Editorial

Could It Be Menopause?

Estrogen deficiency during menopause can have negative effects on both women's well-being and their professional role. Partners and colleagues of women experiencing menopausal symptoms may also be affected. Menopause is a both a personal and workplace issue that is underreported, underdiagnosed, and undertreated. Throughout the COVID-19 pandemic, many articles have addressed burnout in nursing, but few mention that burnout symptoms such as depersonalization and emotional exhaustion may mimic signs of estrogen deficiency.[1] Menopause expert Dr Louise Newson challenges nurses to contemplate their symptoms: "[If] you have a low mood, feel exhausted and irritable, and aren't sleeping well . . . [it] may be the demands of nursing—but could it be the perimenopause or menopause?"[2,3] In this editorial, I will address several aspects of menopause, including implications for personal health and well-being, hormone replacement therapy (HRT), available resources, support in the workplace and at home, partners of menopausal women, caring for menopausal patients, and the association between estrogen and COVID-19.

At the time of writing, 90% of the more than 4 million nurses in the United States were female, with a median age of 52 years.[4] Similarly, in July 2021, 83% of the American Association of Critical-Care Nurses members were female and almost one-third were 45 years of age or older (unpublished data). These demographic data suggest that countless nurses may experience symptoms of perimenopause or menopause. Estrogen levels decline during the phases of perimenopause and menopause, which usually occur between 45 and 55 years of age.[5] Many women are unaware that menopause is the underlying cause of their symptoms or, if they are aware, they assume that symptoms should be tolerated as a natural part of aging.[2,6] In a study of more than 3000 women, Kingsberg et al[7] reported that menopause frequently interfered with sleep, intimate relationships, and general enjoyment of life. I agree with Dr Newson, who suggests we destigmatize menopause and start talking about this important topic.[8,9]

During the perimenopausal phase, some women will experience symptoms of low estrogen levels despite having irregular or heavy periods.[2] Menopause occurs after ovulation stops, either naturally or surgically induced by a hysterectomy.[2] Numerous symptoms are associated with menopause, many of which are thought to be interrelated, including sleep disturbances, fatigue, hot flashes, night sweats, reduced sex drive, and weight gain.[10]

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doi:https://doi.org/10.4037/ccn2021973

Emotional and psychological symptoms are variable and may include mood swings, brain fog, forgetfulness, irritability, anxiety, lack of caring, lack of motivation, and/or depression.[2] Genitourinary syndrome of menopause, previously named *vulvovaginal atrophy,* is underdiagnosed and affects up to 84% of menopausal women.[6,11,12] Symptoms of genitourinary syndrome of menopause may include genital pain, dryness, burning, and itching; sexual pain or discomfort, lack of lubrication, and impaired function; urinary urgency, dysuria, and recurrent urinary tract infections.[6,11,12] Some women also experience changes in vaginal bacterial composition due to low estrogen levels and a more alkaline pH; a position statement by the North American Menopause Society (NAMS) suggests that vaginal estrogen therapy may establish a healthy vaginal microbiota.[6] Increased loss of bone density, cardiovascular disease, and increased mortality are also associated with estrogen deficiency.[13]

Some women have no symptoms and others report mild symptoms that can be managed with nonpharmaceutical methods.[14,15] For example, women with sleeping issues might experience improvement in sleep after reducing caffeine and/or alcohol intake. Although some women report successful symptom relief when using complementary and herbal therapies, such as yoga, St. John's wort, black cohosh, there is currently no scientific evidence to support the use of these therapies to reduce menopausal symptoms.[16,17]

Many women whose symptoms affect their health-related quality of life and well-being[18] have benefited from HRT.[2,6,16] Hormone replacement therapy has received negative attention in the past as a result of a 2002 press release from the Women's Health Initiative, which was leaked before accurate statistical analysis and greatly misrepresented the risks for breast cancer and cardiovascular disease.[2,19-22] Unfortunately, many women abruptly stopped taking HRT, even though HRT initiated within 10 years of menopause has been associated with decreased risk for coronary artery disease, osteoporosis, dementia, and all-cause mortality.[23-25] Breast cancer risk varies depending on the form, dose, and duration of HRT, although the risk is considered small.[22,26,27] Evidence shows that benefits of HRT outweigh risks for the majority of women.[2,3,16,28] Hormone replacement therapy is most beneficial when initiated within 10 years of menopause or before 60 years of age,[23,24] but HRT can be started in older women with close monitoring.[19]

Women with perimenopausal and menopausal symptoms should consider the risk-benefit ratio for HRT with low-dose estrogen.[29] Several HRT options are available, including local vaginal estrogen, systemic hormones (oral or transdermal), or a combination.[2] Women with a history of breast cancer may not be candidates for systemic HRT, but low-dose vaginal estrogen could be an option.[3] Treatment needs to be individualized in consultation with a knowledgeable clinician. According to Dr Simon, women often require higher estrogen doses than what is considered to be a standard dose.[11] Some women may need to trial different options and/or dosing before they find a treatment that works for them.[30] Regrettably, many health care providers in the West have limited menopause expertise, which can lead to inadequate treatment for many women.[3,31]

