Menopause Musings from Melbourne: Key Insights from the 19th Annual IMS Congress

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At Simply Women, like most other women's health care centres, we are seeing a growing number of women presenting with perimenopausal and menopausal symptoms. Attending the 19th Annual IMS Congress in Melbourne late last year, we had the privilege of gaining insights into the latest developments in menopause care. After four days of diverse and valuable content, here are some key takeaways that have already influenced our practice.

Breast Cancer and Menopausal Hormone Therapy (MHT)
Breast cancer risk is one of the most common concerns expressed by both patients and healthcare practitioners when discussing Menopausal Hormone Therapy (MHT). At the congress, Professor Robert Langer, one of the principal investigators of the Women's Health Initiative (WHI) trial, provided valuable insights that helped clarify several misconceptions about MHT. The WHI study, which contributed to widespread fear, suggested that oestrogen and progestin (CEE+MPA) increased breast cancer risk. However, Prof Langer emphasised that the breast cancer outcomes in the WHI were not statistically significant, as breast cancer was a secondary, not primary, focus of the study.

Moreover, it's important to recognise that breast cancer typically starts developing 7-12 years before a detectable mass, meaning the increased rates of breast cancer 3 years into the WHI study cannot be directly attributed to MHT. While synthetic progestins like MPA can mildly stimulate breast tissue, micronised progesterone—now the preferred option—has a neutral effect on breast cancer risk. Additionally, oestrogen, particularly when used alone, has actually been shown to reduce breast cancer risk.

For patients who are concerned about breast cancer, we emphasise that lifestyle factors, such as height, diet, and alcohol consumption, have a greater impact on breast cancer risk than MHT.

Managing Bleeding During the Menopausal Transition
Professor Steven Goldstein's talk on bleeding in the menopausal transition emphasised the importance of using transvaginal ultrasound (TVUS) as the first step when investigating postmenopausal bleeding (PMB). If the endometrial thickness is under 4mm, further investigation via endometrial biopsy is usually unnecessary and unreliable at excluding pathology. For women experiencing erratic bleeding during perimenopause, Goldstein suggested that a low-dose combined contraceptive pill may be more beneficial than MHT. By suppressing ovarian function and providing a stable hormone level, it can improve psychosocial symptoms like irritability and brain fog, as well as provide effective contraception. Low-dose contraceptives can be used up to age 50 in "low-risk" women.

MHT in Osteoporosis Prevention
Professor Bronwyn Stuckey's presentation highlighted the critical role of oestrogen in bone health, describing it as "nature's gift to bones." The menopausal transition represents a unique window of opportunity to use MHT to prevent bone loss and fractures, which significantly impact women's quality of life. The maximal benefit from MHT occurs when it is started early in the transition and continued for a prolonged period, offering gains of up to 20% improvement in BMD. Dr Tobie De Villiers' talk changed our approach to osteoporosis risk assessment. He argued that FRAX is not particularly useful in women under 65, and that primary healthcare providers should feel confident offering DEXA scans to women in perimenopause to assess bone density.

Testosterone Therapy in Postmenopausal Women

Interest in testosterone therapy beyond its use in hypoactive sexual desire disorder (HSDD) is growing, with studies showing the potential cardiovascular benefits but large studies have found no significant benefits for well-being, bone density, major depression, cognitive decline or lean mass.

When considering a diagnosis of HSDD we are encouraged to use the Decreased Sexual Desire Screening Questionnaire (Clayton et al., 2018) to exclude other factors which may contribute to decreased sexual desire. Menopausal hormone therapy (MHT) and the management of vaginal dryness is an important first step.

Experts agree that *total* serum testosterone should be used for screening and treatment is aimed at pre-menopausal female testosterone levels. AndroFeme® (Testosterone 1% in 50mL) is the only approved testosterone formulation for women in Australia. Treatment should be discontinued if there has been no improvement at 6 months (assuming therapeutic levels) and does not need to be weaned.

Lawley Pharmaceuticals has produced a comprehensive Practitioner's Toolkit for AndroFeme® prescribing, which includes initial dosing, titration and the recommended surveillance.

Genitourinary Syndrome of Menopause (GSM)

This was well-covered at the congress with all experts agreeing that GSM is a prevalent yet under-recognised condition that significantly impacts quality of life. Topical oestrogen and DHEA therapy playing key roles in symptom relief and vaginal health restoration.

While vaginal lubricants and moisturisers provide short-term symptom relief, the first-line treatment remains topical vaginal oestrogen. Topical oestrogen has *NOT* been found to improve prolapse or urge incontinence, nor does it have an effect on nerve- endings but it has been shown to improve stress incontinence, prevent recurrent UTIs and reduce dyspareunia.

Relatively new to the Australia is IntraRosa®, a DHEA vaginal pessary. DHEA is synthesised by the adrenal glands and ovaries as an inactive precursor, then converted intracellularly to active hormones (oestrogens and androgens). IntraRosa® is 'bioidentical' to human DHEA and is shown to lower the vaginal pH, improve dyspareunia and decrease vaginal dryness. Vaginal DHEA is seen to provide targeted treatment without the systemic effects.

Other therapies for GSM, include vaginal laser including fractionated CO2 laser and erbium (Er:YAG) laser, which works by causing microdamage in vaginal layers promoting collagen remodeling and neovascularization and is seen as effective for vulvovaginal atrophy. Long-term safety and efficacy data is lacking.