys. **Stress may influence hormone production and thereby influence menstruation.**

As a woman approaches the age of 50, production of eggs begins to become irregular. As a result, the production of estrogen, progesterone and testosterone begin to decline and menses become irregular, (**perimenopause**). Along with these, she may experience hot flashes, mood changes, memory loss, sleep disturbances and changes in sexual desire. Every woman must realize that menopause is not the end, but another phase in life, one that can be very fulfilling if understood and approached with a positive philosophical orientation. (cont'd on P 2)

PATIENT COLUMN— After Laparoscopic Hysterectomy

Feeling Liberated

My recent diagnosis and treatment for fibroids and adenomyosis came after years of living in fear of my menstrual cycle and the accompanying abdominal pains. Prior to treatment, every month I became a hostage to my cycle and the erratic nature of the flow and duration. A major part of my

life involved decisions regarding what to wear, whether to go out to special events and feeling physically drained during my cycle. The colors in my wardrobe changed from a mixture of vibrant and pastel to dull and drab. My social outings were limited to the absolutely necessary and my general upbeat mood be-

came somewhat subdued during this time. After I was diagnosed and given treatment options, a hysterectomy seemed permanent and more than what I wanted at the time; while the other options seemed like temporary quick fixes to what was an unnecessary controlling factor in my life. (cont'd on p 2)

Special points of interest:

Menopause influences the brain, the reproductive tract, the bony skeleton and more.

As a woman approaches the age of 50, production of eggs begins to become irregular, and as a result, menses become irregular, perimenopause.

Lifestyle changes, dietary supplements and exercise must all be part of the adjustment to menopause.

Treatment of hot flashes, mood changes, sleeping disturbances and loss of sexual desire may be customized and may include hormones or alternatives to hormone therapy.

Inside this issue:

- Do African-American women get osteoporosis?* 2
- It feels wonderful to wear white again—ANYTIME!* 2
- Therapy for menopause ..
..Not all about hot flashes. 2
- Surgical removal of the ovaries* 3
- What do the following terms mean?* 3
- Alternatives to hormones for treating menopause* 4
- What's coming in the next issue?* 4

Hysterectomy? Sounded so final, but ———

Feeling liberated (cont'd from p 1)

After deliberating for a few months, I made the decision to have a hysterectomy- a decision that has liberated me. To sum up my feelings today, all I can say is it feels wonderful to wear white again...anytime!

Editorial Comment:

For most gynecologic ailments, there are treatment alternatives. And so it is for fibroids and adenomyosis, (Lap News, Vol. 1 # 1). "Fibroids" is practically a household name, and so

(Menopause cont'd from P1)

Bone loss also begins with perimenopause. This entire process may ebb and flow for years. Menstruation finally stops completely. The terms menopause and post-menopause are then used to refer to the same items—cessation of menses for at least one year and thereafter. **So menopause never ends while a woman is alive!** Symptoms like hot flashes may decrease or disappear, however others like vaginal dryness, continued bone loss, sexual desire, memory loss and changes in mood may persist and may require therapy.

Therapy for menopause begins with an understanding of the bodily changes that may occur beyond the occurrence of hot flashes.

Lifestyle changes are mandatory. First, every

woman should consider menopause as a new stage of her life that requires some adjustment philosophically, emotionally and physically. Adjustments must be made in diet, exercise and clothing.

Some fibroid symptoms may be helped by medication, and fibroids may be removed leaving the uterus in place, (a myomectomy). In the case of adenomyosis, if diagnosed prior to hysterectomy, both medical and conservative surgical therapy may provide relief. Symptoms have such a high probability of recur-

woman should consider menopause as a new stage of her life that requires some adjustment philosophically, emotionally and physically. Adjustments must be made in diet, exercise and clothing.

Not all women experience menopausal symptoms to the same degree. Therefore therapy for menopause must be customized to each patient. All women should take steps to prevent osteoporosis. Treatment of hot flashes, mood changes, sleeping disturbances and loss of sexual desire may be customized and may include hormones or alternatives to hormone therapy. Hormone therapy may include estrogen only, for women without a uterus, estrogen plus progesterone for those with a uterus (or with endometriosis) and/or estrogen/progesterone/testosterone for those

rence, however, that definitive surgery, removal of the uterus, (a hysterectomy) frequently becomes necessary. Such a decision can be an extremely difficult one especially in a woman who is not in a steady relationship and who may want to leave the option open to conceive.

GS chose a Short Stay Laparoscopic Hysterectomy. **Her ovaries were not removed, so she has no menopausal symptoms.** After the surgery, she had very little pain, and "down time" was two weeks. She can now enjoy every aspect of her life—the physical, emotional, social and sexual.

with loss of sexual desire. If you are 50 years of age or older and have stopped menstruating for a year, you are in menopause. **If hot**

A recent study found that African American women may start losing bone mass later than Whites, but then lose bone twice as fast.

flashes came and went, menopause is not over! Consult with your physician to determine your needs, especially regarding your bone health. Judicious use of hormones or alternatives unless otherwise contraindicated may improve the quality of life.