Several resources on menopause and symptom management are available, including the following:

- The 2020 genitourinary syndrome of menopause position statement of NAMS[6]
- Guideline from the National Institute for Health and Care Excellence (NICE) on diagnosis and management of menopause[16]
- Position statement for management of genitourinary syndrome of menopause[32]
- Local NAMS-certified menopause practitioners[33]
- Video series from NAMS on a variety of menopause topics[34]
- IntimMedicine website, including educational resources[35] and A Partner's Guide to Menopause[10]
- My Menopause Doctor website,[36] including videos and podcasts,[30] booklets and fact sheets, and an online training course for health care professionals
- Dr Newson's Balance app[37]

Partners, family, and friends of menopausal women may also experience anxiety and distress related to their loved one's menopausal symptoms.[10] Many are only aware of the more common menopausal symptoms such as hot flashes and night sweats.[30] Radical changes may occur without warning, such as irritability, lack of patience, and decreased sexual interaction with their partner.[30] Increased temperature, from touching a partner, for example, may ignite a hot flash. Over time, these situations can lead to less physical contact. Partners may wonder what they have done wrong or what they could do to make things better. Experts suggest that menopausal women talk about their symptoms openly.[3] Sexual partners can educate themselves

on products such as lubricants, vaginal dilators, and other therapies that may improve functionality and comfort.[3,10] Dr Simon recommends that partners educate themselves on menopause and have compassion for what their partner is experiencing.[10]

The impact of menopause in the workplace is also underrecognized. In a longitudinal study of women 40 to 55 years old who stopped taking HRT, investigators reported that women were 30% more likely to quit their jobs because of menopausal symptoms and difficulty dealing with job-related duties.[38] Studies have also reported absenteeism related to menopause symptoms.[39] Menopausal women experience harassment and discrimination by colleagues who are unsympathetic of their symptoms.[40] In response to this gendered ageism, women report feeling isolated, lonely, disrespected, or vulnerable.[8] Women may be unaware that their symptoms are related to menopause and feel too embarrassed to discuss symptoms with their manager or seek medical help.[5,8] The workplace environment can also have a negative effect on menopausal symptoms. In the health care environment, hot flashes may be induced by warm ambient temperature or wearing additional barrier clothing, such as those worn to prevent infection transmission. Also, a nurse's need to void frequently may be poorly tolerated in the critical care environment when patient coverage by another nurse may be difficult to obtain. A UK position statement encourages employers to create an open, inclusive, and supportive culture regarding menopause and promote open discussion of menopause symptoms.[5] European policies ensure that the workplace is free from harassment, such as derogatory comments about someone's age.[8] Women should not be marginalized or dismissed because of menopausal symptoms.

While meeting with a member of the American Association of Critical-Care Nurses at the National Teaching Institute virtual conference in 2021, I had an awakening about caring for menopausal patients. I realized that during my more than 20 years working at the bedside in critical care, I had never once considered menopause as a reason for my female patients' symptoms. For example, when a female patient is flushed, diaphoretic, and restless, how many nurses have wondered if their patient may be having a hot flash? Actions such as removing extra bed coverings for short periods may increase our patient's comfort. As nurses, we should have conversations with our patients about their menopausal symptoms to help meet their needs. Additionally, we should be mindful about patients' home medications, which are abruptly discontinued when patients are admitted to the intensive care unit. Nurses can advocate for patients to be returned to their menopause medications when appropriate.

Another emerging area of research is the relationship between estrogen and immune response in patients with COVID-19. Premenopausal estrogen levels have been associated with decreased morbidity and mortality in patients with COVID-19.[41,42] Also, premenopausal women are less likely to be hospitalized with COVID-19 than menopausal women.[43] It is unknown if estrogen replacement in menopausal women could play a role in immune modulation,[43] but ongoing studies may soon answer this question.

The COVID-19 pandemic has been extremely challenging for acute and critical care nurses, their colleagues, and families. Factors contributing to emotional and psychological issues experienced by nurses are multifactorial. Is it possible that some nurses may be experiencing menopausal symptoms in addition to other stressors? I hope that you will explore the resources listed herein and share this editorial with other women. Let us start the conversation with friends, colleagues, family, patients, and others to increase awareness of women's health issues during menopause. In the workplace, we should support our female colleagues who are experiencing symptoms of perimenopause and menopause. We do not know what 2022 will bring, but we can continue to work toward a healthier tomorrow. All the best for the holiday season and the New Year! CCN

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