The Agenda

IMS PRE-CONGRESS WORKSHOP

Tuesday June 5, 2018 – 11:30 to 18:00

Fairmont Hotel, Vancouver, Canada

PERIMENOPAUSE – CHALLENGES & SOLUTIONS

Course Development: Elaine Jolly Robert Reid

Moderators: Chui Kin Yuen Robert Reid

11:00 – 11:50 **Lunch**

11:50 – 13:00 **Lunch Symposium: "Breaking News: Confessions from the Experts"**
Moderator: Chui Kin Yuen
Expert Speakers- Celine Bouchard, Elaine Jolly, Robert Reid, Tim Rowe, Wendy Wolfman.

13:00 – 13:10 **Welcome & Introduction**
Moderators: Chui Kin Yuen and Robert Reid

13:10 – 13:35 **Lecture #1: Tim Rowe (CAN)**
Physiology of the Perimenopaus

13:35 – 13:50 Case #1: Wendy Wolfman (CAN)
Diagnosis & Management of the Perimenopause

13:50 – 14:10 Discussion

14:10 – 14:35 **Lecture #2: Rod Baber (Australia)**
Risk Assessment & Screening in the Perimenopause

14:35 – 14:50 Case #2: Marla Shapiro (CAN)
Breast Cancer in the Perimenopause

14:50 – 15:05 Case #3: Cynthia Stuenkel (USA)
CVD & Diabetes during the Perimenopause

15:05 – 15:25 Discussion

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15:45 – 16:10	**Lecture #3: Robert Reid (CAN)** **MHT Regimens in the Perimenopause**
16:10 – 16:25	Case #4: Denise Black (CAN) Oral & Transdermal MHT
16:25 – 16:40	Case #5: Christine Derzko CAN) Local Vaginal Therapies
16:40 – 16:55	Case #6: Michel Fortier (CAN) Progestins and Progestin Intolerance
16:55 – 17:30	Discussion – All Faculty

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19:00 – 21:30 **Dinner Symposium for Faculty and Canadian Delegates.**

Moderator: Vicki Holmes

Topic: When MHT is so good,
Why do less than 10% of Canadian Women take Menopausal Hormone Therapy?
Speaker: Nese Yuksel

What can we do about it? **Speaker: Denise Black**

The **AXE**

Please be on TIME!

BREAKING NEWS
Confessions from the “Experts”

Moderator: Chui Kin Yuen

The Experts:
Elaine Jolly
Celine Bouchard
Tim Rowe
Robert Reid
Wendy Wolfman

Learning Objectives

- Identify mistakes made by “experts”
- Discuss and review these common mistakes together with the “experts”
- Integrate and apply new information when they are faced with similar cases.

Case 1 – Dr. Elaine Jolly
Referral: “Cannot stop MHT at Age 65”

