Gloria Bachmann, MD: [00:00:00]

Welcome to the podcast, the menopausal transition optimally, protecting emotional health, I'm Gloria Bachmann. I'm a professor of Obstetrics and Gynecology at Rutgers Robert Wood, Johnson Medical School. And I'm here with two of my Rutgers colleagues, Dr. Jeff Levine and Dr. Nancy Phillips. Dr. Levine, can you say a few words about yourself?

Jeffrey P. Levine, MD, MPH: [00:00:24]

Hi everybody. Yes, I'm Dr. Jeff Levine, I'm professor AND Director of reproductive and gender health. Programs in the Department of Family Medicine and Community Health here at Rutgers Robert Wood, Johnson Medical School. And I'm really delighted to be part of this podcast. Something I think so important to Primary Care Providers and certainly in terms of dealing with patients, with depressive symptoms, very common, but I think what sometimes very confusing and Elusive, and Elusive can be is how to best manage these symptoms in patients who are going through the menopausal transition.

Nancy A. Philips, MD: [00:01:01]

And I'm Dr. Nancy Phillips. Hi, I'm happy to be here. I am their apartment of Ob-Gyn at Rutgers. I'm also the director for the center for vulva vaginal Health, which includes menopause, perimenopause and menopause symptoms.

Gloria Bachmann, MD: [00:01:19]

Okay, so let's start with a global view of menopause and I think that there are three important aspects. And the first is that all of us as clinicians are going to be seeing more and more perimenopausal and menopausal women. Let's think about it in 2011, women over the age of 50 were twenty one percent of the population by 2021 this group, accounted for 26% of all women and girls globally. So, the Numbers of menopausal patients and obviously perimenopausal patients is increasing as well. Menopausal symptoms including depressive symptoms can affect not only women in their 50s and 60s, but they can continue into their 70s and 80s. So that as a clinician, we can't say, okay we don't have to worry about menopausal symptoms because the patient is 60 or 70, but rather there are many studies that suggest these symptoms can continue into a woman 70s and 80s and I think as Dr. Levine Jeff said that perimenopausal menopausal symptoms can affect how the woman, feels emotionally the depression, as well as the physical mental and the social well-being aspects of her Wellness. So, there are many Reasons why this is such an important topic for all of us to focus on. And unfortunately, for many Healthcare Providers, it's not part of the curriculum during their training. So perimenopausal and menopausal medicine is not always something that a practitioner goes into practice with and has a full understanding of. And I think another really important aspect is we, as the healthcare team have to be Comfortable discussing the menopausal issues that a woman may have that's affecting her Wellness that not only her Wellness but her family's wellness, her career, her relationships, and her self-development. And again, it's not only about hot flashes and night sweats but it's also about the other symptoms, including the depressive symptoms that many women have. So, I'd like to start by. Asking both just Jeff

and Nancy. How do you bring up the topic of perimenopause and menopause in your patients who you're seeing that would fall into this age range between 35 and above Jeff. You want to start.

Jeff P. Levine, MD, MPH: [0:04:06]

I think it's very important to be proactive in asking questions about symptoms that are related to perimenopause to these patients because very often I find patients do not associate. The symptoms to the fact that they may be having hormonal fluctuations. And, and often you can delay diagnosis, and managing something that can dramatically impact their quality of life. For instance, a lot of the patients to one of the first signs of going through menopause transition is actually changes in there bleeding pattern and a lot of them think that that's just normal, then they may have hot flushes or night sweats, sometimes being Tabling enough to interfere with their sleep and then if they're not sleeping, well, they can become irritable and then have mood changes. And again, A lot of times they don't associate that that there may be related to hormonal fluctuations and that this is just something that they have to put up with. So, my advice is to proactively ask patients one about menstrual changes or bleeding patterns, and then are they having Any of these symptoms and if so, are they impacting their quality of life?

Gloria Bachmann, MD: [0:05:24]

So then, if you actually ask the women about the specific symptoms, you just don't say, oh, you're perimenopausal, are you having any problems?

Jeffrey P. Levine, MD, MPH: [0:05:33]

I have to be honest; I didn't used to do that and what was shocking is, how many times they just assume well patients will bring it up there having them. And I found the opposite is true. And, and there are many differences culturally or otherwise. Why often times patients, do not bring these up unsolicited and if I were not to ask them, I probably would never know, and they would suffer in silence.

