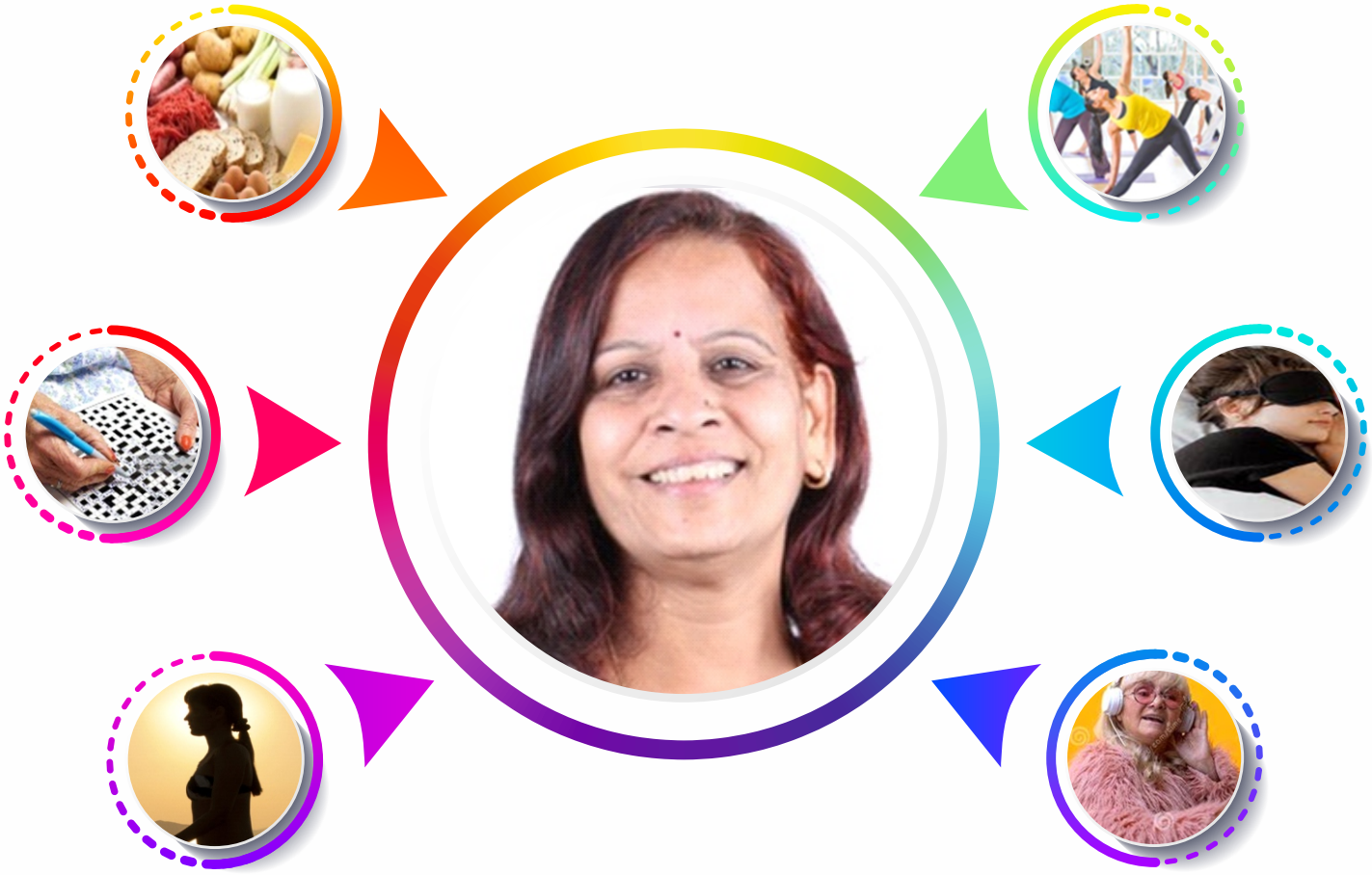
Chennai Menopause Society

"Changes not Challenges"

Healthy Living, Healthy Mind & Healthy Ageing



Souvenir

The answer to old age is to keep one's mind busy and to go on with one's life as if it were interminable Leon Edel

Learn, Unlearn, Relearn

Our Team

Our Team

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Learn, Unlearn, Relearn

P. GEETHA JEEVAN
MINISTER FOR SOCIAL WELFARE
AND WOMEN EMPOWERMENT

SECRETARIAT
CHENNAI - 600 009.

Date 10.10.2022.

