MEDICAL PRACTICE

Contemporary Themes

Guidelines for community menopausal clinics

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Guidelines for community menopausal clinics have been prepared by the medical department of the Family Planning Association in consultation with the medical advisory panel of the association. I summarise them here in the hope that they will be of practical value to those who may wish to establish community menopausal clinics in the National Health Service or private sectors of medicine. They are intended to form a basis for discussion between interested parties, in particular clinic staffs and the local consultant gynaecologist. A full discussion of the risks and benefits of hormone treatment in the menopause is given elsewhere.[1 2] The guidelines are based on experience gained in Family Planning Association menopausal research clinics held in Sheffield and Birmingham under the supervision of Professor Ian Cooke of the department of obstetrics and gynaecology at the University of Sheffield and Professor John R Newton of Birmingham University.

There are three main objectives in setting up a menopausal clinic:

(1) To enable women of menopausal age to have access to sympathetic and knowledgeable doctors for counselling and practical help by increasing the services available in collaboration with consultant gynaecologists.

(2) To relieve unacceptable menopausal symptoms.

(3) To sustain bone integrity and reduce the incidence of senile osteoporosis and fractures in later life.[3]

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Administration

PRELIMINARY CONSULTATIONS AND LOCAL ORGANISATION

The local medical committee should be contacted for their view on whether it would be acceptable for clinic doctors to give hormone replacement therapy in suitable cases, and arrangements for formal consultant gynaecological cover should be made. In addition, the examination of endometrial histopathological specimens and routine cervical cytology of patients receiving hormone replacement therapy by a consultant histopathologist with experience in gynaecological pathology will need to be arranged. The local consultant chemical pathologist or consultant in charge of the local supraregional endocrine assay service should be contacted to make arrangements for any biochemical or hormonal assays required in the course of clinic work. Requisite needles, syringes, and blood sample tubes should be available as well as a suitable method of transport of specimens to the laboratory.

APPOINTMENTS, PUBLICITY, AND STAFFING

A community menopausal clinic seems to function most smoothly if patients can make appointments initially by telephone or personal contact. Primary publicity for such a clinic may be undertaken using newspaper advertisements or local radio. Initially, it seems that medical referrals are few and self-referrals, particularly those generated by contact with other patients, seem to predominate. Ideally, one nurse and one doctor could run a session; the nurse would complement the doctor—for example, by recording blood pressures, performing urine analyses, and perhaps completing record forms.

FINANCIAL ASPECTS

In addition to the separate charges for initial patient selection and subsequent patient acceptance there may need to be a

charge for prescribing and for any screening investigations and endometrial histological tests, such as Vabra aspiration. All these could be part of a composite fee.

Management of patients

The essence of clinical management is to treat unacceptable menopausal symptoms, once these have been disentangled from other psychoneurotic symptoms that may be common at this time of life. The latter symptoms may respond to counselling rather than to hormone replacement therapy.

HORMONE REPLACEMENT THERAPY

The principal criterion for this treatment is the presence of one or more menopausal symptoms. It should be borne in mind that these may be experienced by women who have had a hysterectomy and by women who are still cycling regularly or irregularly. Treatment may not be effective if hot flush is not one of the symptoms. It may be particularly difficult—and vital—to decide whether certain symptoms are due to the menopause or to a primarily psychiatric disturbance.

First visit

The woman will be seen by a doctor to ascertain the nature of her symptoms. Preliminary assessment may indicate major problems that require further medical consultation or referral to specialist services or to her general practitioner. A full history should be obtained and Clinistix urine analysis carried out.

Physical examination including cervical cytology and, where indicated, endometrial sampling should be performed. The history, results of examination, current medication, and any previous treatment for menopausal symptoms should be recorded on a standard form. Samples of record forms, check lists, diary cards, etc, are available on request from the medical department of the Family Planning Association.

Simple haematological and biochemical screening may need to be undertaken. In equivocal cases, after six months' amenorrhoea, blood should be sent for follicle stimulating hormone assay to confirm the diagnosis of the climacteric. A concentration higher than 50 IU/l under these circumstances is regarded as diagnostic; a concentration below 50 IU/l should not necessarily rule out a trial of hormone replacement therapy if symptoms are appropriate.