Gloria Bachmann, MD: [0:05:59]

How true Nancy, what about your approach? How do you bring up the topic of perimenopause menopause in your patients?

Nancy A. Phillips, MD: [0:06:08]

Gloria coming from a gynecologist’s point of view. I think that we routinely talk about periods and menstrual bleeding and irregular bleeding, which is a good introduction in terms of irregularity. But I think, as Jeff said, when we have somebody in the age group, even if they're not presenting with menstrual problems, we almost have to be almost have to be like doctor detective and really talk and really have a conversation with our patients. If they're having irregular bleeding, that's a easy jump off point where we can talk about some of the other perimenopausal symptoms, they may or may not be feeling or tell them what to expect, what may be coming up in the next year or two. If they are having regular periods and they are approaching the age of perimenopause. I think that's also we need to be proactive. as Jeff said in speaking to them about what they might expect, what is a sign of trouble that they may need to see us for that some of the symptoms may not be dangerous to them but certainly impact their quality of life and that part of our job and part of what we want to do for them, is to continue to let them have a good quality of life during that time, and I think mentioning the physical symptoms, the cycle, kind of Psychosocial symptoms, like the irritability, or some memory concentration

problems, the anxiety or depression, as well as the vaginal symptoms, you know, which they now call genital urinary, symptoms of menopause, which are some of the problems that happened with sex, including pain, desire, dryness thing, you know, decreased desire, dryness things like that. So it can be a long conversation, but I think it's important to at least touch on it. And if it sounds like this is something that we really need to look at further. They're not be afraid to reschedule at a time when we can really pay attention to the patient.

Gloria Bachmann, MD: [0:08:19]

So, I'm going to just ask Jeff a question on the patient and in the media and I'm 55. And in the media, I read about hot flashes and night sweats. And then I see you, and I'm a little reluctant and you talked about many symptoms and then you talk about depressive symptoms. And then I, I get a little upset, my say, do you think I'm depressed, dr. Levine. I mean, how, how do you make the Individual feel comfortable that you're not focusing on. Oh, I think you're depressed because an individual May or woman may feel that jey? Is there something that I show in my face that I'm depressed. How do you bring that up?

Jeffrey P. Levine, MD, MPH: [0:09:05]

I think the first thing just, like, I have to do to a lot of my health care colleagues and Learners is one is that, you know, menopause is not like a light switch. You don't go from reproductive age to menopause. There's this perimenopause or menopausal transition action that could take months or years. And during that, there are a lot of changes due to especially estrogen fluctuation as opposed to deficiency that can cause not only those hot flashes night sweats, but it is a window of vulnerability, that leads to susceptibility to depressive symptoms and major depression. In fact, that is the highest percentage of women in at age group in terms of developing depressive symptoms. And the theory is that these hormonal fluctuations increase their sensitivity to life stressors that maybe at other times of their life, they would have been able to deal with more straightforward and so helping them understand that along with their hot flashes and night sweats. It is very common in my patients, that many of them develop mood symptoms, such as irritability or feeling sad or having decreased sexual desire? Are these symptoms that you are experiencing and if so, how long have you had them? And how much are they Impacting your quality of life? So, I think normalizing that it's common and that if it's impacting you I want to know so that I can help it.

Gloria Bachmann, MD: [0:10:42]

That I think is the key that the normalizing. But I'm going to ask Nancy a very this happened to me. That I was seeing a perimenopausal women who came in, with her teen daughter. And she wanted the daughter there with her. And the daughter told me G, my mom's been so depressed in the mother said, not at all. I'm not depressed. How would you handle that? If another person's with the patient who you're seeing, and they're saying my mom's depressed, she's perimenopausal. So, this would obviously be something that Could be from the menopause, but the but the patient herself is denying it.

