Study of general practice consultations and menopausal problems

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Abstract

Objective—To investigate the nature of work related to the menopause in general practice.

Design—Questionnaire study over six months among general practitioners after each consultation with a woman aged 40-69 at which issues related to the climacteric had been discussed.

Setting—9 General practices in the Oxford area.

Subjects—416 Women who had 572 consultations.

Main outcome measures—Age, menopausal state, and first or subsequent consultation. Symptoms were classified together with the treatment and the outcome of the consultation.

Results—The consultation rate varied greatly between practices, the overall rate being 4.4%. There were many premenopausal women and women in their 60s presenting; women with hysterectomies presented more often—36% (37/103) of women with hysterectomies had more than one consultation compared with 26% (38/144) for premenopausal women and 24% (38/155) for postmenopausal women. 409 women had symptoms and 218 were prescribed oestrogen treatment. 156 of the consultations involved discussion and advice only. Only four women were referred to a local specialist clinic.

Conclusion—There is a low overall use of hormone replacement therapy in the general postmenopausal population despite the recent media coverage of its benefits in the prevention of osteoporosis and subsequent fractures.

Introduction

Interest in the menopause and hormone replacement therapy is currently at a high level. Despite several active menopause clinics most care for menopause problems and prescription of hormone replacement therapy is clearly based in general practice.^{1,2} Although prescribing surveys can provide some information on drug use, we have little information on the nature of work related to the menopause in general practice and how this ties in with hormone replacement therapy and other prescribing. In collaboration with nine general practices in the Oxford area we carried out a detailed six month prospective survey of menopause related consultations and their outcome.

Methods

General practitioners from nine practices in and around Oxford took part in the survey. In two practices a single general practitioner collected data on patients from his or her own list and in the remaining seven all the partners participated. The age structure was known for all nine practices.

Over six months the doctors completed a brief questionnaire after each consultation with a woman aged 40-69 years if issues related to the climacteric had been discussed. The questionnaire had been designed

and pretested specifically for the study. Age and menstrual state were recorded together with whether it was a first or follow up consultation. During a first consultation the doctor recorded whether the woman or the doctor had started discussion about the climacteric and whether it was the main reason for the consultation. In follow up consultations the doctor noted how long he or she had been aware of the problem. Symptoms were classified into the following categories: "hot flushes," "psychogenic," "vaginal dryness," "reduced libido," "postmenopausal bleeding or cycle problems," "osteoporosis related," and "others." The outcome of the consultation and the treatment that the woman received were recorded.

Results

There were 572 consultations with 416 women aged 40-69 years; 115 women attended more than once. Overall, 144 were premenopausal, 155 were postmenopausal, 103 had had a hysterectomy, and this information was unknown for 14. A higher proportion of the women who had had hysterectomies had more than one consultation (37/103, 36%) than among the premenopausal (38/144, 26%) and postmenopausal (38/155, 24%) women.

Overall, 192 women had a first menopause related consultation, in 120 of whom it was the declared reason for attending; in 46 the doctor raised the menopause as the basis for presenting symptoms; and in 26 the menopause was discussed but was not the direct reason for the visit. For 219 women their first attendance during the study was as a return visit on a problem first raised at an earlier consultation; in 138 of these the problem had been known to the doctor for more than a year.

The proportion of women of the appropriate age consulting their doctors about the menopause varied considerably between practices (table I). The age structure of the study population is shown in table II. Overall consultations peaked between 45 and 54 years but considerable numbers of older women also attended. Table III shows the age and menstrual state of the women attending.

TABLE 1—Climacteric related consultations over six months by women in each of nine practices

Practice	No of women aged 40-69 in practice population	No of consultations	No (%) of women consulting	No (%) of new patients
1	1508	143	80 (5.3)	34 (2.3)
2	1695	65	52 (3.1)	29 (1.7)
3	379	16	12 (3.2)	5 (1.3)
4	298	17	11 (3.7)	4 (1.3)
5	433	38	30 (6.9)	16 (3.7)
6	197	17	15 (7.6)	5 (2.5)
7	1400	58	39 (2.8)	15 (1.1)
8	1550	138	119 (7.7)	64 (4.1)
9	2071	80	58 (2.8)	22 (1.1)
Total	9531	572	416 (4.4)	194 (2.0)

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One hundred and thirty five women complained of a single climacteric symptom, 120 of two, 62 of three, 31 of four, 40 of five, and 21 of six. Only seven women had no symptoms; those most often discussed were hot flushing (285 women) then psychogenic symptoms (217). Examination of symptoms and age (table IV) showed that psychogenic symptoms were predominant at 40-45 years, hot flushes at 45-59, and vaginal dryness at 60-69. Relating the symptoms to the baseline practice population of the same age altered the emphasis so that the age range in which the various menopausal symptoms, including vaginal dryness, affected the highest proportion of women was 45-59.

