

MENOPAUSE

FACTSHEET



At the current time, menopause is being spoken about widely in the media. However, the amount of information about menopause or perimenopause in the media is not always accurate and so this fact sheet is designed to give information to women who live with a spinal cord injury and are struggling with menopausal symptoms.

The information in this fact sheet is general and is applicable to women, both with and without a spinal cord injury, as there is very little research on the menopause in those women who live with a spinal cord injury. We are currently doing a study, a questionnaire, to gain more information specifically about menopausal symptoms in women living with spinal cord injury and we hope that in the next edition of the fact sheet, we will be able to give more specific information.

What is the menopause?

As a woman gets older, commonly in her mid to late 40s (although occasionally in the late 30s), menstrual cycles can become quite erratic. The ovaries do not release estrogen and progesterone as regularly as before and this leads to menopausal symptoms such as headaches, altered temperature regulation, hot flushes, bladder changes, dryness of the skin, irregular or no periods. This is known as the perimenopause but might be confused with symptoms that are experienced by women living with a spinal cord injury who are not menopausal. Older women who start to experience these symptoms should consider whether they might be due to the menopause or their spinal cord injury.

The menopause itself is defined as the last menstrual period, the average age of which is 51 years in this country. Some older studies from America have suggested that the menopause may occur earlier in women living with spinal cord injury but more recent studies have not confirmed this. The word postmenopausal is only applied to a woman after she has had no periods for a year.

Diagnosis of the menopause?

Many symptoms have been described, and each woman has a varying experience of the menopause. Some women do not have any particular symptoms, their periods stop and they 'sail' through the menopause. However, it is estimated that 1 in 3 struggle with a variety of symptoms, which can include:

- hot flushes
- night sweats
- vaginal soreness
- lack of sleep
- aches and pains
- feelings of exhaustion, anxiety, palpitations, mood swings
- reduced libido
- pain on intercourse

These symptoms can be bad enough to affect home life, work life and also relationships. Data suggests that menopausal symptoms can last on an average of about 7 years, whereas for one in 10 women these symptoms can last for 10 years or longer.

There is not a specific test to decide if you are in the menopause, until after you have not had a period for a year, as hormone levels vary so much. If you are over 45 and experiencing the above menopausal symptoms with erratic or no periods (which might also be due to being on hormonal contraception), then it is appropriate to assume you are in the perimenopause or menopause, and can consider starting treatment. Discuss this with your GP, spinal injury team or a local community sexual health clinic. Hormone replacement therapy is not contraceptive but contraception and HRT can be given together, and therefore you should continue to use contraception. It can be helpful to have a thyroid function test and prolactin level to ensure there is no other reason why your periods have stopped.

menopause

More specific symptoms of the menopause for women living with spinal cord injury, depending on level of injury, may be:

- an increase in spasms
- genito-urinary symptoms, such as pain with passing urine, recurrent urine infections,
- problems with bladder management and worsening incontinence
- skin may become more friable, with an increase in pressure ulcers

Long term effects of the menopause

The menopause also has longer term effects on the body, particularly a steep reduction in bone density. Loss of bone density is already a problem for women living with spinal cord injury, particularly for the bones that are not weight-bearing, such as the hip and thigh, and so you may already be receiving treatment for osteoporosis (thinning of the bones). There is a [fact sheet on osteoporosis management](#) which you may wish to read.

Another long term effect of the menopause is an increase in the risk of heart disease and so it is important that your GP or spinal injury care givers keep a check on your blood pressure as you get older, advise about your weight management and check your blood cholesterol levels.

How to manage the symptoms of the menopause

As the severity of the symptoms can be very varied, there are many different ways to help manage menopausal symptoms. It may be that no one treatment option will help with all the symptoms. Everyone is different as to what treatment will work and what treatment you would like to have. It is important to know about all of these options and then you can make an informed decision about what is the right treatment for you.

Lifestyle modifications to help symptoms

- Cognitive behavioural therapy (CBT). This has good evidence to show it can be effective for a variety of symptoms, including and not limited to hot flushes, night sweats, anxiety and lack of sleep. You can access CBT via your GP or referring yourself to NHS Talking Therapies.
- Minimise alcohol intake
- Stop, or at least reduce, smoking
- Eat a good well balanced diet
- Try to get more sleep
- Get as much exercise and resistance training as you can manage – speak with your physio. This will improve bone and muscle strength. Yoga can be helpful
- Alternative therapies such as acupuncture, aromatherapy or reflexology

Non-hormonal medication

Non prescription medication such as Soy isoflavones, Black cohosh and St John's wort may be used but with caution and with the understanding that they are not regulated. They may also interact with medication that you are already prescribed. Their mechanism of action could be by acting on the estrogen receptor, so you may not want to use them if you do not wish to use medicines that may be acting on the hormonal system.

You will also find a large number of medications which can be bought over the counter at the chemist for the menopause – many of which can be very expensive and may not be very helpful. However, if you find something which improves your symptoms, you may choose to use it but show the tablets to one of your medical care givers.