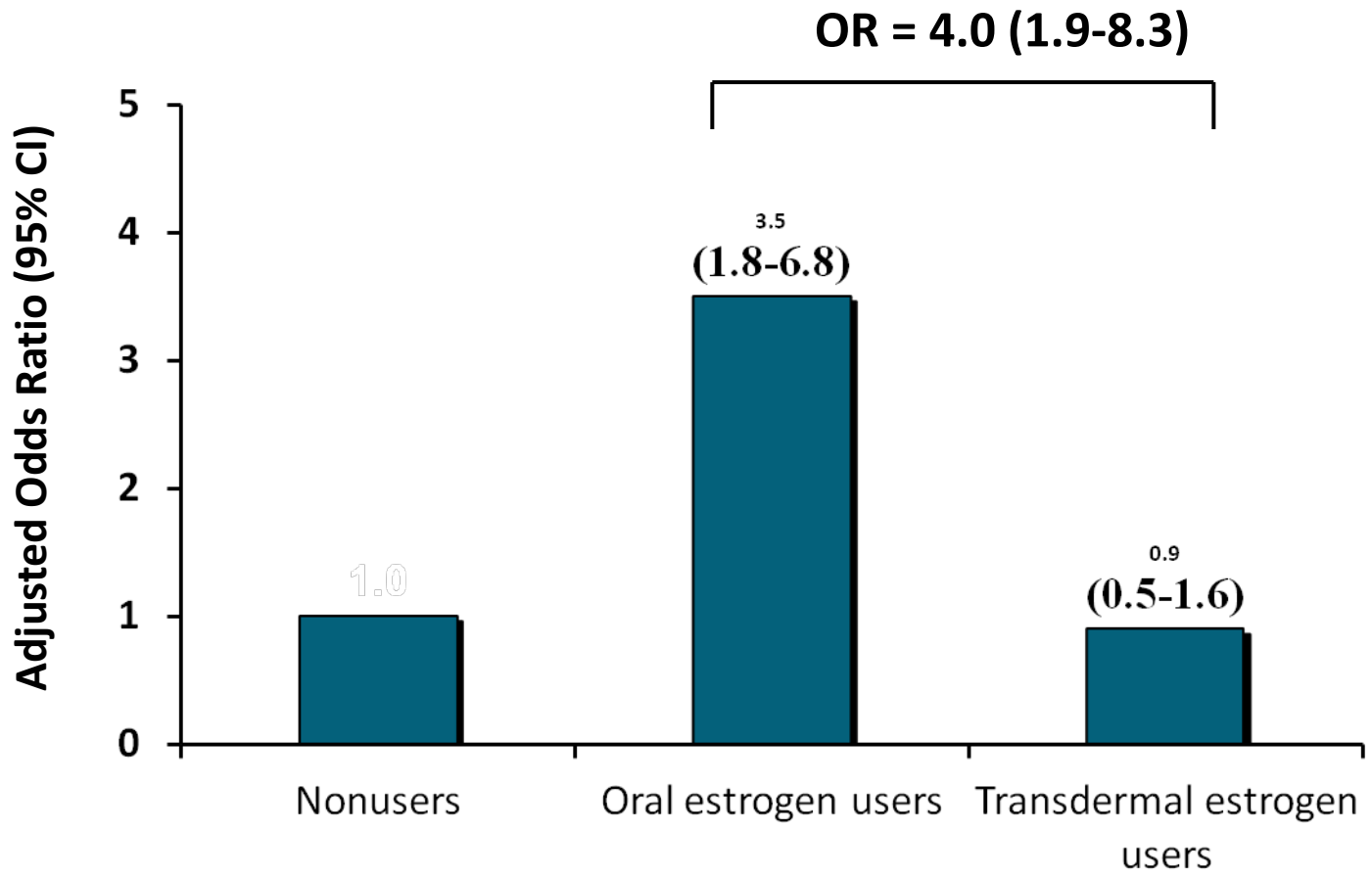
- 65 y/o woman on long term ET CE 0.625 mg
- Surgical Menopause age 51 (fibroids)
- BMI 32; Nonsmoker; G4, P4
- Fibromyalgia; Osteoarthritis; Depression
- Family history unremarkable
- When off estrogen – dreadful VMS & night sweats
- Trial of low dose transdermal HT a little helpful
- Adding gabapentin and clonidine to no avail
- Changing to desvenlafaxine 100 mg also no help
- Patient is DESPERATE!
- Labs CBC, ESR, TSH, Chest and Abd Imaging -24 hr urine - all negative
- Patient begs to go back to CE 0.625 mg
- 6 months later she suffers DVT (popliteal and femoral)

Risk Factors for VTE

- Increasing Age
- Surgical procedures
- Obesity BMI > 30
- Immobility > 3 days
- Smoking
- Post-Thrombotic Syndrome
- Previous VTE
- Varicose Veins with Phlebitis
- Inherited Coagulation Defect
- Hormones & Pregnancy

VTE and HRT [Green-top guideline no. 19] 3rd ed. London: RCOB; 2011.

Risk of VTE with Oral vs. Transdermal Estrogen: The ESTHER Study



Scarabin PY, et al. Differential association of oral and transdermal oestrogen-replacement therapy with venous thromboembolism risk. Lancet 2003;362(9382):428-32.