One hundred and fifty six of the 572 consultations were for only discussion and advice whereas in 142 treatment was started. Treatment was continued in 214 consultations and discontinued or changed in 24. In the remaining 36 consultations the women were referred to menopause clinics (4), gynaecology clinics (23), and others (9), including a homoeopath and dietitian.

Half of the women (218) were receiving oestrogen treatment (opposed or unopposed) and 19 were taking progestogens alone. Psychotropic and anxiolytic treatment was used by 19 and eight respectively. Other treatments were clonidine (35), β blockers (11), and vitamin B6 (nine). Prescription of calcium was minimal, being used by only four women. Thirty women who had had hysterectomies were taking combined oestrogen and progestogen preparations. Forty women who had not had hysterectomies were taking oestrogen without progestogen, mostly as vaginal oestrogen; they were mainly older women (two thirds were 55 or more).

Of the 50 women presenting only with hot flushes 21 received oestrogen, 14 clonidine, 10 no treatment,

TABLE V—Rate of use of hormone replacement therapy in practice populations by women in each age group

Age	No using hormone therapy (current, initiated, or discontinued)	Practice populations	Rate of use (%)
40-	11	2212	0.5
45-	66	1755	3.8
50-	59	1532	3.9
55-	54	1434	3.8
60-	14	1249	1.1
65-69	14	1349	1.0
Total	218	9531	2.3

and five various other treatments. Of the 33 women presenting only with vaginal dryness, 26 received oestrogen, most vaginally, and seven no treatment. Of the 14 women who presented with psychogenic symptoms alone, six received no treatment, five oestrogen, one vitamin B6, one an anxiolytic, and the remaining woman both an anxiolytic and oestrogen.

We examined the age range of women who had a consultation for hormone replacement therapy during the study and related this to the equivalent practice populations stratified by age (table V). This provided a minimum statistic for hormone replacement therapy use by age, though we might have missed some users who had no contact with their doctor over the six months of the study. The level of use was low with only 2.3% of the practice populations aged 40-69 years receiving hormone replacement therapy, rising to 3.8% for the perimenopausal age groups (45-59 years).

We found that as well as half of the women consulting, who were currently taking some form of oestrogen treatment, overall 232 had taken an oestrogen preparation at some time. Yet 409 of the women studied had some symptoms at the time of consultation.

Discussion

This study examines the everyday management of menopause related issues in general practice. We recognise that one partner in each practice was sufficiently interested in this subject to agree to monitor the study, but in all but two of the practices the other partners needed no particular interest in this topic. Thus the experience should be reasonably representative of general practice in the Oxford area.

We found that 4.4% of women aged 40-69 years consulted during the study with problems related to the menopause. The younger women often presented with menstrual cycle disturbances together with menopausal symptoms. Self limiting symptoms such as hot flushes and psychogenic symptoms decreased in frequency with age beyond their peak at 50-54 years. Hot flushes were the most common complaint, which concurs with previous studies.^{1,3} In the oldest women (over 60) vaginal dryness was the predominant problem (table IV), but it was actually more commonly reported below 60.

Women who had had hysterectomies visited more

TABLE II—Menopause related consultations over six months by age of women

Age	No of women in study	Total No of patients in practices	Consultation rate (%)
40-	35	2212	1.6
45-	140	1755	8.0
50-	125	1532	8.2
55-	75	1434	5.2
60-	24	1249	1.9
65-69	16	1349	1.2
Not known	1		
Total	416	9531	4.4

TABLE III—Age and menstrual state of women in study

	No (%) of premenopausal women (n=144)	No (%) of postmenopausal women (n=155)	No (%) of women with hysterectomies (n=103)
40-	25 (17.4)	2 (1.3)	6 (5.8)
45-	70 (48.6)	30 (19.4)	33 (32.0)
50-	42 (29.2)	48 (31.0)	33 (32.0)
55-	7 (4.9)	51 (32.9)	16 (15.5)
60-		15 (9.7)	8 (7.8)
65-69		9 (5.8)	6 (5.8)
Not known			1 (1.0)

