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Women at midlife

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What do we mean by ‘midlife’?

It is important that we look after ourselves throughout life to live the healthiest life we can. Yet the reality is life demands often mean we cannot prioritise our own health enough. Between work and family we often don’t have the time to think much about our health until around midlife, which is the life stage when most of us have a few key realisations:

- If we don’t make time to look after ourselves, sooner or later we will be forced to make time to be ill.
- In terms of activity, if we don’t use it, we will lose it.
- Also, for many of us, midlife is the stage where we start to have more time to focus on our own health and to prioritise good health more so than we did in our youth.

So, what do we mean by ‘midlife’? The evidence suggests that this depends on where we are in the lifespan, and our historical, social, structural and cultural context. Younger adults in their twenties consider middle age as 30–55 years, whereas older adults in their sixties to seventies perceive middle age as 40–70 years. For women in the early 1900s (www.abs.gov/socialtrends) or current day Australian Indigenous women (www.abs.gov.au; 2012 data) with an average life expectancy of approximately 60 years, the term ‘midlife’ could conceivably apply to the ages of 25–40 years. Contrast this to the non-Indigenous Australian woman born in

1985 who has a life expectancy of 80 years, and the term *midlife* or *middle adulthood* typically covers the ages of 40–65 years.¹ Currently, there are 2,885,212 Australian midlife women aged 45–64 years (www.abs.gov.au; 2013 data).

Human development across the life span is influenced by both individual biological, psychological and social dimensions, and environmental factors (societal, cultural and physical).² Historical (associated with changing historical times and different social expectations) and gender-related factors are also important. The life stage described as ‘middle adulthood’ or ‘midlife’ for women often also involves significant transitions, including the biological transition of menopause, psychological transition into what is the second half of life, and social transitions related to work and relationships. It has been proposed that the four areas generally important in midlife are: (1) health (physical, psychological), (2) employment (paid and unpaid work), (3) relationships, and (4) the search for meaning and purpose.

Health

The significant health event for most midlife women is menopause. However, midlife may also see the onset of health problems, often in the form of risk factors such as high blood pressure, which may herald significant problems in later life. Screening for health risk factors becomes increasingly important from midlife onwards. Mental health problems during this life stage are not as common compared with earlier years, but anxiety and depression are still common.

Work

Work (paid or unpaid) is an important aspect of midlife, providing a sense of usefulness, competence and purpose as well as financial resources to ensure economic stability. However, retirement from paid work (voluntary or involuntary) may also occur during midlife, creating challenges. Work may influence and be influenced

by health and relationship status; women are often disadvantaged economically following divorce and may not have prepared as well as men with their superannuation.

Relationships

Intimate relationships continue to be important throughout midlife and have a significant impact on health and wellbeing. Midlife is often a time of stable marriage and increased marital satisfaction; although, it can also be a time when women initiate separation/divorce. Previously, midlife was perceived as the time for parenting adolescent children and children leaving home; however, as increasing numbers of older women are able to have children (often via assisted reproductive technologies) parenting of younger children is increasingly common for midlife women. Midlife may also be a time when women become a grandparent. 'Refilling of the empty nest' occurs as adult children return to the parental home, often for financial reasons, presenting challenges. Changes in relationships with ageing parents can occur as elderly parents require care or a parent dies. Between 25–30% of midlife women are caring for a frail or disabled person.

Search for meaning and purpose

Midlife is a time of evaluation of the spiritual dimension and reflection on life.⁴ This may involve determining 'what matters to me rather than what society says should matter', rejecting values/ideas that no longer have meaning, and assessing 'what have I accomplished and what I still wish to accomplish'.