MESSAGE

I am pleased to know that Chennai Menopause Society along with the Obstetric & Gynaecological Society of Southern India, is conducting an Annual Conference on Healthy Living, Healthy Mind & Healthy Ageing with the aim to Learn, Re-Learn, Un-Learn the fact and myths about the consequences of Menopause.

India's elderly population (aged 60 and above), according to the National Statistical Office's (NSO) "Elderly in India 2021" report, is projected to touch 194 million in 2031 from 138 million in 2021, a 41 percent increase over a decade. The report mentions that there will be 93 million males and 101 million females in 2031, up from 67 million males and 71 million females in 2021. The life expectancy of women is about 70.95 years. Women, live longer than men.

Indian women attain menopause at 46.5 years of age and hence, one third of their life is spent during postmenopausal period. Menopause has short and long-term consequences which will result in an enormous public health burden. Most Indian women suffer menopausal symptoms in silence, but they have the right to live a healthy life.

The mission of the Chennai Menopause Society is to promote and support access to the best practices of healthy care for women through their menopause transition and menopause years. The vision of the Chennai Menopause Society is that all peri menopause and post menopause women must have fully informed mid-life and beyond health choices and empower them to have easy access to health services. Chennai Menopause Society conducts awareness programmes about nutrition, exercise, lifestyle modifications to various sections of women like teachers, nurses, paramedics and housewives. It also conducts screening camps and charitable health clinics.

The Annual Congress of Chennai Menopause Society team, led by Dr. Hephzibah Kirubamani, on Health Living, Healthy Mind & Healthy Ageing, has a very well laid out program which will be immensely useful, informative and enlighten doctors who look after women past their mid-life age and beyond. My heartiest congratulations to the team of the Chennai Menopause Society, and I wish them all success for the forthcoming Congress on 16th October, 2022.

10/10/22

(P. GEETHA JEEVAN)

CMS President's Message

Dear Colleagues, Seniors & Friends

Greetings from Chennai menopause Society, I have pleasure in inviting you all to the annual conference of Chennai Menopause Society on **"Healthy Living, Healthy Mind & Healthy Aging"** on Sunday 16th October 2022. Precongress workshop on Office Hysteroscopy and Awareness Programme for PHC doctors and for paramedical will be held on Friday 14th October 2022.

Chennai Menopause Society's vision is "To promote wellbeing of Midlife women & Menopausal women" and Mission is to increase awareness about Peri & Postmenopausal health issues by Public forum & awareness programme for Teachers, Lecturers, Para medicals, public and students. We have conducted Guru Kul programme among medical students. To promote healthy aging among midlife women, NCD health camps were conducted. To promote research on Menopause among young doctor's various competitions were conducted for poster presentation, paper presentation & quiz and awards were given. Every month CME programme was conducted. Our membership is on the increasing trend. We will continue our mission

I thank all the members for their support and encouragement. Together we will continue to do our mission for midlife and menopause women's health.

LONG LIVE CMS

Dr.N. Hephzibah Kirubamani

President Chennai menopause Society

IMPACT OF MENOPAUSE

Dr. Deepa Thangamani
MD OG, DNB OG, MRCOG, FRCOG.,
Consultant Apollo First med hospitals, Chennai. Consultant Thamarai Fertility Solutions Exclusives, Chennai.

The Menopause - Short Term & Long-Term Effects

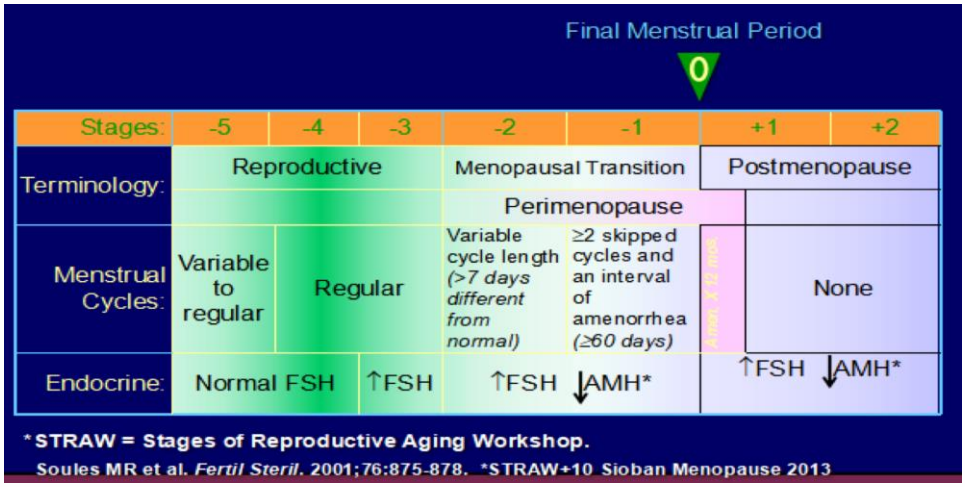
The menopause is the stage in a woman's life when her ovaries stop producing eggs. This leads to a gradual decrease in levels of hormones oestrogen and progesterone, which in turn leads to the gradual disappearance of monthly periods. The fall in hormone levels can trigger a range of symptoms, although each woman's experience can be different. The process of the menopause can take several years. A woman is said to be postmenopausal when she has had no period for one year.