Nancy A. Phillips, MD: [0:11:25]

Well, I think in that situation I have a conversation and you say to the daughter, what in your mother's actions activities were in your observation, make you think that your mom is depressed and have that see how the mom reacts to it. And if the daughter says something like, well she will let me go out at night because she doesn't trust me. That's not really depressed but if she says wow, she really used to love of to come to my softball games, but now she doesn't want to come out of the house anymore. It might be that she does have some depression that she's not recognizing, and I think it's important for us to tease out the symptoms of Depression versus the symptoms of menopause. Does she not want to go to the softball games? Because she's hot and she gets hot flashes and she's embarrassed. Does she have to go to the bathroom every 10 minutes? So, she doesn't want to have to go somewhere where there's not a bathroom she likes, or does she really have this general feeling of not wanting to do things and not wanting to leave the house? Does she have a history of depression? Could this be a time when the depression is resurfacing? And I think that's, that's what you have to do. And, and you can't blame everything on menopause, and you can't discard menopause, or discount menopause. But you also have to look at, you know, is this a primary depression? Is this a reactivation of a prior depression or is this kind of secondary to the symptoms of menopause, which are affecting your life in such a way that it may appear, like depression? But we're not treating you classically, like depression, rather the symptoms that are contributing to it.

Gloria Bachmann, MD: [0:13:13]

Yeah, Nancy, you brought up something very interesting. I like to ask Jeff how he handles it but if I ask an individual patient who is going through menopause about depressive symptoms, they answer me right back. I've been depressed my whole life. How do you handle that? I mean, do you say is it exacerbated? I mean, tell me a little bit about it. How would you handle that?

Jeffrey P. Levine, MD, MPH: [0:13:39]

I think, I think, you know, very often we go straight to closed-ended questions, but somebody said that to me, I would ask open ended, can you tell me a little bit more about that? Have you ever been diagnosed as having depression? Have you ever been put on medication specifically for depression? And if so, did it help, you know, if you stopped it and why did you stop? Did you get better? Did it? Not work. And then that is a patient. I think we are all familiar with a phq-2. You know, where if they are having symptoms of depressed mood and a lack of interest, and I would probably perform a phq-9. Unfortunately, there is no menopause specific. Mood disorder scale, but phq-9 is something almost all people. Primary Care Providers are very familiar with. So if somebody says yes to one of the classic Phq-2 questions to depressed mood, whether it's all her life, or for a period of time and or you know, lack of are very familiar with so somebody says yes to one of the classic PH2, two questions to press mood, whether it's all her life or for a period of time and or you know, lack of Interest would probably perform a full pH 29, it'll do two things one, try to sort out. Do they have some depressive symptoms and how severe is this? They're having some sub syndrome depressive symptoms or are they having major depressive disorder because that's going to also help me decide how I might best manage it one if they have a history of it and to how serious or severe are these depressive symptoms and the third thing is like a Nancy said, very astutely is how do these temporally relate to other menopausal symptoms. The hot flashes and night sweats that they have bad hot flushes. They're not sleeping, and it makes it irritable, obviously, that can lead to depressive symptoms but that combination history of depression or

not, the severity of their depressive symptoms and are they associated with others are somatic? Is it common in menopause transition. Those vasomotor symptoms really will help guide me on what the best management maybe for them.

Gloria Bachmann, MD: [00:15:51]

And Nancy asked Jeff before about having a young teen daughter, come in. But what about the effect of the partner on the depression and you are a vulva vaginal expert, how do you handle when the woman says to you? Oh, I'm really very depressed and it's because my sex life is horrific. Now, I mean with this change, I am just unable to have satisfying sexual exchange and it's making me very depressed and you know my relationship with my partner is horrific. I mean, how do you tease out what to do next?

Nancy A. Phillips, MD: [0:16:32]

Again, I think it is good patient interaction, open-ended questions and asking the patient, what is her goal? If somebody comes to me with vaginal dryness or painful sex and her goal is to have penetrative sexual intercourse with a male with a female using things. Other, you know, other things like fingers or twice, if that's her goal will then that's what we worked for. If she comes to me with decreased desire and sometimes it's not a primary desire problem, but a secondary desire because of having pain, sometimes it's a desire mismatch, sometimes her desire is still good, but her husband's desire is higher and so that you need to know what the patient's goal is. What is her husband's goal? Are they looking for the same goals and then you have to work on what those goals are or what that compromise is, and sometimes that involves recommending therapy or counseling,

Gloria Bachmann, MD: [0:17:41]

So that one involves a partner, would you, would do a pelvic exam first, wouldn't you just, just to assess the vulva vaginal area?