The concept of the 'midlife crisis' is contentious, with descriptions of burden and loss such as 'empty nesters', 'sandwiched generation', and 'reduced fertility' contrasting with the fact that midlife is a time when individuals seem to come into their own, and that midlife can be a time of peak personal control and power, with increasing ability to master our environment, autonomy, and personal relations.⁵ Midlife 'crisis' may be better termed midlife 'consciousness' as individuals reassess life. The stereotype that

midlife is a negative age period for women is also contentious. In certain cultures, midlife women are freed from restrictions placed on younger women, able to exercise greater authority, and eligible for special status; in contrast to the emphasis on youth and beauty and prevention of ageing in Western culture. Perception versus real life experience is also important, with pre-menopausal women having more negative beliefs about menopause than post-menopausal women. Post-menopausal women are freed from unintended pregnancy and post-menopausal women rated menopause 'as the first day of the rest of my life'. Midlife for women should perhaps be better considered as a time of transition and opportunity rather than a negative event.

Much of our understanding of Australian womens' experience at midlife is derived from two large studies, the Melbourne Women's Midlife Health Project and the ongoing Australian Longitudinal Study on Womens' Health. The Melbourne study looked at the health and wellbeing (including hormonal changes) of women living in Melbourne as they progressed through into midlife and menopause. The Australian study, which commenced in 1996, is an ongoing study of approximately 40,000 women as they progress through life. The study includes a midlife group (born 1946–51) and collects data about many aspects of life every three years. The learnings from these important studies provide much of the basis for what is discussed in this chapter.

Body changes

Menopause

At birth, the ovaries of female infants contain approximately one million immature eggs. During reproductive life, only about 400 of these eggs will ever mature and be released at ovulation; the others will die off without being released from the ovary. This begins before birth and continues throughout life, speeding up after 35 years of age until few eggs remain, the point at which menopause occurs. Menopause is defined as occurring around the

final menstrual period, and natural menopause occurs when the number of eggs reach a critical level and hormonal changes then occur. There are dramatic changes in the key female hormones, oestrogen and progesterone. Testosterone is also produced in women but declines slowly between ages 20–45 years with little change at menopause. Before menopause, as hormones change gradually, women experience the menopause transition, which usually lasts around five years and involves variable hormone patterns and menstrual cycle patterns (for example, change in frequency and or bleeding pattern, skipping menstrual periods — see Table 1). The term *perimenopause* includes the menopause transition plus the 12 months after menopause. The average age of menopause in Australian women is 51 years (normal range 45–55 years). While the menopausal transition and menopause itself is a natural biological process, menopause also occurs in the context of different individual circumstances and social and cultural contexts. How a woman and her society/culture perceive menopause will influence her unique experience of menopause.⁶

Studies demonstrate that only vasomotor symptoms (for example, hot flushes and night sweats), changes in the reproductive tract (for example, vaginal dryness), and sleep disturbance have a consistent association with the low hormones occurring in menopause.⁷ Other symptoms may also occur (Table 2). The frequency and severity of symptoms peaks at different stages through menopause; hot flushes, night sweats, and sleep problems increase across the menopause transition, whereas breast tenderness and migraines are prominent early then decrease, and vaginal dryness is most common in postmenopausal women. Menopausal symptoms can have a negative impact on quality of life, particularly if the woman has a negative perspective of menopause and its significance in life. The most problematic symptoms of menopause are hot flushes and night sweats.⁸ A ‘hot flush’ usually involves a sudden feeling of warmth/heat, which may include skin redness, sweating and a fast heart beat or palpitations. This often starts in

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Table 1

Changes in Hormone Levels, Menstrual Cycles, Follicle Numbers and Symptoms Around Menopause

	Late pre-menopausal	Early menopausal transition	Late menopausal transition	Final menstrual period	Post-menopause
Average age (individual variation)	>35 years	40s	Late 40s to early 50s	Average age 51 years	50s onwards
Menstrual cycles	Regular	Irregular Varying length of cycle	Irregular Increasing skipped menstrual periods		No menstrual periods
Hormonal changes	Rising FSH* but still within normal range Normal oestrogen levels	Normal to ↑ FSH levels Variable oestrogen levels	↑ FSH Variable to low oestrogen		↑ FSH Low oestrogen
Ovarian follicle numbers	Increased rate of decline	Approximately 1,000	Declining — approximately 100		0–10
Symptoms	Decreasing fertility		Hot flushes prominent Insomnia Mood change Bone loss starts		Vaginal dryness Hot flushes Bone loss