Case 2 – Dr. Celine Bouchard

- 60 year old woman, widow for the last 5 years; same partner for 30 years; she is still working as civil servant.
- G2 P2 with normal vaginal deliveries. She has a natural menopause at age 52 and HT was started early for severe vasomotor symptoms. (Estradiol 50 ug patch twice weekly + micronized progesterone 100 mg at hs).
- Her past history has nothing relevant. She does not use any concomittant medication, no smoking history and no allergies. She was referred by her family physician for post menopausal bleeding. She reported a recent bleeding episode similar to a heavy period for 5 days, 2 months ago; there was intermittent spotting after this initial episode .
- Her last gynecological examination was 6 years ago and she had neglected gynecological follow up after her husband's death.
- Physical examination was normal with normal vital signs.
- Gynecological examination reported a normal vulva without any signs of lesions. The vagina was normal and the cervix was slightly enlarged but of normal appearance; Pap smear was taken . There was no bleeding after Pap done
- Bimanual exam revealed a normal menopausal uterus, contour was regular, mobile without any abnormal adnexal masses.
- Endometrial biopsy demonstated scant tissue with hysterometry at 8 cm. Material was sent for histology.
- Results : Normal Pap and endometrial biosy showing atrophy without any signs of neoplasia.
- Patient was advised that the investigation is normal and was told that she may continue HT at same dosage since she does not want to stop HT for her life quality.
- 3 months later: patient has a repeated epidode of heavy bleeding and went to ER.
- At examination, there was a visible lesion in the vagina at the right lateral cul de sac. Biopsy was taken and result came back as : **invasive squamous cell carcinoma of vagina**

Conclusion

- Take nothing for granted even if you think that you are an experienced gynecologist.
- Let us remind the importance of an attentive clinical examination bearing in mind that a small lesion may be hidden in vaginal folds.
- Not all postmenopausal bleeding is from endometrial origin or caused by atrophy. Attentive inspection of vulva to eliminate small lesions that could be responsible for postmenopausal bleeding bleeding is also very important.
- The etiology of postmenopausal bleeding is varied and we must take into account all the possibilities in our questionnaire and examination.

Case 3 – Dr. Tim Rowe

- 47-year old G5P3A2 presents with intermenstrual bleeding for 3 months
- She has been on oral contraceptives since her mid-30s, and for more than 10 years has been on a 50µg ethinyl estradiol, 500µg dl-norgestrel pill
- Smokes 10-15 cigarettes daily, has done so for 30 years
- Three uneventful vaginal deliveries, one miscarriage, one TA
- No significant past medical or surgical history
- General physical examination unremarkable – BMI 27.3, BP 140/85
- Pelvic examination shows 6mm polyp in cervical os, excised (pathology benign)
- Advised that smoking plus high-dose OC use will increase CV risk – pt not sure about stopping OC use as she divorced 18 months ago and needs reliable contraception
- Serum FSH at the end of pill-free week 18 IU/L
- Pt reassured that risk of pregnancy off OCs is “very low”
- Pt discontinues use of oral contraceptive, begins program to cut down smoking
- Two months later, reports “positive pregnancy test” – she is NOT HAPPY
- Pt miscarries at 5-6 weeks
- Pt has IUD inserted, continues to have regular cycles

Case 4 – Dr. Robert Reid
Oops: Be Careful what you promise!

- A woman with past breast cancer, treatment completed 2 years ago, severe GSM
- Afraid, despite my reassurances, that there would be systemic absorption of vaginal 17 beta estradiol 25 ug which could impact breast cancer recurrence risk
- To confirm the lack of absorption a pre treatment E2 measurement was obtained followed 1 week later by another E2 measurement
- Surprisingly (for me) there was an unexpected elevation in circulating E2
- No evidence of systemic absorption was seen with a repeat E2 after three weeks of treatment
- Transient absorption of vaginal 17 beta estradiol 25 ug resulted from extremely thin atrophic vaginal epithelium and resolved as a healthier epithelium developed

Transient Vaginal Estradiol Absorption??