Menopause and osteoporosis. Are African American women at risk for osteoporosis?

African American women contrary to popular belief lose bone particularly after menopause. Many authorities consider postmenopausal Whites and Asians to be at risk. African Americans must be added to the list. **More than 50% of my African American patients over age 50 who are screened have osteopenia, (mild bone loss).**

Osteoporosis (severe bone loss) is mostly painless unless so severe that there are associated deformities especially of the spine. The

major problem of osteoporosis is the greater risk of a fracture of the hip or spine with less than severe trauma. So it is quite common that patients with osteopenia and osteoporosis feel fine, have no symptoms until mild trauma, a slip or gentle fall results in a major fracture.

So regardless of race, if you are over age 50, you should have a bone density test every two years. Unless medically contraindicated, you should use supplemental calcium with vitamin D (1200 mg per day). You should

walk at least three miles per day three times per week. **If your bone density test indicates that you have lost bone, then you should be taking prescribed medication to build bone.**

Be smart! Do not wait for the tragic fracture. Some risk factors for osteoporosis include being female, menopausal, diet low in calcium, certain drugs and smoking!

Stop smoking! Have a balanced diet, take your calcium supplements, exercise regularly and get your regular checkups.

Surgical Menopause: abrupt cessation of ovarian function.

Surgical removal of normal ovaries to cure endometriosis?

While the exact cause of endometriosis is unknown, we do know that it is influenced by the hormone estrogen. That's why endometriosis symptoms may significantly improve during menopause. In the past therefore it was quite common to induce menopause by removing the ovaries when treating particularly severe endometriosis.

But since menopause may be associated with its own constellation of symptoms requiring medical management, surgical removal of the ovaries should be considered with that in mind. In addition, recent reports regarding the safety of hormone replacement therapy have

raised more questions than provided answers. Many women faced with the option of using hormones or using an alternative method are now deciding against hormonal therapy.

So while removal of the ovaries may help treat endometriosis symptoms, it is likely to cause menopausal symptoms that may be difficult to manage particularly in the young woman who is opposed to taking hormone replacement therapy.

An alternative may be the medical induction of temporary menopause by using a drug belonging to the class called GnRH agonists. Such use may result in improvement in the

endometriosis symptoms. Even when adverse effects occur as a result of the GnRH agonist, they may be successfully treated by using medication similar to birth control pills. Such medical therapy may be used indefinitely.

So if you are faced with making a decision to remove the ovaries to treat endometriosis, plan well beyond the removal. Have a plan to treat the resulting menopausal symptoms. If that poses a problem, remember that you may keep the ovaries and use a GnRH agonist. Should that fail, you will still have the option open to remove the ovaries.

Surgical removal of normal ovaries at time of hysterectomy?

Most medical decision-making involves balancing anticipated benefits against possible risks. And so it is when considering the removal of normal ovaries at the time of a hysterectomy for benign disease.

First, the anticipated benefit of removing normal ovaries is the prevention of later cancer of the ovary and/or breast in patients with the Brca gene. The average lifetime risk of developing ovarian cancer is 1 in 70. If a family member is affected, however, that risk increases. The negative impact of removal includes immediate menopause in the younger woman and possible decrease in sexual desire. These symptoms develop as a result of failure of ovarian production of both female and male hormones, and may be minimized by prescribing these hormones. Since the symptoms may already be present in the woman already in menopause, removal of the ovaries to prevent cancer is usually an easier decision, particularly if there is a family history of ovarian cancer and/or the Brca gene.

Prior to menopause, however you may choose to keep your ovaries if your cancer risk is low, par-

ticularly if you do not desire to take hormones. If your cancer risk is high and you have no contraindication for taking hormones, you may choose to have the ovaries removed.

If you keep the ovaries, regular pelvic examinations by your gynecologist, a pelvic sonogram and CA 125 may help detect early development of cancer of the ovaries. Recent scientific reports suggest that there may be more harm than good in removing the ovaries in a pre-menopausal woman:

Bilateral oophorectomy versus ovarian conservation: effects on long-term women's health.