Note: *FSH = follicle stimulating hormone produced by the pituitary gland. Table adapted from Harlow et al., 2012.⁹

the upper body and progresses to the head, lasting 30 seconds to 5 minutes. A ‘night sweat’ is a hot flush that occurs at night with sweating. Hot flushes usually commence during the menopausal transition, with the highest frequency reported around the time of menopause, and becoming less frequent after this. Up to 80% of women will experience hot flushes and sweats, usually lasting 5–7 years; however, some may have symptoms for shorter or longer periods (even into their seventies). The cause of hot flushes is not

Table 2

Symptoms Experienced by Australian Women During Reproductive Ageing

Symptom	Menopausal stage when symptoms peak
Breast tenderness	Pre-menopausal, Early menopausal transition
Vaginal dryness	Late menopausal transition, Post-menopausal
Hot flushes	Late menopausal transition, Post-menopausal
Night sweats	Late menopausal transition, Post-menopausal
Insomnia	Late menopausal transition, Post-menopausal
Lack of energy	No specific changes with menopause
Skin irritation (crawling or dryness)	No specific changes with menopause
Dry eyes	No specific changes with menopause
Swelling of body parts	No specific changes with menopause
Backache	No specific changes with menopause
Dizzy spells	No specific changes with menopause
Headaches	No specific changes with menopause
Nervous tension	No specific changes with menopause
Depression	No specific changes with menopause
Tingling in hands and feet	No specific changes with menopause
Shortness of breath on exertion	No specific changes with menopause
Rapid heart beat	No specific changes with menopause
Problems with urine control	No specific changes with menopause

Note: At least 20% of women in one of the stages reported the symptom. Five or more symptoms were more commonly reported by women during the late menopause transition and post menopause compared with the pre-menopause and early menopause transition. Table adapted from Dennerstein et al., 2000.¹⁰

well understood but involve brain chemical messengers that affect temperature control and responses. Other life factors associated with hot flushes and sweats are listed in Table 3. Vaginal dryness is common, affecting up to 50% of postmenopausal women and increases after menopause. Vaginal changes include thinning, with decreased elasticity, blood flow, and lubricating secretions with predisposition to urinary tract infections. This can result in symptoms that include discomfort, burning, itching, pain with sexual intercourse, and incontinence. Women are often reluctant to raise issues related to vaginal or sexual symptoms with their

Table 3**Factors associated with hot flushes and night sweats**

Low oestrogen levels
Earlier age at menopause
Smoking
Surgical menopause (both ovaries surgically removed)
Obesity or weight gain
Increased alcohol intake
Co-existing stress/illness
Co-existing medical illness
Lower income
Ethnicity and culture: Less likely in Asian women
Lower educational level
Negative attitude to menopause and ageing
Hotter climates/ temperature: symptoms worse in summer
Previous menstrual problems/pre-menstrual tension

doctor. A significant decline in sexual functioning is observed across the natural menopause transition, with the percentage of women in the Melbourne study reporting sexual challenges increasing from 42% to 88%.¹¹ Difficulties with sexual function include problems with desire/libido, arousal, orgasm and pain with intercourse with associated distress and potential for relationship impact. The change in sexual function across the menopause transition is related to falling oestrogen (but not testosterone) levels. However, many other factors impact on sexual function, including physiological factors (for example, age, illness, menopausal status, effect of medication) and psycho-social factors (for example, partner/relationship issues, cultural influences, education, self-image, concurrent depression and anxiety). In women with natural menopause, the four factors correlating best with sexual function are a woman's psychological health, her relationship with her sexual partner, her expectations regarding the relationship's future and her past sexual experience.¹² Changes in sexual function can be distressing for women and for their

partners. Women are encouraged to talk to their partners about the changes occurring during this phase of life and to seek help where needed.