It may be helpful to take a vaginal smear and assess the vaginal wall karyopyknotic index to confirm oestrogen deficiency or to arrange for plasma or urinary oestrogens to be measured. Suitability for hormone replacement therapy may be further assessed according to a check list of "menopausal" symptoms (table I) and a list of exclusion criteria (table II). Where possible treatment should be deferred for one month to obtain base line clinical information and to await the results of investigations. The patient should be given a diary card to record her menopausal symptoms over the succeeding month.

Second visit

The following procedures should be carried out at the second visit one month later: (1) review diary card and results of screening tests; (2) complete screening protocol (table II); (3) decide on treatment of choice; and (4) initiate treatment.

Contraindications

Table III summarises the circumstances in which hormone replacement therapy is contraindicated. It should be used with caution in women with severe psychiatric disturbance and diabetes. In the former, if other symptoms and tests clearly point to oestrogen deficiency, treatment may be given but psychiatric care may be essential as well. In the latter the possibility of treatment should first be discussed with the doctor managing the diabetes.

TABLE I—*Check list of "menopausal" symptoms*

Symptoms	BMI rating*	Yes	No
Hot flushes or cold sweats†‡	4	☐	☐
Numbness and tingling†	2	☐	☐
Nervousness and irritability†	2	☐	☐
Depression†	1	☐	☐
Sensation of crawling on the skin†	1	☐	☐
Dizzy spells	1	☐	☐
Headaches	1	☐	☐
Pounding of the heart	1	☐	☐
Poor sleep	2	☐	☐
Tiredness	1	☐	☐
"Rheumatic pains"	1	☐	☐
Weight gain†		☐	☐
"Flooding" or heavy periods†§		☐	☐
Breast pains		☐	☐
Feeling of suffocation		☐	☐
Loss of confidence‡		☐	☐
Difficulty in making decisions‡		☐	☐
Difficulty with sexual intercourse‡‖		☐	☐

*First 11 symptoms comprise the Blatt menopausal index (BMI)[5]; a total rating score of 12 is said to be indicative of the menopause.
†Indicative of the menopause according to Neugarten and Kraines.[6]
‡Indicative of the menopause according to Vessey and Bungay.[1]
§This cannot be regarded as a menopausal symptom without investigation; the cause must be established.
‖This may respond to local oestrogen (for example, dienoestrol cream); the same contraindications apply to vaginal as to oral oestrogens.

TABLE II—*Example of screening protocol before prescribing hormone replacement therapy*

Patient's name _____

Patient exclusion criteria

(to be filled in before prescribing hormone replacement therapy)

Major contraindications

	Yes	No
(1) Has the patient previously experienced major side effects with oral contraceptives?	☐	☐
(2) Is there any presence of:		
(a) Malignant tumours of the breast or endometrium	☐	☐
(b) Severe liver or renal dysfunction	☐	☐
(c) Undiagnosed vaginal bleeding	☐	☐
(d) Familial hyperlipidaemia	☐	☐
(3) Is there any history of:		
(a) Cerebrovascular accidents or severe headache	☐	☐
(b) Hypertension	☐	☐
(c) Thromboembolic episodes	☐	☐
(4) Is there any cardiac disease:		
(a) Angina or ischaemic heart disease	☐	☐
(b) Mitral stenosis with atrial fibrillation	☐	☐
(c) Prosthetic heart valve	☐	☐
(d) Cyanotic heart disease with polycythaemia	☐	☐
(5) Is there any possibility that the patient is pregnant?	☐	☐

If the answer to any of these questions is YES, please do not prescribe hormone replacement therapy.

Relative contraindications

(1) Does the patient exhibit any evidence of severe psychiatric disturbance?	☐	☐
(2) Is the patient diabetic?	☐	☐
(3) Is the patient a heavy smoker?	☐	☐

If the answer to any of these questions is YES, use hormone replacement therapy with caution.