Nancy A. Phillips, MD: [0:17:55]

Well, absolutely. Anybody who comes in with any kind of sexual complaint That even if it's a desire complaint, sometimes people don't realize that they don't have desire because they're having peeing, or they have atrophy and it's hard to have desire for something that causes pain. So, I think, like I said before, we have to take their symptom, look at all the possible related symptoms, that may be contributing to it, both the psychosocial, the hormonal deficiencies physiologic and put that all together to figure out what really is going on. But I also think it's really important when somebody comes to you. And says there are having if you ask somebody, are you having painful sex and they say yes before launching into a whole Evaluation and treatment. You might just want to say, well is your goal to have sex? Because sometimes they'll say, I don't really want to have sex in my husband, just got diagnosed with some heart condition and we are not afraid to have sex. I just want to be comfortable. You have to guide. What you treat with? What the patient wants.

Gloria Bachmann, MD: [0:19:19]

Exactly. So that it has to be an open dialogue, right?

Nancy A. Phillips, MD: [0:19:23]

And I would also say going back to the mother with the teenage girl at some point. I would have the teenage girl step out of the room. So, I could have a better discussion with the mother where other things may come up, especially sexual things relationship things. She may not want to talk about her relationship with her husband. In front of her daughter, or her partner, or her significant other

Gloria Bachmann, MD: [0:19:49]

Okay. Now I'm going to bring up a tough question because with depression and obviously it can impact relationships and partners. How do you both have? Someone leaves the room when you want to talk about these sensitive issues and a partner comes in or a an adult child comes in, or there's a young child, who the mothers carry for how do you comfortably say? And we do say, can we talk for a few minutes? The depressive symptoms, the problem? You're having, how do you, how do you, how do you do that?

Jeffrey P. Levine, MD, MPH: [00:20:28]

I mean, I don't ask like basically say I'm now I'm going to talk to your mom. Your what your partner or I'm going to examine them. And if you can wait in the waiting room, I will come and get you when I'm done unless the patient insists or requests for them to stay in the room. I mean the patient is the one who's going to guide me and so there are situations where certainly it's helpful to have the partner in the room very helpful especially when it comes to sexual dysfunction. But there are other times and often patients are the last ones to How depressed they are so very often they can help. But there are certain parts that it's very important, at least for a period of time to talk alone. Also, to identify to make sure they're not in a unstable or abusive relationship. So sometimes you want to at least have a little time alone, just to assess for that. But II would have my patient help dictate that, but usually, Then I'll act, I will tell the patient there. Whoever's in there with them, to please go. Wait in the waiting room and I'll come get them. I don't, I rather ask for forgiveness the permission.

Gloria Bachmann, MD: [0:21:29]

That's a very good point. Nancy, do you do the same?

Nancy A. Phillips, MD: [0:21:33]

I agree. I will just request that. I have a few minutes with the patient by herself and ask the other person to wait in the waiting room and say that after we finish our evaluation and we're going to talk about what, where we're going from here. I will bring them back in the room. That's what the patient would like.

Jeffrey P. Levine, MD, MPH: [00:21:53]

I do want to clarify that more times than not having the partner. There is not common but extremely Helpful. So, I do want to emphasize more often than not, it's nice to know one that they have a caring partner too, you can clear up misperceptions into it. Helps to have them both on the same page with your management plan and they can provide Insight, that sometimes the patient isn't even aware of. So just want to clear while yes, it's important and especially with my minors, I do that, but I think more often than not, it's helpful when they have their partner with them.

Gloria Bachmann, MD: [00:22:27]

Yeah, I agree with that. I find that as well, Jeff, that because it's a two-way street many times and sometimes you don't recognize some of the issues in yourself, but your loved one will recognize. But I want to get back. Sorry, I'm sorry.

Nancy A. Phillips, MD [0:22:42]

Well, I was going to say which is why it's really, I think important to acknowledge that you're appreciative that the partners there, and that they're taking an interest in that and that you want to involve them. But for the exam, it may be better for them to step out of the room.

Gloria Bachmann, MD: [0:23:01]

Exactly, exactly. So, we talked about a little bit about the, the sexual aspects and another common correlation that I see. And I'd like to hear Jeff first what you do is an individual who puts equal weight. I'm so depressed and I can't sleep. I'm getting night sweats and What comes first, what do you do? How do you manage when the patient has two issues that they're dealing with? And they feel that there is separate that I'm depressed, I'm depressed all day and then like, I'm getting hot flushes at night, sweats hot flushes.