Weight

'Weight gain' was the second most common fear associated with menopause after 'ageing', reported by Australian women.¹³ Animal and human studies suggest that weight gain is associated with ageing rather than menopause, with an increase of approximately half a kilo per year (equivalent to the additional energy from around one plain sweet biscuit per day). However, at menopause there is an increase in total fat, less muscle and decreased physical activity is seen, and we change shape as fat moves from a more female pear shape to more of an apple shape, with more fat around the tummy area (our waistline changes and clothes often don't fit in the same way).¹⁴ This is important for future health as tummy fat is associated with an increased risk of heart disease, diabetes and certain cancers (breast and uterine), as well as affecting the way we feel about ourselves. Hormone replacement therapy, in contrast to common misconceptions, does not cause weight gain and indeed may assist to slow the body changes that occur at around menopause.

Weight is usually described in relation to height and described as a body mass index (BMI). We divide this BMI into different groups based on the health impact: (1) recommended or healthy weight (BMI 18.5–24.9), overweight or less healthy weight (BMI 25–29.9) and (3) unhealthy weight or obese (BMI >30). As a population we are all getting larger, and the proportion of midlife women in the Australian study who were overweight or obese increased from 44% to 59% over 11 years (www.alsw.org.au). Risk factors for weight gain were increased energy intake, more take-away meals, living in the country, less physical activity with more 'sitting time', lower education levels and lower income. Obese and overweight women had poorer physical health and

mood compared with women in the healthy weight range. Overweight and obesity were also risk factors for high blood pressure, heart disease, asthma, arthritis and diabetes. Obesity is also a major risk factor for urinary incontinence, cancer (breast, uterine and colon), memory decline and depression.¹⁵

Mood

Mood disorders are more common in women than men, with anxiety more common than depression.¹⁶ Poor mental health is experienced by a minority of midlife women, with anxiety and/or depression found in 40% of 55-year-old and 30% of 61-year-old women (www.ALSWH.gov.au: 2013 report). Across midlife, four patterns of poor mental health were evident: (1) most women (75%) reported low levels of poor mental health, (2) 7% experienced chronic poor mental health, (3) 13% reported poor mental health until age 56–61 years with subsequent increase, and (4) 5% reported poor mental health peaking at age 56–61 years and then falling. So there is no set pattern.

Mental health is determined by many interconnected factors. Mood symptoms are commonly reported by women around menopause (see Table 2) and menopausal symptoms overlap with mood symptoms (for example, poor sleep, fast heartbeat, tiredness and poor concentration). It is unclear whether these mood symptoms are caused by menopause or not. Mood symptoms are associated more with women who have a sudden onset of menopause with surgical removal of the ovaries and women with a negative attitude to menopause or ageing, hot flushes and sweats. Other risk factors for mood problems at midlife include past mental illness, lower education, unemployment, lower income, non-English speaking, not being in a relationship, poor social support, and caring for people with illness and chronic illness.

The relationship between mental health and physical health is also complex. Smoking, excess alcohol, being underweight or obese, less physical activity and a high fat and sugar diet are also

associated with poor mental health and with physical ill health. A history of anxiety and/or depression is associated with an increased risk of heart disease, stroke, diabetes and arthritis. Hormone replacement therapy (HRT) may improve depressive symptoms in women with vasomotor symptoms, but has little effect on mood otherwise.

Thinking and memory

As with mood, memory and concentration are commonly reported by women to change around menopause, and again, many factors may contribute, including sleep, low mood and life stresses. Mild changes in memory and thinking are part of ageing and there is no evidence that menopause worsens this. Our hormones — mainly oestrogen — affect nerve cells and blood vessels in the brain and may impact on brain function, but more research is needed. HRT commenced in older women (>65 years) is associated with an increased risk of dementia, but if commenced close to the time of menopause may be protective; yet again, this is not clear and more research is needed.