The average age at which women in the UK start the menopause is 51, and for most women it happens between the ages of 45 and 55.

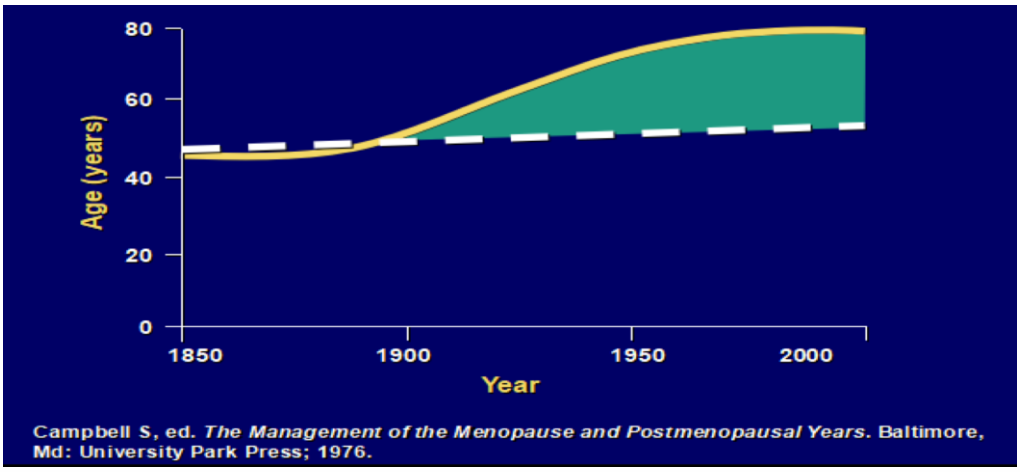
To prevent pregnancy, it is recommended that contraception is continued for one year after the last period if this occurs after 50 years of age, and

Menopause terminology : STRAW * Staging system

AGE AT MENOPAUSE HAS REMAINED CONSTANT WHILE LIFE EXPECTANCY HAS INCREASED



Two years if periods end before 50 years of age **Menopause - Short-Term Effects**



Irregular Periods

The most common early sign is irregular or fluctuating periods. This can involve longer than normal cycles and missed periods.

Hot Flushes/Night Sweats

Three out of four women have hot flushes and night sweats during their menopause. They usually start as a feeling of pressure in the head, followed by a wave of heat passing over the body.

Vaginal Dryness

Most women experience vaginal dryness during the menopause. This is because the vaginal tissue becomes thinner as a result of lower oestrogen levels. (See Atrophic Vaginitis leaflet).

Aches and Pains

Joints may start to feel stiffer, painful or weak.

Skin and Hair Changes

Skin can become dryer and hair brittle.

Sleep Disturbance

Altered sleep patterns can be a problem.

Mood, Confidence and Concentration Changes

Lack of concentration and clear thinking can affect some women. Psychological changes, including irritability, tearfulness and mild depression are also common. It is understandable to feel a wide range of emotions during this time of major change.

Loss of Sex Drive

A loss of interest in sex can be caused by some of the emotional and physical symptoms of the menopause.

Stress Incontinence

Lack of oestrogen causes the lining of the bladder to become thinner, which may make it harder to control the passing of urine. Passing urine more often or noticing small ‘leaks’ when coughing or sneezing are also common. Urine infections can also occur.

Menopause – Long-Term Effects

Even though the short-term symptoms appear more unpleasant, it is the long-term symptoms of oestrogen deficiency that can cause the more serious health problems. When a woman reaches the menopause, her risk of developing Heart Disease and Osteoporosis increases as a direct result of the decrease in oestrogen:

Heart Disease

Cardiovascular disease is the most common cause of death in western women. Before the menopause, fewer women suffer from the condition than men, but, from the menopause onwards, incidence increases. The role of oestrogen in protecting the heart and blood vessels is very important; the body’s own oestrogen prior to the menopause is understood to have a positive effect on cholesterol levels and general body fat distribution.