Jeffrey P. Levine, MD.MPH: [00:23:44]

Great question. You know, chicken or the egg or everyone at cart before the horse, whatever he wants to Metaphor, you want to use. But to me the three things that help is number one. Do they have a history of depression? And they have a history of depression where they treated for it. And did they respond to an antidepressant medicine is very important because it's not common for patients, to develop major depressive disorder is very common to get depressive symptoms and perimenopause. Like I said, one of the most common but to develop a first-time, major depressive disorder is not common, so very often if they have major depression, you know a phq-9 or 15 or higher, I'm more likely going to start with an SSRI or snri. That is the outline of managing depression and all patients, including perimenopause patients, including cognitive behavioral therapy but especially if they had a history of depression and had responded to a ssri or snri, that's when I'm going to do. The other thing to be keeping line is, there are several ssris and snris that are also effective for improving vasomotor symptoms. I use those in a lot of my breast cancer survivors who don't have to depressive disorder. So, it is possible to Start with an SSRI snri and those patients and you might not only improve their depressive symptoms but some of their

vasomotor symptoms as well. On the other hand, if they don't if they score lower on your phq-9 and they are overwhelming symptoms or more the hot flashes and night sweats, there is actually evidence. that estrogen therapy whether and hormone therapy or postmenopausal doses or in Combined oral contraceptives. Can help treat depressive symptoms, especially in perimenopausal patients and in that. those patients I might choose either. If they are also having bleeding cycle issues or pregnancy prevention is important as well. I might start with a combined oral contraceptive where they're later in perimenopause and I'm not so worried about weeding their Cycles or pregnancy prevention. I might use a low dose hormone therapy so history of depression severity of Depressive symptoms and their co somatic symptoms in terms of how closures and night sweats are being. Of course, like Nancy said, the goal treatment. What is the patient were concerned about? And I have patients who say I don't care if I'm irritable or not you know too bad. They're going to have to put up with it. I don't want to be having these horrible hot sweats or nights you know these hot flushes or night sweats. So that combination I think helped dictates what I'm going to start first. What's nice is that we have of two very beneficial therapies that actually can help treat both, I think it's, what's, what's work before? The severity and as well as their coexisting symptoms and not to forget about things, like cognitive behavioral therapy nonpharmacologic things that will help as well.

Gloria Bachmann, MD: [00:26:44]

Exactly, I just want to ask Nancy though, one other point and that is. And sometimes the patient asks me and, you know, they have depressive symptoms are in the perimenopause, they'll say, well, how long will this last and how long will I have to have interventions? What do you tell them? How do you give them a guesstimate of you know what your plans are? And when do you see them again? So that you can assess mean, how do you counsel them?

Nancy A. Phillips, MD: [0:27:17]

I think that's a really great question without a really great answer. I think I think whenever you start, Something new. It's important to see somebody back within the four to six-week range. I think this is an excellent role for Telehealth, because if you're not checking rechecking on any physical abnormality, such as a vaginal problem, I don't think you need to have an exam. So, this is an excellent role for Telehealth. I tell patients, let's not look at where we're going to be five years from. Now, let's look at where we're going to be six months from now and this is an ongoing relationship where we may change things, you know, as Jeff was saying, he put a beautifully about how to decide what to treat first. I may treat you first for your hot flushes and your hot flushes do away. And you come back three months later and even though I've spoken to you in between now all of a sudden you feel more depressed. So, it's an ongoing management and I don't think you should say, well, this has to go on forever because nobody wants to hear that. I think you have to say this is an ongoing relationship and ongoing problem perimenopause on average, can be as short as one year up to five years. In some people maybe a little bit longer and I think you just have to say we're going to take this one step at a time and as things change will adapt and if you do have to be on this, for the next, And yours. If it's making you feel good or if it's making your life better. Let's talk about being on it for the next ten years. Let's talk about the pros and cons of that, especially

the hormone therapy, which I don't know that we're going into that here, but I think it's an ongoing relationship and it changes over time.