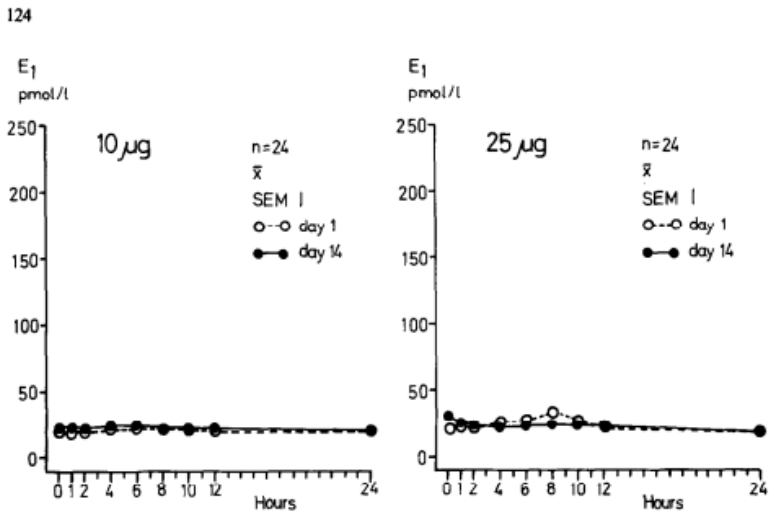


Fig. 2. Plasma levels of oestrone on days 1 and 14 after vaginal administration of 10 and 25 µg 17β-oestradiol, respectively.

Nilsson K, Heimer G. Low-dose estradiol in the treatment of urogenital estrogen deficiency—a pharmacokinetic and pharmacodynamic study. Maturitas 1992; 15: 121–127.

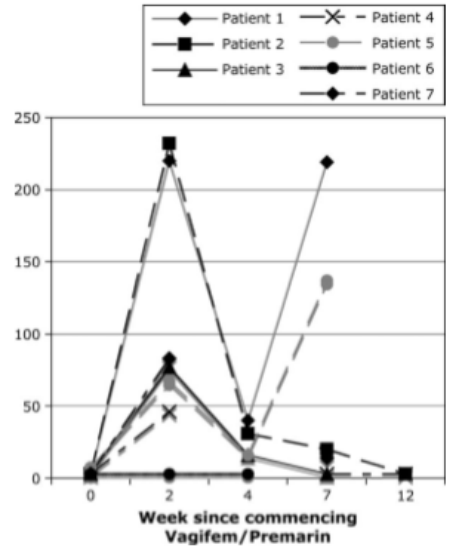


Figure 1. Serum estradiol levels in women receiving concurrent aromatase inhibitors and Vagifem.

Kendall A, Dowsett M, Folkerd E, Smit I. Caution: Vaginal estradiol appears to be contraindicated in postmenopausal women on adjuvant aromatase inhibitors. Annals of Oncology 17: 584–587, 2006

Case 5 – Dr. Wendy Wolfman

- 49 year old G1P1 presents with a 3 month history of irregular vaginal bleeding
- Bleeding is heavy for 5 days every 6 weeks with irregular bleeding with no specific pattern –using 2 pantiliners on non-heavy days
- Slightly worse with intercourse and bowel movement
- No pain, no significant meds or past history
- Examination: Caucasian female slightly overweight normal VS
- Abdomen-benign, perineum normal, cervix grossly normal on inspection, bimanual –uterus slightly bulky
- Pap normal, ultrasound- endometrium 9 mm, uterine fibroids, largest 4 cm, none submucosal
- Endometrial biopsy showed proliferative endometrium
- ? Next step

Next step

- Patient taken to the OR-nothing on perineum or in vagina, hysteroscopy, no polyps D &C-no malignancy
- Patient returns 3 weeks post-op-annoyed and still bleeding-no difference
- Taken to exam room-malodor noticed-? Retained sponge
- Cervix normal-no sponge rotated speculum completely-tucked under urethra anteriorly was fungating lesion-biopsy-amelanotic melanoma

Amelanotic Melanoma

- Rare
- Review 1992-2014, 16 primary genital melanoma-9 vaginal, 6 vulvar and 1 cervical
- 4 atypical amelanotic tumor
- Wide local surgery , radical surgery in 6 and radiotherapy performed
- 2 patients alive without recurrence, other 13 rapidly recurred

Ferraioli D Arch Gynecol Obstet 2016

What I learned

- Not all abnormal bleeding is from atrophy or uterine source
- Systematically examine the vulva, urethra, vagina, cervix and perirectal areas
- **Rotate the speculum to view the area under the urethra and posterior**

Discussion