Signature _____ Date _____

TABLE III—*Circumstances in which hormone replacement therapy is contraindicated*

Previous major side effects during oral contraceptive treatment	Hypertension
Carcinoma of the breast or endometrium	Thromboembolic episodes
Undiagnosed vaginal bleeding	Familial hyperlipidaemia
Severe liver or renal disease	Cerebrovascular accidents or severe headache
Certain forms of heart disease	Pregnancy

Procedure

In cases in which hormone replacement therapy is indicated the treatment regimen should be explained and the patient provided with written notes and appropriate instructions. The patient should be given a diary card to indicate the interrelations of her major symptoms, such as flushes or sweats, the tablet taking, and her withdrawal bleeding, together with instructions for filling in the diary card. A standard letter should be sent to the general practitioner concerned.

First phase treatment—Three to six months' initial treatment with re-evaluation after this time is recommended. Patients receiving treatment should be seen three and six months after the start of treatment.

Second phase treatment—At the end of the first phase of treatment a period of three months without treatment may allow the patient to view her response to treatment in a better perspective. If severe symptoms recur then earlier reinstitution should be considered. Where improvement has been dramatic some women may resent any interruption in treatment and allowance must be made for such cases. Conversely, some women feel able to cope and do not request further treatment after a three month break.

Place of long term treatment

Some people feel that long term or permanent replacement therapy cannot be justified on present evidence. Others argue that it can be justified on the grounds of prevention of osteoporosis, but the optimal duration of treatment for this purpose remains to be determined.[3] If after the first phase of treatment a patient requires further treatment for alleviating unacceptable menopausal symptoms it would be reasonable to offer further six to nine month cycles.

Long term monitoring should include: six monthly checks of weight and blood pressure; annual clinical examination of the breast; annual pelvic examination; and endometrial biopsy in women with a uterus if indicated (see below).

Recommended regimens

The choice of regimen will depend on the patient, any previous operations, the severity of the symptoms, and the type of clinic she is attending. The treatment policy should be decided between the local gynaecologist and the clinic team. The following recommendations are for guidance only.

Patients with a previous hysterectomy—These patients may be given daily continuous oestrogen, such as Premarin 0·625 mg or ethinyl oestradiol 30 μg. The possible value of a progestogen in protecting breast tissue is unconfirmed.

Patients with a uterus—A sequential preparation containing the lowest effective daily dose of oestrogen and at least 10 days' treatment with progestogen should be given initially. If possible a preparation containing the equivalent of not more than 30 μg ethinyl oestradiol should be used, but some women will need more than this. As some women have hot flushes during the week without treatment some doctors prefer to avoid withdrawing oestrogen completely during each cycle.

TABLE IV—*Sequential preparations available for use in hormone replacement therapy*

Sequential preparations	Oestrogen (dose)	Progestogen (dose)
Trisequens	Oestradiol + oestriol (1·5–3 mg for 28 days)	Norethisterone acetate (1 mg for 10 days)
Cyclo-Progynova	Oestradiol (1 mg or 2 mg for 21 days)	Levonorgestrel (0·25 mg for 10 days)
Menophase	Mestranol (12·5–50 μg for 28 days)	Norethisterone (0·75–1 mg for 13 days)
Prempak	Conjugated equine oestrogens (0·625 or 1·25 mg for 21 days)	Norgestrel (0·5 mg for 7 days)

Sequential preparations—There are several sequential preparations available (table IV) and the pharmacological aspects have been summarised elsewhere.[4] The cost per cycle varies from £1·78 upwards and there is in addition a double prescription charge (currently £2·80). There are some advantages in terms of cost and low dosage in using ethinyl oestradiol 10-20 μg for 28 days with an added progestogen for 10 days (table V). This could cost about £1·00 per cycle. The lowest effective dose of progestogen has not, however, yet been established.

