Transcript Details

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Released: 11/01/2022
Valid until: 03/30/2023
Time needed to complete: 30 minutes

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Menopause Matters…Let's Start Paying Attention to Racial and Ethnic Differences: Overview of Disparities

Announcer:
Welcome to CME on ReachMD. This activity titled: Menopause Matters, Let's Start Paying Attention to Racial and Ethnic Differences, Overview of Disparities is sponsored by the Academy for Continued Healthcare Learning, and Purdue University College of Pharmacy, and is supported by an educational grant from Astellas. Before starting this activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Kagan:
Welcome to this activity, Menopause Matters, Let's Start Paying Attention to Racial and Ethnic Differences. I'm Dr. Risa Kagan, a Clinical Professor in the department of Obstetrics, Gynecology, and Reproductive Sciences at the University of California, San Francisco. I'm also a gynecologist and clinical researcher and consultant at the Sutter East Bay Medical Group in Berkeley, California.

Dr. Neal-Perry:
Hi, I'm Dr. Genevieve Neal-Perry. I'm the chair for the Department of OB/GYN at the University of North Carolina. I'm also a reproductive endocrinologist, and my research interest is in menopause and modifiers of menopause. So, welcome.

Dr. Kagan:
In this first module, we will address racial and ethnic disparities faced by women during the menopausal transition.

To set the stage for this first module, I would like to first discuss with you how do we actually define stage and diagnose menopause or the stage of life. The gold standard now has been, and this is a chart from the STRAW+10, Stages of Reproductive Aging Workshop, otherwise known as STRAW, that was updated from an enhanced - from an earlier workshop that went on in 2001, where the earlier workshop only indicated over this time period in life, mostly bleeding patterns and FSH levels.

And as you can see here, this updated version is really what we most women fall into. And we as clinicians and researchers use in order to stage and diagnose when somebody is in their reproductive years, as you can see, going through the menopausal transition, which encompasses the perimenopause, and also in the postmenopausal years.

Now by definition, I was listening to women and whenever they talk, they say, 'Am I in menopause? Am I in menopause?' Well, I'm in menopause for years on end, they talk about. Really what they're talking about is during the menopausal transition, defined as being either in this early, late - or early late postmenopausal time.

We define menopause as one day in time if somebody even knows it, but many women don't if they are, for instance, on oral contraceptive pills, or if they've had their ovaries out. Sometimes people don't know because they've had a chemically induced menopause or chemotherapy. But if one knows their natural final menstrual period, as you can see here, it's at time zero.

And what we have before that final menstrual period are five stages prior to that final menstrual period and two stages thereafter and subgroups. This enhanced STRAW+10 incorporates not just menstrual changes, incorporate supportive criteria looking at both other FSH and the AMH, anti-Mullerian hormone, inhibin levels, looking at antral follicle counts, and also incorporates symptoms that many

women may have.

For the most part, when people are talking about this, most women do when they sound in menopause, really what they're describing is this perimenopausal time of life where they're going through the transition, whether it be early or late during this perimenopause, had their final menstrual period. And then one year out from that final menstrual period, is the true definition of what we call postmenopause.

And most of what we're going to discuss here today related to the symptoms, usually is happening during this time period. And this is an excellent way in educating your patients and colleagues about proper terminology.

Now I'd like to hear from a patient and describing her own menopausal diagnosis and symptoms.

Patient:
Hello, my name is Chanez. When I was in my late 30s, I noticed that I was not having a regular period. And I called my physician at the time and made an appointment and went over. He was fantastic. He said to me, 'I believe that you're in menopause. I'm not sure. But I believe that you are.' And we had a blood test done.

And what was so remarkable about that, and explaining to him, I was having hot flashes as well. And I had forgetfulness going on - a little forgetfulness going on. And I noticed that when I was rushed, or a little anxious about anything, the hot flashes would come on. So my doctor called me at home on a Saturday after he had gotten the results of the blood tests, and he told me, 'Yes, you are in menopause,' and asked me to come over to his office. And I did, and that's when we went over different therapies for the time while being in menopause.

Dr. Kagan:
Dr. Neal-Perry, our patient had an excellent description, of what she went through, but she appears to have had an early onset of menopause, which is, I understand, quite common in women of color. Can you please share what we've learned about menopausal symptoms across different races and ethnicities?