Osteoporosis

Osteoporosis is a condition of the bones, where a gradual thinning of the bone causes them to become brittle and fragile, leading to a stooping posture, backache and an increased risk of fractures. Lack of oestrogen is partly responsible for Osteoporosis.

Managing Symptoms

1. Avoid caffeine and reduce alcohol to improve sleeping and flushes.

2. Wear loose layers of clothing and consider swapping duvet for blankets to help cope with flushes, sweats and chills.

3. Cut down or ideally stop smoking.

4. Eat a balanced diet, rich in Calcium, Magnesium and Vitamin D to protect bones, and Omega 3 for heart health.

5. Keeping weight in health BMI range will reduce menopause flushes and protect against many cancers - in particular breast cancer.

6. Regular exercise will improve mood. Weight bearing exercise helps keep bones strong.

7. Relaxation/mindlessness/meditation will reduce menopause symptoms and improve general wellbeing.

8. Cognitive Behaviour Therapy (CBT) can relieve low mood, anxiety and flushes.

MOOD CHANGES AND AGING

Dr. G. Vanishree

Mental health and well-being are as important in older age as at any other time of life. Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the workforce. While most have good mental health, many older adults are at risk of developing mental disorders.

Mood disorders in the elderly are a growing source of morbidity and mortality. Unfortunately, mood disorders in later life frequently are not diagnosed and treated. Appropriate, prompt diagnosis and treatment of late-life mood disorders can significantly improve the quality of life of patients and families and may prove lifesaving.

Depression is a true and treatable medical condition, not a normal part of aging. However older adults are at an increased risk for experiencing depression.

Societal roles and expectations may contribute to the heightened rate of depression in aging women. Elderly women with particular types of stressors seem to be at increased risk for perimenopausal and postmenopausal depression. Such stressors include- Lack of social support, unemployment, surgical menopause and poor overall health status.

Physical activity has positive physical, mental, and emotional effects. Physical performance factors are strongly associated with depression symptom, suggesting that physical performance improvements play an important role in preventing depression.

Aging induces physiological changes and affects all of organs. Nutritional status and mental health deteriorate with aging. The risk of severe depression in patients with malnutrition was 15.5 times higher than non-depressed persons.

In a study on positive mood and aging, it was observed that mood improves as age increases over time until age 71, at which the positive effect of age on mood tempers, and eventually reverses. Stable cognitive function is important for maintaining healthy mood states in late life. It also plays a role in buffering against the effects of negative late-life experiences, such as losses in physical health and/or death of spouses and peers.

The dysphoric mood during the early perimenopausal transition is most common in women with relatively low educational status. Therefore, low levels of education may be a marker for other stressors, such as ongoing low socioeconomic status.

Although most women transition to menopause without experiencing psychiatric problems, an estimated 20% have depression at some point during menopause. Studies of mood during menopause have generally revealed an increased risk of depression during perimenopause with

a decrease in risk during postmenopausal years. Depressive symptoms increased during the menopausal transition and decreased after menopause. The strongest predictor of depressed mood was a prior history of depression, along with fluctuations in reproductive hormone levels associated with depressed mood.

Depression during perimenopause is likely due to fluctuating and declining oestrogen levels in part. Steroid hormones, such as oestrogen, act in the central nervous system (CNS) by means of various mechanisms. Although the precise mechanisms are yet unknown, regulation of neurotransmitters- serotonin and norepinephrine may change as oestrogen levels fluctuate and thus contribute to depression. Because oestrogen facilitates the actions of serotonin and norepinephrine, a decline in oestrogen concentrations may, in turn, decrease levels of these neurotransmitters.

It is important to prepare health providers and societies to meet the specific needs of older populations, including training for health professionals in providing care for older people.

Promoting positive mental health, increasing early assessment and diagnosis of depression, risk reduction by increasing the use of other clinical preventive services like blood pressure checks, cancer screenings, and blood sugar testing are important measures in management of psychiatric disorders in elderly.

Mental health in the elderly can be improved by helping those with depression to remain active, independent, and involved in their community as long as possible. Providing resources to help caregivers stay healthy and deliver quality care to their care recipients is an important step.

SEXUALLY TRANSMITTED INFECTIONS (STI) IN MIDLIFE

Dr. R Premalatha
MD, DGO, DNB, FRCOG, FICOG.,
Past President OGSSI

STDs or STIs (sexually transmitted infections), Include syphilis, gonorrhoea, chlamydial infections, genital herpes, hepatitis B, genital warts, HIV/AIDS, HPV, and trichomoniasis. Recent data reveal that significant numbers of STIs and unintended pregnancies occur among mid-life women. Both STIs and unintended pregnancy can result in serious health consequences for mid-life women. STIs can result in pelvic inflammatory disease and ectopic pregnancy. Unintended pregnancy can result in increased morbidity and mortality to the woman and the fetus.