TABLE V—*Progestogens available for use in hormone replacement therapy*

Progestogens available (for use with ethinyl oestradiol 10–20 μg):
Norethisterone 5 mg (Primolut N, Utovlan)
Medroxyprogesterone acetate 5 mg (Provera)
Dydrogesterone 10 mg (Duphaston)
Progesterone 200 mg and 400 mg suppository (Cyclogest)
Progestogen only contraceptive pills:
Norethisterone 0·035 mg (Micronor, Noriday)
DL-Norgestrel 0·075 mg (Neogest)
Levonorgestrel 0·030 mg (Microval, Norgeston)
Ethynodiol diacetate 0·5 mg (Femulen)

ENDOMETRIAL EXAMINATION

In the United States the average yearly incidence of endometrial carcinoma in women not taking oestrogen is 0·7 per thousand, and 50-75% of cases are associated with abnormal vaginal bleeding. It has been estimated that routine endometrial biopsy would uncover one case per 2900 asymptomatic women.[2] Table VI shows the incidence figures for endometrial carcinoma in the United Kingdom (Birmingham cancer registry figures).

TABLE VI—*Incidence (per 1000 population) of endometrial carcinoma in the United Kingdom (Birmingham cancer registry)*

Age (years)	45–49	50–54	55–59	60–64	65–69
Incidence	0·14	0·32	0·44	0·45	0·47

Opinions differ and current practice varies throughout Britain regarding the need for routine endometrial histological examination before and during hormone replacement therapy. Because of the possible risk of endometrial carcinoma during treatment some people regard pretreatment endometrial histology as essential and recommend that this should be repeated every six to 12 months during treatment. Others consider that it has been reasonably shown that the use of 10 days' treatment with progestogen given sequentially with oestrogen each cycle prevents endometrial hyperplasia and protects the endometrium, making sampling of the endometrium routinely in patients receiving 10 days' treatment with progestogen unnecessary.

As opinion is still divided data need to continue to be collected until the matter is resolved. Facilities for endometrial sampling, preferably by suction aspiration or outpatient curettage, should be available in service clinics. There must be suitable arrangements for prompt referral in the area in cases of difficulty.

The following policy is recommended:

(1) Pretreatment endometrial sampling should ideally be undertaken in all patients before hormone replacement therapy is started to detect any asymptomatic endometrial carcinoma.

(2) No patient with intermenstrual bleeding or heavy or irregular periods of unknown aetiology should begin treatment without having the cause established by endometrial sampling.

(3) No patient who develops intermenstrual bleeding during treatment should continue without having the cause established.

(4) Endometrial sampling is normally advisable every two years, irrespective of symptoms, in women with a uterus receiving treatment.

If the policy of the gynaecologist providing formal cover for the clinic differs from the above, the gynaecologist's policy must be respected. If endometrial histology is indicated, and endometrial sampling at the clinic proves technically impossible, the patient should be referred for gynaecological consultation with a view to examination under anaesthesia, dilatation of the cervix, and curettage. Previous experience or specific training is essential for any doctor who undertakes endometrial sampling. The consultant gynaecologist may be helpful in arranging this.

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5 Blatt MHG, Wiesbader H, Kupperman HS. Vitamin E and climacteric syndrome. Failure of effective control as measured by menopausal index. *Arch Intern Med* 1953;**91**:792-9.

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MATERIA NON MEDICA

Therapy for outlandishness

"Look Daddy, they're kissing?" said our 2½ year old. It was early Saturday afternoon and therefore not the time for sex on television. I went to see what he meant. He was quite right. Football was on and he looked at me in a rather perplexed way as if to ask, "Is kissing a part of the game?" Thankfully he didn't, his vocabulary not yet having reached such proportions. He seems equally puzzled whilst watching cricket and wonders what's going on when a batsman is out.

I have often wondered why it is that professional sportsmen, cricketers and footballers in particular, have to indulge in such an excessive display of kisses and embraces, almost to suffocation point, having scored a goal or taken a wicket. After all, they're only doing a job for which they are paid, some of them quite handsomely too. How can it be brought home to them that this effusiveness is quite unnecessary? I have thought of a novel method of bringing this to their attention. How about making a film of other professional people behaving in a like manner when achieving success in their job? And one profession instantly springs to mind—ours. Take the surgeon, for example. Once the gall bladder or appendix is out in the kidney dish, a congratulatory hug from the scrub nurse, a kiss from the anaesthetist and an embrace from the houseman (better still, housewoman) could well be in order. I can recollect many pretty anaesthetic colleagues whose congratulatory kisses and embraces would have been most welcome, even at the risk of having to re-scrub halfway through the operation.