Dr. Neal-Perry:
Thank you for that. And yes, going through menopause at the age of 30 is quite young. And that would be young, regardless of your race or ethnicity. But in the context of kind of the menopausal transition, African American women, as well as Latina, do experience the menopause at a different time, as well as a different duration.

So in general, and on average, when compared to white peers, African American women, Asians, Latina will begin menopause anywhere from 1.2 to 1.7 years earlier, for black and Latina women. Also, the transition which basically means from the time in which you had your last period, to the time when you no longer having a period is different, it is often longer. And - which can be also associated with more intense vasomotor symptoms or hot flashes. And as a result, the women have disrupted sleep, they have a real loss in the quality of their life. And the important thing to understand is that we know that there are things that can modify your experience with the menopause, such as weight and smoking status. And what they've been able to demonstrate in a study of women across the nation on a longitudinal study focused on a menopausal experience of women is that when you control for weight, and when you control for smoking, African American women as well as Latina, will have a worse and more severe menopausal transition.

Dr. Kagan:
Dr. Neal-Perry, one thing I neglected to say when he talked about the STRAW+10, is that the average age of menopause, natural menopause is 51. Some say 51.2, 51.4, but basically around 51. And women now are living generally, the average is around 80 years. So women are going to live a third or even more like up to 40% of their life in this postmenopausal era. And I think that's important for us to take into consideration when we're discussing these issues.

Dr. Neal-Perry:
It is important to take into consideration and so when we look at a Latina and we look at African American women, the onset of the menopause or the perimenopause can be 2 to 3 years in some cases earlier than their white counterparts. And in addition to that, they will spend a longer duration, and so what I'd like to do is move to demonstrate a slide that was some work that was done by Nancy Avis as part of the Study of the Women Across the Nation. And what they specifically did in this in this paper in *JAMA*, as well as some work that's been done in the *Menopause Journal* is they show the duration of men - the duration of symptoms, specifically in the relationship between race and ethnicity.

And what you'll see in this figure on the Y axis, that's the proportion of women, and you can see on the X axis is the duration of vasomotor symptoms or hot flashes, that African American women in general will have on average about 10.1 years of experiencing menopausal symptoms, vasomotor symptoms. And that's a long time, particularly when we think about the fact that most, you know, when we look at some of the studies where they're suggesting that you only treat for 5 years. So that when we think about treatment, we

really have to think about who's presenting with those symptoms. And if you have a woman who is of color and African American woman tell you that, 'I still have symptoms,' you have to pause and really take a listen, because on average, it's much longer.

In terms of who's likely to have a shorter duration, if you look at the figure here, again, the Chinese, which is a dotted line, and our Japanese women, report a shorter duration of symptoms. When we compare non-Hispanic white women to Hispanic white women, there's like 6.5 versus 8.9 years for duration of hot flashes. So you can imagine that hot flashes that are bothersome, meaning that they wake you up at night, they, you know, you feel like you cannot continue your work, to have it for such a long duration of time is significant.

And so, we really want to take a stop and pause and listen to our patients. And understand that if they're telling us it's different, and you're coming from a different racial or ethnic - ethnic background, that will likely be the case.

Okay. So, you know, when thinking about our vasomotor symptoms, you know, it's really important that we continue to talk about quality of life. And so, what I'd like to do is to turn this over to Dr. Kagan, who can tell us a little bit more about quality of life, and some of the consequences that menopausal symptoms give rise to in women who are affected.

Dr. Kagan:
Well, you know, even though hot flashes, vasomotor symptoms, are clearly the hallmark of menopause, there are clearly some other symptoms that women have during this transitional period. Due to fluctuations in their endogenous levels of estradiol and gonadotropins, many people are going through stress, they have lack of sleep, and of course hot flashes. But independent of hot flashes, people can have mood and cognitive changes that may be contributed and worse with hot flashes, but independent of that many women will describe things such as brain fog, increase in anxiety.

We know from many studies that women who have mood disorders may have worsening symptoms. In fact, somebody who has endogenous depression, who is very stable on their SSI has been doing fine for years, all of a sudden, they'll come in complaining of worsening depression, worsening symptoms.

And there are some studies also showing that new onset depression can also occur during this time of transition. Now, some women need to be treated with SSRIs, SNRIs, CBT, but for some women, especially if they're affected by hot flashes, they will need to consider hormone therapy or alternative therapies.

Another area is sleep. And what is shown is, sure, hot flashes can affect sleep but independent of hot flashes, many women describe sleep disorders. Approximately 40 to 60% of women in some studies really talk about sleep disturbances during this transition. And worse with hot flashes if they have it on top.