Non hormonal prescription medication

There are various non-hormonal medication available to help with some of the menopausal symptoms. These include:

- Fezolinetant is a new non-hormonal drug approved by NICE for treatment of hot flushes. There is a small risk of damage to the liver in some women and liver function needs to be monitored before and during treatment.
- Oxybutinin, which also helps with urinary urgency, has been found to be effective in helping hot flushes and night sweats;
- Certain anti-depressant medications are helpful to treat mood swings and anxiety symptoms associated with the use of Tamoxifen. These include low dose Paroxetine and Venlafaxine. Some anti-depressants such as Fluoxetine and Paroxetine (higher dose) cannot be taken at the same time as Tamoxifen.
- Gabapentin/ Pregabalin can help with aches and pains, and also hot flushes and sweats.

All of these medications can have their own side-effects and it is recommended that you start with a small dose and increase gradually so that the benefits outweigh any side-effects.

Hormonal medication (Hormone replacement therapy, HRT)

HRT can be 80-90% effective; the main hormone which helps with menopausal symptoms is estrogen. This replaces the estrogen which is no longer being produced by the ovaries at the menopause. If you have a uterus, you must combine the estrogen tablets with a progesterone preparation so that the lining of the womb does not become abnormally thickened. These tablets are taken daily and known as **continuous combined HRT**.

In the peri-menopause, women often need a higher dose of estrogen and the progesterone can be used for only 12 – 14 days of each month. A few days after stopping the progesterone, you should expect to have a light period/ withdrawal bleed. This type of HRT is known as **sequential combined HRT**.

Common considerations when taking HRT

1. Blood tests are usually not required. They are not helpful in diagnosing the menopause nor needed before starting HRT.
2. Starting HRT is an individual decision for each woman and the kind of HRT/ dose/ preparation that is suitable can be different for different women. Your GP or menopause specialist will guide you.

Common considerations when taking HRT (continued)

3. **Estrogen** (estradiol) can be used in the form of:

- a patch (used twice a week),
- gel/ spray (used daily). Some women do not absorb medications well through the skin or can find the methods inconvenient,
- tablets (used daily) can be taken, but these can increase the risk of blood clots slightly; so it depends on what your individual thrombosis risk is before taking estrogen by tablet.

The advantage of using estrogen by patch, gel or spray is that it is absorbed through the skin and reduces the chance of getting a deep vein thrombosis. So, for women living with a spinal cord injury, these would be the preferred ways of using estrogen.

If tablets are the only way to use HRT, then you would need a discussion of what your individual risk of thrombosis is, as well as the benefits and risks, with the person prescribing your HRT. Many women living with SCI long term, do not have a significantly increased risk of thrombosis despite their paralysis – except in the first year after injury.

There are other side effects from using estrogens which include headaches, breast pain and irregular vaginal bleeding.

4. **Progesterone/ progestogens** can also be used in different forms:

Tablets

Image: The Guardian



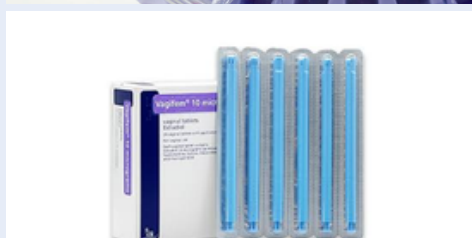
Patches

Image: The Guardian



Pessaries - which you may find less easy to insert

Image: E-Surgery



As the hormone coil

Image: NHS



Progesterone can also have side effects such as bloating, irregular vaginal bleeding, mood swings and breast tenderness.

5. HRT is usually started in a small dose and increased slowly till your menopause symptoms settle. Different preparations can be tried until you find one that suits you best. The treatments are modified on your symptoms and choices rather than by any blood tests.
6. Younger women will need a higher dose of estrogen, but always with progesterone if you have a uterus.
7. HRT has the most benefit when it is started early in the menopause transition and there is no arbitrary time limit as to when it should be discontinued. It can be used as long as it is giving you benefit and all your screening is normal.
8. HRT is a very confusing subject for you to take on so be guided by your GP, menopause or spinal cord injury specialist. You may find a choice between **body identical HRT** or **bioidentical HRT**. The body identical HRT are chemicals that are identical to the hormones in your body and manufactured in a highly regulated system and therefore **recommended by the NHS**, British Menopause Society and NICE.

The bioidentical hormones are marketed as being more like your own hormones but they are produced in pharmacies which are not regulated in the same way and therefore **not recommended, nor prescribed on the NHS**.

Benefits and risks of HRT

The main benefit is to improve your symptoms of the menopause. You may find that your menopause symptoms are improved quickly after starting HRT but you need to be reviewed after 3 months as doses may need to be changed.

There are long-term benefits from HRT which include:

- Improvement of bone strength and prevention of loss/ improvement of bone mineral density, and prevention of fractures. This is important in women who have a spinal cord injury, but there is unfortunately very little data specific to women living with a spinal cord injury.
- Reduction in the risk of heart disease. There is evidence for this if HRT is started early within the first 10 years of the menopause or before the age of 60 years.