TABLE IV—Menopausal symptoms by age of women consulting as percentage of study group and of practice populations

Symptom	40-		45-		50-		55-		60-		65-69		Total	
	Study group (n=35)	Practice population (n=2212)	Study group (n=140)	Practice population (n=1755)	Study group (n=125)	Practice population (n=1532)	Study group (n=75)	Practice population (n=1434)	Study group (n=24)	Practice population (n=1249)	Study group (n=16)	Practice population (n=1349)	Study group (n=9351)	Practice population (n=9351)
Hot flushes	20 57.1	0.9	101 72.1	5.8	97 77.6	6.3	54 72.0	3.8	11 45.8	0.9	2 12.5	0.2	285 3.0	3.0
Psychogenic symptoms	26 74.3	1.2	73 52.1	4.2	64 51.2	4.2	45 60.0	3.1	7 29.2	0.6	2 12.5	0.2	217 2.3	2.3
Vaginal dryness	11 31.4	0.5	48 34.3	2.7	58 46.4	3.8	40 53.3	2.8	17 70.8	1.4	13 81.3	1.0	187 2.0	2.0
Reduced libido	8 22.9	0.4	27 19.3	1.5	26 20.8	1.7	23 30.7	1.6	4 16.7	0.3			88 0.9	0.9
Osteoporosis related symptoms	5 14.3	0.2	27 19.3	1.5	34 27.2	2.2	27 36.0	1.9	4 16.7	0.3	6 37.5	0.4	103 1.1	1.1
Postmenopausal bleeding or cycle disturbances	18 51.4	0.8	59 42.1	3.4	30 24.0	2.0	6 8.0	0.4			1 6.3	0.1	114 1.2	1.2
Other			9 6.4	0.5	3 2.4	0.2	2 2.6	0.1	2 8.3	0.2			16 0.2	0.2

often than those who had not had them. They presented more often with hot flushes, concurring with previous work showing that such women experience a high incidence of menopausal symptoms.¹ Psychogenic symptoms peaked in the early 40s, agreeing with the finding of Ballinger that psychological symptoms are more common in the two years before the menopause.⁴

Only four women presenting to their doctor during the study were referred to the local specialist menopause clinic. Most were seen and treated in general practice.

The fact that 156 (27%) of the consultations included discussion and advice alone highlights the vital role of general practitioners in teaching and reassuring menopausal women and suggests the misleading conclusions which might be drawn from surveys based only on prescribing.

Our study does not suggest that substantial numbers of asymptomatic women are consulting their general practitioners to discuss prevention of osteoporosis, as, of the 103 who discussed it, only 12 did not have another climacteric symptom which would have been more likely to have led to the consultation. This might suggest that the current interest in osteoporosis may prompt women who attend with symptoms to discuss it but may not itself generate many new consultations in asymptomatic women. Factors affecting this might be a lack of public awareness or inertia to seek an appointment with the doctor for advice. Interestingly,

in a recent survey a large proportion of women judged osteoporosis to be the most important menopausal problem.⁵ Though 77% in that survey expressed an interest in taking hormone replacement therapy, 74% of these thought that they needed further information. The use of hormone replacement therapy has been urged to prevent osteoporosis,⁶ and it is well established that women who have had a hysterectomy or oophorectomy are at additional risk.⁷ Despite the current reasonable understanding of these topics there is a gap between the potential for prevention of osteoporosis and fractures and its delivery to women at risk.⁸ Further community based studies are important if we are to understand the basis for this gap between possibility and reality.

- 1 Barlow DH, Grosset KA, Hart H, Hart DM. A study of the experience of Glasgow women in the climacteric years. *Br J Obstet Gynaecol* 1989;96:1192-7.
- 2 Shears MR. Brighton practitioners' attitudes to HRT. *Practitioner* 1989;233:146-9.
- 3 Thomson B, Hart SA, Dunro D. Menopausal age and symptomatology in general practice. *J Biosoc Sci* 1973;5:71.
- 4 Ballinger CB. Psychiatric morbidity and the menopause: screening of general practice sample. *BMJ* 1975;iii:344-6.
- 5 Draper J, Roland M. Perimenopausal women's views on taking hormone replacement therapy to prevent osteoporosis. *BMJ* 1990;300:786-8.
- 6 Belchetz P. Hormone replacement. *BMJ* 1989;298:1467-8.
- 7 Aitken JM, Hart DM, Lindsey R. Oestrogen replacement therapy for prevention of osteoporosis after hysterectomy. *BMJ* 1973;iii:515-8.
- 8 Spector TD. Use of oestrogen replacement therapy in high risk groups in the United Kingdom. *BMJ* 1989;299:1434-5.