Clearly, all of this creates disruption of their work, their social commitments, their quality of life in so many ways and their family relationships. I would like to present to you and share with you a brief report that I published in menopause this past year, based again on SWAN data, which we - it's called the impact of sleep disturbances on employment and work productivity among midlife women in the SWAN database. And as we said before, this is a longitudinal epidemiologic cohort study looking at multiracial and multiethnic women across seven sites in the United States.

And this was taken from the first 10-year annual follow-up visits. These women were at baseline were at age 42 to 52 in enrollment. As you can see, it was over 2,489 working women. These were working women and during this transition, the risk of unemployment was 31% higher for women with new onset sleep disturbances versus women who did not have this. Now the onset of sleep disturbances were associated with, as you can see here, is 0.44 to 0.57 hours of work reduction that was not significant, but if they reported this, okay, and work time. And when this was, you know, through various, you know, economics and various – and so many other authors were experts in this field of looking at work productivity and wages lost, sleep problems were associated with an annual loss of productivity of about $517 to $524 per woman, which calculated out to about $2.2 billion per year in lost productivity among these women aged 42 to 64 nationwide. And this is not the first report or study at all that is in our literature showing post WHI. There were a number of reports of women who went off of hormone therapy, and they just couldn't sleep, independent of the hot flashes, again, some related to hot flashes, some not, and the loss of productivity for women during this time period of their life.

Dr. Neal-Perry:
So at this point, I'd like to pivot and talk about the physiologic - other physiological consequences of the menopause or perimenopause, and specifically bone loss, and the risk for fracture.

The Women's Health Initiative, as many people are aware of the study that was done, well - close to - well over 5,000 women looking at the impact of hormonal therapy in terms of preventing or increasing the risk for different morbidities and as well as mortality. And in particular, what WHI, the Women's Health Initiative, study showed was that women with severe or moderate vasomotor symptoms, hot

flashes, have lower bone mass density at the femoral neck and the lumbar spine.

And so these are areas that are - where you have an increased risk for fractures as well as significant morbidity. Specifically, the rates of hip fracture, it was about an average of 8.2 years of follow-up. And this association in terms of the risk for fracture did not relate to your BMI, or your body mass index. And this is really important as well, because we thought for some time that if you're heavier, that protected you in terms of your risk for fractures. And what WHI showed was that vasomotor symptoms, or hot flashes by themselves, were an independent risk factor for a fracture. So really important for us to understand that as we think about how we manage our women with vasomotor symptoms that are disruptive.

The other thing that we kind of alluded to, in terms of ___ is heart disease. In addition to having an impact or increasing your risk for a bone disease or bone - or morbidity related to bone health, we also have found through studies with KEEPS, Kronos Early Estrogen Prevention Study, as well as some other studies that vasomotor symptoms - worsening vasomotor symptoms are also associated with what we call subclinical cardiovascular disease.

And so in this next figure that I'm going to show you, on the Y axis is the probability of experiencing a vasomotor symptoms. So the higher the number, the more likely it is. And on the Y axis - on the X axis is the year in which you have your final menstrual period. So for people who have a low probability of having hot flashes, their risk for cardiovascular intimal thickness, intima-media thickness, and that's basically the thickness of the blood vessels that are important for vascular health. The likelihood of them having thickening which is associated with cardiovascular disease is low, right? So the fewer hot flashes you have, the less likely you are to have evidence of cardiovascular disease, subclinical cardiovascular disease. The more hot flashes that you have, meaning you're consistently experiencing hot flashes, you're more likely to have evidence of subclinical cardiovascular disease. And so when we say subclinical, that means you haven't had a heart attack, right? You haven't had any evidence physically that suggests that you have cardiovascular disease, but there is a direct relationship, or a tight relationship I should say, between those folks or individuals who have hot flashes and a risk for subclinical cardiovascular disease, which is a risk factor for heart disease as we get older as for females.

You know, we talked a little bit about the increased risk for cardiovascular disease and how that's related to your vasomotor symptoms.

The other thing that I wanted to talk about was allostatic load and its role in terms of risk for disease, and particularly in African American women or race. So the Study of Women Across the Nation looked specifically at allostatic load. And so what is that? It's a measure of cumulative biological risk in aging. So the score for in terms of establishing the score is based on your systolic, diastolic blood pressure, C-reactive protein, your high-density lipoproteins, your total cholesterol, your body mass index, your waist-hip ratio, fasting serum glucose, triglyceride, DHEAS values, things that we often also associated with metabolic syndrome.