Managing now and for the future

Risk perception and screening

Although cardiovascular disease accounts for 41% and breast cancer 3% of all female deaths in Australia, midlife women generally think the risk of breast cancer is much higher than the risk of heart disease. This is concerning as it influences our decisions to screen for heart disease risk factors and to focus on prevention. Recommended screening for midlife women is shown in Table 4. Recent data (www.canceraustralia.gov.au; 2012 overview) showed some of us may have screening, but this is patchy at best. As we get older we are less likely to have a Pap test and more likely to have a mammogram, cholesterol test and bowel cancer screen. Smokers are less likely to have any screening tests. Women with unhealthy weight or poorer health are more likely to have cholesterol tests

Table 4
Screening Strategies at Midlife

Age	What should be done?
45–49 years	Consider: <ul style="list-style-type: none"> • Smoking, Nutrition, Alcohol, Physical activity (SNAP) • Risk of diabetes using Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK) • Skin cancer risk • Cardiovascular risk: absolute cardiovascular risk • Depression in increased risk groups • Risk factors for osteoporosis
Measure:	<ul style="list-style-type: none"> • Weight, height (calculate BMI) and waist circumference • Blood pressure • Cholesterol levels • Blood sugar in patients at high risk of diabetes.
Perform:	<ul style="list-style-type: none"> • Pap test every two years • Mammogram if family history indicates high risk.
50–64 years	Repeat above and add: <ul style="list-style-type: none"> • Mammogram every two years • Bowel cancer screening with faecal occult blood testing (FOBT) at least every two years • Potentially colonoscopy if increased risk • Other tests if high risk such as bone density

Note: Adapted from information on the Royal Australian College of General Practitioners website (www.racgp.org.au).

but less likely to have Pap tests or mammograms. More visits to the general practitioner were associated with increased health checks.¹⁷

Long-term health risks

Midlife is an opportunity to identify risks and change our health behaviours to help us live healthy lives as we age. Lifestyle factors, such as diet, physical activity, alcohol intake and smoking are critical factors in future health. The midlife/healthy ageing mantra should be to:

- maintain weight in the healthy range (or as close to as possible, avoiding weight gain)

- adopt a good diet (www.nhmrc.gov.au; 2013 guidelines)
 - eat a variety of foods from the five basic food groups — fruit, vegetables, protein (lean meat, fish, eggs, legumes), wholegrain cereals, low fat dairy
 - limit intake of saturated fat, added salt and added sugar
 - drink water
- engage in 150–300 minutes of moderate physical activity each week, including weight bearing and aerobic exercise
- avoid overconsumption of alcohol (no more than 1–2 standard drinks per day; www.nhmrc.gov.au)
- stop smoking.

Cardiovascular disease

Although cardiovascular disease (heart disease and stroke) is the leading cause of death in women, we usually think of these as conditions that affect mainly men. Hence, women are less likely to be screened for risk factors for heart disease, present for help later, are less likely to be tested or treated the same, and more likely to die with a heart attack than men. Risk factors for cardiovascular disease are outlined in the cardiovascular disease chapter of this book. Women who are 45 years old with two or more risk factors have a 31% chance of having a major cardiovascular event by age 80, compared with women with no risk factors (only a 4% chance by 80).

Australian midlife women's risk factors are changing, with fewer women smoking but more women who are obese or overweight. Higher weight increases type 2 diabetes and high blood pressure. Chapter 3 in the book *Young at Heart: Looking After Your Cardiovascular System* discusses these important risk factors in more detail, how you can calculate your personal risk of cardiovascular disease using the online risk calculator (<http://www.cvdcheck.org.au/>) and what steps you can take to minimise your risk now and in future. Oestrogen has both 'good' and 'bad' effects

on the heart and blood vessels, including protection against blocking cholesterol deposits, effects on cholesterol, and increasing the risk of developing clots. Evidence about hormones and the cardiovascular system suggests that on balance oestrogen protects the cardiovascular system in younger women, whereas in older women the harmful pro-clotting effects dominate, increasing the risk of heart disease. HRT for menopausal symptoms in healthy peri- or postmenopausal women under the age of 60 years does not increase their risk of cardiovascular disease, but it also does not prevent it. For high risk women who have already had a cardiovascular event, HRT may increase their risk further and is not recommended.¹⁸