Gloria Bachmann, MD: [0:29:14]

Exactly. What are the comments? I also hear, is that family members will tell the woman, the premenopausal woman who comes in with Depression or other symptoms written, bear it I didn't take anything. None of your family members. Took anything? Why do you need anything? What's wrong? What do you say to them Jeff?

Jeffrey P. Levine, MD, MPH: [00:29:38]

I think they're very fortunate that we live in a time now where we recognize depression as a medical condition that's not only very common, certainly nothing to be ashamed about and that it's treatable. And especially in the perimenopausal transition, or the menopausal transition of this, perimenopausal period, we know there's a direct correlation with hormonal, fluctuation, and increased sensitivity stressors, where women would otherwise be able to Deal with those stressors but become vulnerable to depressive symptoms and depression. It is not. It is physiological and nothing for them to be ashamed about. And it's unfortunate that they have relatives or friends who were not seeing seeking clinical care or were recognized or appreciated that these symptoms were common and could be treated. But fortunately, they're here and I would like to help them and how can I best help them?

Gloria Bachmann, MD: [00:30:40]

Now I'm going to ask both of you this same question and obviously it's a very difficult question but depressive symptoms there is a whole spectrum of depressive symptoms the depressive symptoms or you know they're not as severe and interfering with the individual’s life versus the person can't get out of bed. So there's a spectrum, how do you ask Retain the degree of the depressive symptoms that that premenopausal woman is coming into your office. You have asked her about them, and she says, yes, I have them. How do you determine the degree, or how, it's impacting her Wellness, her lifestyle, and possibly even endangering her Jeff. You want to start?

Jeffrey P. Levine, MD, MPH: [00:31:36]

Well, I guess, look, I like asking open and closed ended questions and I like the art of medicine but there are times where using validated screening tools can be helpful. And I think that's where the phq-9 can be. Extremely helpful. It doesn't exclude me. Asking other symptoms, that you only use PHP 9, you'll totally miss all the vasomotor and other symptoms. That could be Associated. But in terms of determining how serious are these patients’ depressive symptoms? Do they have? She has substance Journal depression, or do they have you know, if their phq-9 is over 15, do they have major depressive disorder along with do they have any feelings about hurting themselves or others? And if so, do they have a plan for that? Obviously puts a whole different level on what I'm going to do in the immediacy,

right? I think Nancy said a lot of primary care colleagues tell me I don't have time to address this well, guess what most of this just validating it and telling the patient. Let's schedule a time when we can address it together is okay. This is not going to go away overnight. They probably didn't have it overnight. You don't have to address it in one visit. However, if they report to depressed of symptoms, I think you're obligated to at least do some type of screening to make sure they don't have major depressive disorder and certainly that they're not having suicidal or homicidal ideations because that does have to be treated immediately.

Gloria Bachmann, MD: [00:33:07]

Nancy. Anything to add to that.

Nancy A. Phillips, MD: [0:33:09]

I don't have a lot to add to that. I think Jeff answered that wonderfully. I just think it's important for people all Physicians. All Healthcare Providers, to know what to do in that situation. Who do you call? Who's your Social Service? What are your 1-800 numbers? Where do you tell this patient to go? So, I think rather than having to say, oh no, what do I do? Now, you need to know beforehand. You're going to do in that situation because that situation, although rare, may come up.

Jeffrey P. Levine, MD, MPH: [00:33:42]

But again, I want to emphasize depressive symptoms are very common in the perimenopause of patient, but major depressive disorder is an initial diagnosis is not common. It's going to be more patients who had a history of depression. You're probably gonna have a high index of Suspicion. A heightened awareness for screening, those patients anyway. So, I want to make sure we understand that I want to encourage and lighten. My primary care providers. That this is something you can and should be treating and not to fear it. Because, again, most of these patients can be managed with medicines. You are already comfortable using like ssrn arise or snris and medications. You should get comfortable using terms of hormonal therapy that especially in this patient population are very safe and effective.

Gloria Bachmann, MD: [00:34:34]

I want to thank both of you, Dr. Levine, and Dr. Phillips for joining me for this podcast and I look forward to collaborating with you. The two of you in the future. Thank you very much.

Nancy A. Phillips, MD: [0:34:48]

Thank you, Gloria.

Jeffrey P. Levine, MD, MPH: [0:34:53]

And I want to thank our audience for participating in this podcast and I look forward to having you join us for future ones as well.