And so what SWAN did was to look at allostatic load in African American women. And on the Y axis, you see what the actual calculated score is, and the X axis is time to follow-up. And so what they show is that baseline measures of African American race and, you know, when you consider low family income, older age, ability to read/speak only in English significantly associated with higher levels of allostatic load over the study period, so that if you're African American, over time, your allostatic load is higher. Remember, and these are all things that can affect the heart, it can again, affect quality of life, as well as longevity. If you have a low family income, you're older to begin with, if you don't speak English, all of these things are associated with an increased allostatic load, thereby implying that the menopausal experience that women have really adds to further allostatic load.

Dr. Kagan:
Okay, well, let's turn now to the reasons that some women face disparities during their assessment and management of menopausal symptoms.

And what I'd like to do is to introduce to you the concept of social determinants of health. And many people nowadays, especially are writing about, really the patient is in the center. In our case, it's women. And there are five domains that we must look at in this concept of social determinants of what makes somebody healthy. And one is, of course, education and access to quality care, healthcare access, quality is another, and where they get their health care from, if they get any at all, the neighborhood and the environment in which one lives, and who around them are influencing them, the economic stability of the patient and their household, and their family. And then, of course, the social and community context. And in specifically looking at each of these domains, I'd like to turn it over to Dr. Neal-Perry to describe each one of those.

Dr. Neal-Perry:
Thank you, Dr. Kagan.

So when we talk about education, access, and quality, we're talking about health literacy. Understanding, you know, how to use your healthcare system, understanding when you're giving information, what that means and how to follow through with recommendations. Really important in terms of outcomes.

When we talk about healthcare access and quality, we're talking about structural racism, travel barriers, things that are kind of built into the system that reduce the likelihood of success or negatively impact outcomes. So what might be an example of that? An example of that might be many of us have resident clinics, if you work in an academic environment. If you have a resident clinic that is solely set up so that the people with the lowest literacy, the lowest income, or only going to people with the least amount experience, and in clinics where there is more turnover, there likely to be gaps in that care. And so that might be an example of structural racism. And it also may contribute to lack of coordination of care, which again, has an impact on access and quality of care, as well as unequal access to therapies. So when we talk about that, what do we need? There are data that show particularly let's talk about surgery, where there are differences in terms of if, as a person of color, you have pain, you've already identified your pain score, but you're less likely to receive pain medication than your non-minority counterpart. So there are ways that – and things that are set up in our healthcare system that create barriers and that make it hard for our patients to seek equal care.

In terms of the neighborhood and build environment, proximity to services, healthcare systems, as well as pharmacies. So if someone has to drive an hour or take a bus an hour to get to the doctor, they may be less likely to follow up. If someone is given a prescription when they leave their doctor's office, and they don't have access to a pharmacy, then they're less likely to actually fill that prescription.

For - when we think about obesity, the lack of facilities where they might be able to exercise, the lack of parks in areas where we know that obesity is endemic so that they don't have the opportunity to exercise, they don't have access to fresh fruit. And these are all the things that are kind of structural and baked in that are likely to result in poor outcomes.

Economic stability, you know, why did why would that matter because of health insurance, right? Health insurance determines access to care. Or if you do have health insurance, and only gives you limited access, meaning you can only go to one doctor, that is not stability.

Social and community context. This is really, really important that we as providers, understand and are aware of cultural contexts of care, cultural awareness, social awareness. What are the things that will reduce the likelihood that someone who is compliant, or improve the likelihood that they are compliant? It is important to understand that there are communities where there is real mistrust and the reasons for that mistrust as well placed. And so building up a trust dynamic, really important. Because if a patient doesn't trust you, if they fear that you don't have their best interests in heart, then they're not likely to follow up with the care that you're recommending.

And so as we provide care, it's really important that we think about these things, and that there is an active process, as we think about them, so that we can really make in ways as we try to take care of our patients.