Osteoporosis

Women aged over 50 years have a one in three risk of sustaining an osteoporotic fracture (a fracture related to weakened bones rather than due to injury) by age 80 years. The most common fractures are at the hip, spine, wrist, upper arm, ribs or forearm, with the fracture usually occurring without any significant injury or with a simple fall. For example, spinal fractures are usually 'silent': they occur when we cough or move and women only notice decreasing height or changing to a slumped posture as the spine bones fracture or collapse a little. They matter, however, as they are a vital sign that further more serious fractures are likely to occur. Osteoporosis or weakening of the bones does not cause pain or arthritis in itself, but is a key risk factor for serious osteoporotic fractures. These serious fractures can have a significant impact on health and wellbeing, including pain, loss of independence (the need to move from home into assisted aged care) and increased risk of death. Hip fractures, for example, require major surgery and are associated with a 20% risk of death. Hence, osteoporosis and related risk factors are important to recognise and manage to reduce the fracture risk and include family history especially of fractures, age, low calcium intake, low vitamin D levels, low levels

of physical activity, menopause (especially early menopause), smoking, excess alcohol and being underweight. Midlife is an ideal time to discuss with your doctor your individual osteoporosis risk and whether you need a bone density test. This is because menopause is associated with a significant loss of bone and increased risk of osteoporosis. Oestrogen reduces loss of bone. Although bone loss commences around the time of menopause, most women develop fractures after the age of 65 years. Once one fracture has occurred, you are four times more likely to have another. For these reasons, fracture prevention is the key and midlife is a key time for prevention to minimise fracture risk in later years. Prevention strategies include:

- ensuring adequate calcium intake (1200 mg per day). Use a supplement if diet is insufficient.
- obtaining adequate vitamin D. This is mainly produced in our bodies through sun exposure and vitamin D formation in our skin. Low Vitamin D levels are *very* common in Australian women and supplements may be required if inadequate safe sun exposure. Midlife is a good time to have your vitamin D level checked.
- weight bearing exercise such as power walking or strength training
- stopping smoking
- reducing alcohol intake if excessive.

HRT maintains bone strength, which is especially important in women with early menopause as it helps prevent early bone loss. HRT also reduces the risk of fractures by approximately 70%, which is similar to specific osteoporosis medications. If used for menopausal symptoms, HRT will protect your bones at the time; however, as most fractures occur in older women when the benefits of HRT are usually outweighed by the risks, HRT is not usually used for osteoporosis alone.

Type 2 diabetes

The world is in the grip of a diabetes epidemic, with more than one million Australians diagnosed with the disease. Diabetes is characterised by high blood sugar levels and is caused by genetic and lifestyle factors. Diabetes affects most body systems, especially kidneys, eyes, cardiovascular and nervous systems. Any increase in weight, even within the healthy weight range, increases risk. A woman's lifetime risk of getting diabetes is 18% in normal weight, 35% in overweight, and 75% in obese women. Other risk factors for diabetes include family history, low physical activity levels, ethnicity (Indigenous, Pacific Islander, Asian), pre-diabetes, diabetes in pregnancy and high blood pressure.

Your risk of diabetes can be calculated using the Ausdiab risk calculator (www.diabetesaustralia.com.au). Talk to your doctor if your score is above 12, as other tests may be appropriate. We know that the risk of type 2 diabetes can be reduced by more than half with relatively simple healthy lifestyle changes. Once it has developed, complications include depression, memory impairment, cardiovascular disease, eye and kidney disease. These complications are largely preventable, and those with diabetes can live a happy and relatively healthy life if their lifestyle is healthy, they visit a doctor regularly, have complication screening and take the appropriate treatments. Lifestyle recommendations to prevent diabetes and reduce complications when you have diabetes are:

- maintaining a healthy weight (or at minimum preventing weight gain)
- regular physical activity
- making healthy food choices
- checking and managing blood pressure
- checking and managing cholesterol levels
- not smoking

HRT use is associated with a small decrease in risk of type 2 diabetes but is not used specifically to prevent diabetes. In addition, for those with diabetes:

- checking and managing blood sugar levels. This can be by home blood sugar testing, which is usually combined with special three-monthly overall average tests (HbA1C tests) done by a general practitioner (GP).
- having your eyes checked every 1–2 years by your optometrist or medical eye specialist
- having your kidney urine and blood tests every 1–2 years
- having your feet checked with your doctor and if needed, cared for by a podiatrist
- seeing a dietician and diabetes educator intermittently
- seeing a medical specialist for diabetes if your diabetes, blood pressure, cholesterol or other risk factors are not well controlled
- considering whether aspirin may help reduce your cardiovascular risk factors.

Cancer

Most cancers (65%) will occur in women 60 years of age or older. However, cancer risks rise in midlife. Breast cancer is the most common cancer in women (risk of one in eight women being diagnosed before 85 years), followed by bowel, melanoma, and lung cancer in that order. In contrast, lung cancer is the most common cause of cancer death in women, followed by breast cancer and colon cancer (www.canceraustralia.gov.au; 2012 overview). The death rates from these cancers has fallen over the past 20 years with increased screening, improved treatments and survival, especially for breast cancer. Many women are not aware of the risk factors for breast cancer. Weight, diet, alcohol intake, smoking and physical activity are important risk factors for cancer

and can be modified. Family history can also be a risk factor. Your risk of breast cancer can be calculated using www.cancer.gov.au/affected-cancer/cancer-types/breast-cancer/your-risk/calculate. There is an ongoing debate as to the extent to which HRT is associated with an increased risk of breast cancer. International menopause guidelines state that the increased risk of breast cancer with HRT is small (<0.1% per year, which is less than the risk associated with many lifestyle factors) and related to the use of the HRT form that includes both oestrogen and progestin hormones, and with the duration of HRT use. HRT is not recommended for women with a history of breast cancer. HRT is also associated with a small reduction in bowel cancer.

All women should talk to their doctor about their risk of cancer, including breast, cervical and bowel cancer, as these can be prevented and early screening and detection significantly improves outcomes.

Strategies for the menopause transition/menopause

Management of menopausal symptoms is best individualised in discussion with your GP. For many, understanding and education is all that is needed; while for others, specific treatment may be appropriate. HRT is the most effective treatment for hot flushes and sweats and for vaginal dryness. Other menopause-related complaints, including joint/muscle aches and pains, depressed mood, sleep disturbance, sexual function and quality of life may improve with HRT. The decision to use HRT is an individual one best made in consultation with your doctor, taking into consideration your personal risk factors, menopausal symptoms and general life stresses. Oestrogen-only HRT is used in women who have had a hysterectomy, whereas oestrogen should be combined with a progestogen in women who have a uterus to prevent uterine cancer. There is some evidence to suggest that oestrogen in the form of a skin patch or gel is preferable to tablet forms of oestrogen. Different progestogens may be associated with different risk

profiles, but more research is needed. For women aged 50–59 years, the usual age group experiencing menopausal symptoms, the most common harmful side effect of HRT is the development of blood clots, including deep venous thrombosis and stroke. This is uncommon (around 1–2 women per 1,000 per year), and HRT doubles this risk. However, other risk factors such as age, obesity and smoking have a much bigger impact on blood clotting risk, and given that HRT doubles the overall risk, women who smoke, are over 60 years, or are obese should carefully discuss the risks with their doctor. Vaginal oestrogen is the preferred treatment for vaginal dryness and discomfort with sexual intercourse, and may also improve urinary symptoms. Vaginal oestrogen has minimal side effects or risks. There is evidence to suggest that testosterone therapy may be helpful for decreased sexual function, but long-term safety data is not yet available.