Bilateral oophorectomy at the time of hysterectomy for benign disease is commonly practiced to prevent the subsequent development of ovarian cancer. Currently, bilateral oophorectomy is performed in 55% of all U.S. women having a hysterectomy, with approximately 300,000 prophylactic oophorectomies performed every year. Observational studies show that estrogen deficiency, resulting from premenopausal or postmenopausal oophorectomy, is associ-

I am scheduled to have a hysterectomy. Should I also consent to have my ovaries removed?

ated with higher risks of coronary artery disease, stroke, hip fracture, Parkinsonism, dementia, cognitive impairment, depression, and anxiety. These studies suggest that bilateral oophorectomy may do more harm than good. In women not at high risk for development of ovarian or breast cancer, removing the ovaries at the time of hysterectomy should be approached with caution. Copyright 2010. Published by Elsevier Inc. Parker WH John Wayne Cancer Institute at Saint John's Health Center, Santa Monica, California 90401, USA. wparker@prrgyn.com *J Minim Invasive Gynecol.* 2010 Mar-Apr;17(2):141-2.

And what do the following terms mean?

Perimenopause: refers to the period of time prior to complete cessation of the menses when a woman may begin to experience irregular cycles, hot flashes, mood changes and decrease in sexual desire.

Menopause: refers to the period of time one year after complete cessation of menses and thereafter.

Postmenopausal: similar to menopausal.

Osteopenia: loss of bone, between normal and osteoporosis. Fracture risk is moderate.

Osteoporosis: loss of bone, more severe than osteopenia and with high fracture risk.

Dexa Scan: a method of screening to determine bone health.

FSH and LH: Hormones produced by the pituitary gland. The levels become high in menopause.

John P.A. George, MD, F.A.C.O.G.

6323 Georgia Avenue NW # 201
Washington, DC 20011
Phone: 202-291-0039
Fax: 202-829-4009
E-mail: JGeorge585@aol.com
Website: www.lapscope.com

Are my aching joints due to osteoporosis?

Changes in bone structure occur in or near the joints, (arthritis) and away from the joints as bone substance is lost (osteopenia or osteoporosis). The most likely cause of aching joints therefore is arthritis. **The danger of osteopenia and osteoporosis lies in the fact that bones are weaker and more susceptible to fracture with minor trauma.**

So if you are approaching or have achieved menopause, do not wait for symptoms to determine when you should take precautions. You can lessen your chances of having a fracture of the spine or hip by taking supplemental calcium, weight-bearing exercise, (walking 3 miles per day 3 times

Laparoscopy News is a monthly newsletter published by Dr. George as a source of information for patients.

*This issue was prompted by the fact that **many of our patients have a poor concept of what menopause means. Most think of menopause as a period in their lives around the age of 50 when hot flashes occur. They also think of menopause as ending when hot flashes go away. The truth is that “menopause is not gone in a flash”! It persists for the remainder of one’s life, affecting organs like the brain, bones, the vagina and more. Also in this issue, GS shares her experience after a laparoscopic hysterectomy. Submit your comments and read those of others in the next issue. You may submit via E-mail your anecdote or comment in not more than 100 words. Comments may be related to articles in “Laparoscopy News”, and will be published in the subsequent issue of Lap News..***

Next issue: More patient comments—



What are some alternatives to hormones for treating menopause?

Not long ago, hormone therapy for menopause was considered **THE** thing to do not only to treat hot flashes but to gain a sense of well being, to improve memory loss and to enhance the health of the cardiovascular system. Within the past two years, however two large NIH sponsored studies related to use of hormones were stopped. The first study was comparing women who took a combination estrogen and progesterone to women who did not. **Those on the hormones had a slightly higher occurrence of breast cancer, blood clots, stroke and heart attacks, but a lower occurrence of fractures and colon cancer.** In the second study women taking estrogens alone were compared with a group who were not on hormones. **Those on estrogen had a slightly higher occurrence of blood clots, stroke and heart attacks.** There is still debate regarding the study conclusions.

There is no doubt that hormones are beneficial. **However as is the case with all medications, benefits must be weighed against risks.** The American College of Obstetricians and Gynecologists recognizing that there are still unanswered questions about hormone use has recommended that women who choose to take the medication should probably use the smallest effective dose for a short period of time, probably five years. Instead of taking hormones, a woman may choose to use medication specific for building bone, anti depressants for hot flashes or herbal preparations for relief of some menopausal symptoms.

Black cohosh helps relieve hot flashes and night sweats. Studies indicate it is effective in many women but for short-

term treatment only. It may lower blood pressure as well. **In rare cases, hepatitis has been reported.** **Soy** may be effective in reducing menopausal symptoms. It also may lower cholesterol. Only food forms of soy, like tofu and soy milk, are recommended. Soy in tablet or powder form is not advised. **Flaxseed ground or oil**-may ease menopause symptoms in some women; not others. **Vitamin E oil** applied to the vagina helps improve lubrication and may also reduce hot flashes **Exercise and meditation** reduce irritability, even hot flashes, in some women. Yoga combines both. Exercise also helps most people sleep better. **Cold drinks** help you feel cooler. Avoid caffeine and alcohol, which are diuretics that encourage dehydration. Try cold water or fruit juices with antioxidants.