So, you know, as we kind of talk about this, there is an unmet need, right, in the management of symptoms of hot flashes, particularly our underrepresented minority population, because as we demonstrated, there is a significant burden and a disproportionate burden of symptoms for our patients. And that has other consequences, which include heart disease, which include risk for bone disease. And so it's really important that we recognize that. Important that we train our clinicians at all levels so that we start not once you're a resident, but that we actually start in medical school, that we are ensuring that we're graduating individuals who are culturally aware, that we are ensuring that we have a healthcare force that is reflective of the neighborhood that they serve, that we are training our providers at all levels, again, about implicit bias. Implicit bias, it can work in positive and negative ways. And so important to recognize that we all have that. So it's not that you know, you're a bad person that you have implicit bias, but you need to understand how that might actually impact who you offer care to, who you listen to, and how you treat people who fit within a context that you identified in terms of that bias.

Lack of effective options. Treatment of symptoms are really important in terms of the vasomotor symptoms. Understanding that patients may not have the same level of healthcare literacy, so helping them understand why it's important for the management. Listening to them and helping them understand what the symptoms are, so that they can recognize it and ask for treatment and be really direct in terms of what are your concerns? What makes you uncomfortable about the management that we're offering? Or what, you know - where - how can we meet in the middle so that you have a better quality of life?

Understanding that the Women's Health Initiative data was confusing. It was confusing for physicians, so you can imagine how confusing it is for our patients. And so it's really important that we're educated, that we understand what the nuances are in terms of the management, and that we can relay that information in a digestible way for the patient who seek care from us. And that we're really thoughtful in terms of how we are managing our patients, particularly our women of color.

So, before we leave this topic and move to the next module, which is focused actually on treatment, let's discuss the strategies used to address menopausal symptoms and unmet needs, particularly for women of color.

Dr. Kagan, you know, when you have your women of color present to you with complaints that, when you hear it, it sounds like vasomotor symptoms, how do you initiate that discussion?

Dr. Kagan:
So we've got to re-educate not only our providers that are not specialists like us, and also educate our public, our consumers, the women and really get out there to wherever they learn. So I'd like to say that sure, you know, for some women, they can learn on the internet. But guess what, not everybody has a computer at their access. So you're asking me about - I do my teaching at our public hospital with the residents. And one of the things they specifically have me coming to is a menopause clinic so we can service this patient population with good, accurate, evidence-based information. And while doing that, we can educate the patient, the woman, as well as the residents, who are really just beginning to learn again about how to take a good history, understand what the patient wants, find out even something as simple as what can we offer them if they're interested? And what kind of educational material can we give at the proper grade level or proper literacy that they will understand to make an informed, what we call shared decision-making?

Dr. Neal-Perry:
Absolutely.

Dr. Kagan:
And from my own experience, I sometimes really have to really see patients back. So one of the things we're trying to do with the resident clinic, since the residents are changing so much, to get continuity of care is to have patients come back where at least the same attending is there. So we – so they build some trust knowing that I'm overseeing the situation.

Also, I like to know when somebody's made a decision, if they understand and have them, you know, actually, from what I've taught them, have them say back to me what they think are the pros and cons of going on a therapy. They don't have to look at a formulary. And in many of the public institutions, there's something listed, but that may not be right for that patient.

So I find it quite challenging, but I do go the extra step to try to find out what is going to be the right therapy for that woman because, for instance, somebody may be a smoker, very obese, have hypertension, diabetes, and they would do better on a transdermal estradiol. Well, I need to find out if that's even available on - for that an economic - whether they can afford that, and making a choice between eating versus getting that prescription.

So this is the scenario. And I think it's really particularly challenging for women of color.

Dr. Neal-Perry:
Absolutely. And, you know, and I'm glad you brought up the point about the different types of interventions, because in most, and with many insurances, they don't actually allow you to use a transdermal. So it does create an additional stressor. And it's so important to talk to the patients because they may not immediately tell you that they were not able to purchase the medication. And then so they continue to suffer.

From the perspective of, you know, of educating our residents, you know, when we do our surveys of our graduates, one of the areas that they always, always talk about in terms of ___ is learning and understanding how to manage menopausal patients. And really cannot underestimate the importance of having those conversations and ensuring that residents have exposure and clinics that are menopausal clinics or practices that have a component of menopausal management.

But, you know, but in addition to us in terms of as physicians there are other kind of healthcare avenues that people enter in, and ask your nurse practitioner, that it could be your midwife. And so it's really important to not just educate our physicians, our residents, but it's also important to educate our, you know - our multidisciplinary team around how better to manage the menopause. And also, you know, if you're not comfortable with it, to refer that patient out and not just dismiss those complaints.

Dr. Kagan:
Absolutely.

Announcer:
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