For women who are unable to or choose not to use HRT, non-hormonal alternatives are available for the relief of vasomotor symptoms, although these are generally not as effective as HRT. These agents include antidepressants (for example, venlafaxine, paroxetine, escitalopram and desvenlafaxine), gabapentin, pregabalin and clonidine. Each of these medications have their own side effects and have not been subjected to long-term study. Women are also interested in complementary and alternative therapies for menopause; however, very few therapies, apart from mindfulness training, have been shown to be effective (see Table 5). Non-hormonal vaginal moisturisers and vaginal lubricants can assist with the management of vaginal symptoms. Lifestyle changes, including dietary (avoiding red wine/spicy food/excess caffeine) and environmental (dress in layers/fan), can assist with the management of flushes and sweats. Exercise does not reduce these symptoms but may improve feelings of wellbeing and is an important part of a healthy lifestyle.

Table 5**Complementary and Alternative Therapies for Menopausal Symptoms**

Therapy	Effectiveness
Mindfulness training/ Cognitive behavioural therapy	Reduction in intensity of hot flushes and night sweats by 30–40% at six months. Improved mood, sleep, sexual function, quality of life.
Acupuncture	Variable results seen in small studies — evidence of benefit
Hypnotherapy	Limited evidence of benefit
Yoga	One pilot study only — promising
Paced breathing	Limited evidence of benefit
Magnetic therapy	No evidence of benefit
Homeopathy	No evidence of benefit
Herbal therapies	No evidence of benefit
Isoflavone/soy supplements	Limited evidence of benefit
Compounded 'bioidentical' hormone therapy	Not recommended due to safety concerns

Partners, family and self-care

It is known that life stress and anxiety make it harder to look after ourselves and make our tolerance and severity of menopausal symptoms worse. At midlife and through menopause, remember to be kind to yourself, look after your mental and physical health, and where possible reduce your stress levels. Enlist your friends, partner and family for support. Many of us go through midlife informed by the experiences of other women around us. This can be very helpful, but be aware that other women's experiences will differ to yours: we are all individuals, and education and awareness more broadly may help at this time of transition. We also know that most Australian women do not share their experiences with their families. Recent research shows that most women do not talk to their partners about menopausal experiences and most partners reported feeling that they experienced menopause and its mood impact indirectly, by being exposed to the frustrations, symptoms, mood changes and sexual functional changes, yet not understanding them or knowing how to help. For example, many interpreted

reduced sexual interest as a reflection of a poor relationship rather than a change that occurred at midlife. We would encourage all women to openly communicate with their family and partners. Discuss the physical and emotional challenges that can occur and how they are affecting you. Knowledge is power and that goes both for women and for their partners and families.

Conclusion

Midlife, the life stage between 45–64 years, can be considered as a time of biological, psychological and social transition. Health, work, relationships and the search for meaning in life are key components of midlife. The decline in oestrogen at menopause brings with it shorter-term symptoms such as hot flushes, night sweats and vaginal symptoms. It also brings increased risks for cardiovascular and osteoporosis and fracture. However, many of these illnesses are preventable or, if detected early, progression can be prevented. Key to prevention for most common illnesses occurring at midlife and beyond is a healthy lifestyle that includes a healthy diet, regular physical activity, avoidance of excess alcohol consumption, and NOT smoking. Midlife is a perfect time to focus a little more on ourselves. Having insight into what your personal risks are is very important. We recommend that you complete a risk calculator provided in the list of websites and make an appointment with your doctor just to discuss these risks. Having a prevention plan and developing a screening plan for blood sugar, cholesterol, blood pressure, weight monitoring, pap smears, mammograms, bowel cancer screening and bone density tests should also be discussed. Remember, early diagnosis allows us to prevent progress of disease or improve outcomes. Midlife is also a time to focus on your quality of life and future directions, and to think about you and how you will spend your coming years. In essence, midlife is a time to reflect, reassess and resolve to make changes to optimise health and wellbeing, and quality of life into older age.

Helpful websites

Online resources providing information regarding the topics discussed in this chapter and risk calculators are listed here:

- www.jeanhailes.org.au (midlife health)
- www.menopause.org.au
- www.diabetesaustralia.org.au
- www.heartfoundation.org.au
- www.osteoporosis.org.au
- www.canceraustralia.org.au
- www.beyondblue.org.au (depression)

Endnotes

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