Problems from HRT

1. Bleeding can be one of the commonest side-effects of HRT and is one of the main reasons why women discontinue it. You should see your GP about any unusual bleeding, and it may need to be investigated further but it usually tends to be due to an imbalance of the hormones you are taking and this can be adjusted.

2. Breast cancer. Most women are worried about the risk of breast cancer and this is understandable since all women have a 1 in 6 to 1 in 8 lifetime risk of developing breast cancer. The Women's Health Initiative data (published in 2002) suggests that estrogen HRT alone does not increase the risk of breast cancer and it may actually reduce it, whereas combined HRT has a slightly increased risk. However, this was work from some years ago and the HRT prescribed in the study was as Conjugated Equine Estrogen and Progestogen, which are both synthetic. Women on these were found to have a slightly increased risk of breast cancer. The HRT prescribed these days is different and body-identical, and observational data now suggests that this does not lead to an increased risk of breast cancer.

Lifestyle factors also play a part, and maintaining a good weight, reducing smoking/ alcohol intake and increasing exercise will reduce the risk of breast cancer.

3. Blood clots. Estrogen tablets (oral) can increase the risk of blood clots and so this is an important consideration for women with SCI. However, this increase is small and transient, so it may still be an appropriate way of taking estrogen for certain women who have no previous history of thrombosis. Estrogen given through the skin in the form of a patch/ gel or spray does not increase the risk of thrombosis.

Estrogen which is given via a skin absorption route does not increase the risk of heart disease and stroke, this is also reduced by using body-identical estrogen.

Genito-urinary syndrome of the menopause

There are estrogen receptors in the vulva, vagina and also around the urethra, and lack of estrogen can affect women by causing dryness/ soreness/ itching/pain with sexual intercourse/ pain when passing urine. This can be one of the main concerns for women living with SCI.

The estrogen in HRT may or may not help with genito-urinary symptoms but using estrogen locally has significant benefit. This is available in the form of pessaries, creams, gels and can be used along with taking HRT or on it's own. A vaginal ring is also available and this lasts for 3 months, so is another option. The amount of estrogen absorbed in the blood is minimal and so it is quite safe to use.

All of these products have the drawback of needing to be inserted into the vagina which may be a challenge when living with a SCI and limited mobility. There are products available to use with an applicator, used similarly to a tampon.

Low libido (Hypoactive sexual desire disorder)

As women age, libido does reduce; this may be noticed from the late 30s, in the 40s and 50s. It can also be one of the symptoms of the peri-menopause/ post-menopause. For women, low libido can have multiple reasons. Standard HRT may help improve libido by improving general quality of life, a feeling of well-being. In women for whom this does not help, there is the option of using testosterone.

Testosterone is a hormone made by the ovaries and also other glands in the body, the levels of which reduce with ageing +/- menopause. Data suggests taking testosterone may help improve libido and sexual responsiveness/ satisfaction. Blood tests do not tell us if we have enough testosterone or not. It is available as an unlicensed preparation for women, the preparation used has been developed for men. A baseline blood test is therefore recommended to ensure the levels are not raised so that it can be administered safely.

If the level is within the normal range or not raised, then testosterone can be prescribed in a gel form and is used at one tenth of the dose used for men. At 3 months and then 6 months, blood tests are repeated to ensure testosterone levels are not raised over normal. Provided you feel there is a benefit from using testosterone, then you can continue to use it with monitoring by yearly blood tests. As written above, this is not a 'licensed' medication for women but there is research data to show its benefit.

Conclusion

No one woman's menopausal journey is the same. There are many different strategies to help navigate this phase of life and usually it is a combination of various lifestyle measures, along with medication, be it hormonal or non-hormonal. Which strategy to use is an individual decision, made by yourself, with knowledge and discussion with a healthcare professional. You may also choose not to use HRT but again need advice from your care giver, particularly about osteoporosis prevention.

Unfortunately, the evidence on how the menopause affects women with spinal cord injury is sparse and we do not know whether particular benefits and risks of the available treatments affect women living with spinal cord injury differently. However, many women living with spinal cord injury choose to use HRT with appropriate advice and support. **You do not need to put up with the symptoms!**

References and helpful links

Daisy Network

www.daisynetwork.org

NICE: Menopause: Identification and management (Updated Nov 2024)

<https://www.nice.org.uk/guidance/ng23/resources/menopause-identification-and-management-pdf-1837330217413>

Women's Health Concern

www.womens-health-concern.org

Risks and Benefits of Estrogen plus Progestin in Healthy Postmenopausal women, Principal results from the Womens Health Initiative Randomised Controlled Trial, JAMA, July 17, 2002- Vol 288, No 3, pb 321

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About SIA

Spinal Injuries Association (SIA) is the UK's leading charity for everyone affected by spinal cord injury. We provide free, specialist support to help you navigate the mental and physical challenges you may face now and throughout your life.

Our nationwide team can connect you with our trusted network of experts and partners, offering guidance on legal matters, care, housing, finance, mental health and more. You can reach our support line on **0800 980 0501**.

We are the voice of people with spinal cord injury. Through our expertise we can connect you to the services and organisations you need through our network for all. Join the SIA community for free at www.spinal.co.uk

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