And what about the radiologist? After a superb double contrast barium enema, when he proudly displays a solitary polyp, marking it with the customary arrow (to the great benefit of the likes of me), he is hugged and kissed by his radiographers.

Alas for the dermatologist, he does not have many instant successes and certainly not many to turn to for embraces. He is like the snooker player who, in all his sartorial elegance, conducts himself with calmness and dignity, remaining at a cue's length from the object (much like the dermatologist!) and success, when it does come, is gradual, being quietly enjoyed with an unassuming smile.

All our professional sportsmen should be shown a video recording of the above goings-on in a hospital: it might just bring home to them the need to grow up and curb their juvenile instincts. Otherwise, for the sake of my little boy, I'll soon have to find some plausible explanation for this outlandishness seen on our football and cricket pitches.—PRADIP K DATTA, consultant surgeon, Wick, Scotland.

Hollywood 1982

If you wish to retain one of life's illusions, do not go to Hollywood. For if you think the heart of movieland is a continual and vibrant kaleidoscope of mink-clad beauties with pouting lips and household names, or raunchy men with pencil-thin moustaches and sidearms, all set in a background of neon lights and Cadillacs, you are in for a disappointment.

Today Sunset Boulevard is a rather run-down, seedy and narrowish street boasting a sprinkling of flaking hotels, faded restaurants (commonly of a fast food variety), some sightless office buildings, a brace or so of dry-cleaning shops and their ilk, and accommodating a steady flow of ladies (and men) of easy virtue. These young people not infrequently have migrated to this area in the mistaken belief that movie stardom for them is just around the corner. The harsh reality is that at any one time, 80% of all actors, good and bad, are unemployed.

The foot and hand prints (and, in Bob Hope's case, nose print too) are still there, perpetuated in concrete in the forecourt of Mann's Chinese Theatre on Hollywood Boulevard. Significantly perhaps, most of the 60 or so recorded names are of people who were stars when Hollywood really was the tinsel city we fantasise about—Bette Davis, Cary Grant, Marilyn Monroe.

The Beverly Hills area—no "hills," incidentally, it just scans better—is at the end of the Strip, and is replete with opulent homes and lush gardens, just as you imagine. They are now largely protected from the vulgar gaze of massed tourists by the imposition of a limit on the size of vehicles passing through the district. In any case, few actors live there nowadays. But at least you can see the odd familiar film location as you rubberneck around—Arnold's Place of *Happy Days*, the church used in *10*, and so on.

For the passage of folding money the old studios are only too glad to take parties around their down-at-heel sets, now used for TV productions. (Ah! So that's how they make Superman fly. Oh! There's the house from *Psycho*, and so on.) The museum at Universal studios displays some touching curios, such as Shirley Temple's teddy bear, Henry Fonda's oscar, the tablet of stone that Charlton Heston brought down from Mount Sinai, still etched with the Ten Commandments in ancient Hebrew. And near the door is a memento that somehow sums it up: preserved behind glass sit the hat and gloves worn by Rod Steiger when playing the part of W C Fields in a film of his life. Not Fields's real hat, mind you, a facsimile. Even the tinsel has tinsel.

Hollywood is an idea not a place.—JAMES H LEAVESLEY, general practitioner, Perth, Western Australia.

An elderly patient has asked for "reflexology" treatment for osteoarthritis of the knees. What is this treatment and is it safe in a fit person?

Reflexology is described by Stanway in his book on alternative medicine.[1] The theory is that each part of the body is represented in the tissues of the foot and manipulation of the appropriate area of the foot will improve the area of the body affected by disease. The lungs are represented, for instance, in an area just behind the second to fourth metatarsal heads, the heart in an area just behind this, the rectum over the heel, and so on. The knee is represented on the outer side of the foot, about the base of the fifth metatarsal. It is unlikely, therefore, that manipulation of or attention to this part of the anatomy will have an adverse effect on the knees.—F DUDLEY HART, consultant rheumatologist, London.

1 Stanway AT. *Alternative medicine: a guide to natural therapies.* London: MacDonald and Jane's, 1980.