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ANY QUESTIONS

What is a suitable treatment for a hangover?

Despite the wealth of publications relating to all other aspects of ethanol abuse there is a dearth on the pathogenesis and treatment of hangover. This is surprising in view of its socioeconomic importance in loss of working days, let alone the self inflicted misery it causes to people.

Twenty per cent of 1266 normal drinkers when "tipsy, high, or drunk" reported no hangover symptoms; regardless of the level of drinking, symptoms occurred more often in association with negative life events, neuroticism, guilt about drinking, and depression or anger while drinking.¹ Another variable is the presence of congeners that give alcoholic drinks their special flavours. These additional alcohols, aldehydes, ketones, tannins, anthocyanins, catechins, and other phenolic flavonoids may exert differing effects from ethanol, and the greater their content the greater the hangover.²

In this multisystem syndrome symptomatic treatment ranging from the logical and compatible to the bizarre (raw root ginger slowly chewed for nausea) has been advocated. The throbbing headache is best treated with a gastric non-irritant analgesic such as paracetamol 1 g four hourly. Caffeine, as a cup of coffee, constricts extracranial arteries and, as a stimulant, combats the accompanying depression and lassitude; it does not improve impaired performance of complex behavioural and cognitive tasks such as driving. As the sedative (and anaesthetic) effect of ethanol wears off hypersensitivity to sound, light, and pain supervenes. ("Dear Alka Seltzer, please can you make your tablets quieter?" quoted by Maryon Davis.)³ Withdrawal to a darkened, silent room and further sleep, if feasible, are better than the alternative short term cure of more ethanol (the hair of the dog that bit you) or tranquillisers. This slippery descent into tolerance and dependence is best avoided.

Dehydration from diuresis should ideally be prevented by taking water while and after drinking. The risk of alcohol induced hypoglycaemia makes sweetened fresh fruit juice, also containing vitamin C, a better fluid replacement. Alternatively, a salt-glucose solution (Dioralyte) may be used. Honey has no special benefits as

fructose is effective in promoting hepatic oxidation of ethanol only if given intravenously during acute intoxication. Gastritis, causing nausea, anorexia, and epigastric pain, may be exacerbated and progress to bleeding if aspirin or other non-steroidal anti-inflammatory drugs have been given. Sodium bicarbonate as a fizzy mineral water usually suffices, and antacids or antiemetics, such as metoclopramide, are rarely necessary.

Any of the above symptoms alone are unpleasant but in concert create the specific dissonance of a hangover. A placebo controlled, double blind study of tolfenamic acid, a non-steroidal anti-inflammatory drug prostaglandin inhibitor, in 30 subjects showed a significant reduction in hangover symptoms if the subjects took it when starting to drink and before going to bed.³ The potential for such drugs to cause gastric bleeding unpredictably discourages such prophylactic use. — E R BECK, *consultant physician, London*

- 1 Harburg E, Davis D, Cummings KM, Gunn R. Negative affect, alcohol consumption and hangover symptoms among normal drinkers in a small community. *J Stud Alcohol* 1981;42:998-1012.
- 2 Maryon Davis A. *Pssst . . . A really useful guide to alcohol*. London: Pan, 1989:136-42.
- 3 Kaivola S, Parantainen J, Osterman T, Timonen H. Hangover headache and prostaglandins: prophylactic treatment with tolfenamic acid. *Cephalgia* 1983;3:31-6.

In the church of St Mary, Worsborough, South Yorkshire, is the following memorial to Thomas Elmhirst "whose promising parts were intercepted by an early death" in 1632:

*"This boy noe Albion was yet gray haired borne,
Who saw old age And night as soone as morne."*

Could your expert speculate about the diagnosis?

Speculation is the appropriate word given the poetic language and the absence of information about the boy's age at death. Small for weight babies often look wizened at birth and possibly more severe intrauterine malnutrition might be associated with changes in hair pigment, as in children with kwashiorkor. Other conditions come to mind, such as biliary atresia, progeria (premature aging), and endocrine diseases like congenital adrenal hyperplasia and hypothyroidism, but none of these is likely to be fatal at birth. — A PATON, *honorary physician, Oxford*