As per CDC, rates of chlamydia and gonorrhoea in women over age 35 have seen a steady incline over the past decade, and syphilis rates have climbed steeply. PID is prevalent and associated with previous STI diagnosis. Improving sexual health among midlife women requires age-sensitive interventions, on the sexual safety at this stage of life. IUD use was not associated with an increased risk of PID in general, but in women > or =35 years, IUD use was associated with a risk of PID [odds ratio (OR) = 4.2,]

Non-sexually transmitted bacterial pathogens and PID association in older women are reported by microbial culture in cases of PID from a study from East Taiwan. The pathogenesis of PID in these patients is more likely direct extension from adjacent intra-abdominal viscera, such as appendicitis, diverticulitis, and bowel perforation, rather than ascending infection. Another study showed that bacterial vaginosis and trichomonas vaginalis were the most common pathogens responsible for PID among postmenopausal women

Women living with HIV on HAART live longer. Symptoms experienced by women living with HIV include symptoms related to HIV infection itself, those related to opportunistic infections, and those related to medications and treatments. There is clear evidence from numerous studies that women infected with HIV are vulnerable to worse menopausal symptoms, increased risks of T2DM, cardiovascular disease, osteoporosis, cancer, and neurocognitive impairment. HIV-infected women appear to have more vasomotor symptoms, vaginal dryness and dyspareunia, and adverse mood symptoms. Women on HAART live longer and it has also been associated with an increase in metabolic disturbances. A number of studies have pointed to possible detrimental effects of both HIV infection and HAART linkage to the development of T2DM or the metabolic syndrome.

HCV coinfection also has been examined as a possible modifier of development of metabolic abnormality.
HIV infection is associated with higher triglycerides and lower HDL cholesterol. Carotid intimal medial thickness has been observed to be increased in HIV infected women and men.

An increased prevalence of low bone mineral density (BMD) has been consistently found among HIV+ individuals. Estrogen deficiency with the onset of menopause can be expected to exacerbate HIV-associated bone-loss.

Aging increases the risk of cancers of many types, and HIV infection exacerbates this risk. Cervical cancer risk is known to be greater in HIV-infected women, and they are at lifelong risk for increased cervical screening anomalies. Other cancers more common in HIV infected individuals include non-Hodgkin's lymphoma and multiple myeloma.

Menopausal HIV infected women should be encouraged to optimize their cardiovascular health, maintain their weight within the normal range, stop smoking and adhere to osteoporosis and cancer screening guidelines as appropriate. It is too early to know whether hormone therapy will pose a net benefit to HIV infected women, but over the short term, treatment of menopausal symptoms, be it hormonal or non-hormonal, is likely to be indicated.

STI treatment guidelines released by the CDC in July21, recommendation is for taking detailed sexual history in midlife women to screen risk factors for asymptomatic STIs before they actually start causing morbidity in the form of a disease. For those with a positive gonorrhoea/chlamydia (GC/CT) screen, a nucleic acid amplification test (NAAT) vaginal swab is the preferred specimen source. For contact testing – asymptomatic people who have had a high-risk sexual exposure – providers should test for gonorrhoea, chlamydia, HIV, and syphilis but not for herpes, high-risk HPV, hepatitis B, hepatitis C, or bacterial vaginosis. HIV screening only needs to occur once between the ages of 15 and 65 for low-risk people and then once annually (or more often if necessary) for those who have a sex partner with HIV, use injectable drugs, engage in commercial sex work, have a new sex partner with unknown HIV status, received care at an STD or TB clinic. Trichomoniasis screening should occur annually in women living with HIV.
There is a compelling need for interventions to reduce STIs and unintended pregnancy in this population of women, review the literature regarding STIs and unintended pregnancy in mid-life women, identify gaps in current resources, and make recommendations for health care practice and future research.

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MEDICAL MANAGEMENT OF UTERINE FIBROIDS IN MIDLIFE

Dr. T K Shaanthy Gunasingh
Vice President, Chennai Menopause Society

Midlife is acknowledged as one's early 40s to early 60s. With increase in longevity, the range continues to be redefined upwards. Hence, it includes premenopausal, perimenopausal and post- menopausal women.

Uterine Fibroids (Leiomyoma) are the commonest tumours in the female with a prevalence of 70 – 80% at 50 years. The true incidence and prevalence are much higher because most women are asymptomatic and diagnosed incidentally on clinical examination and imaging. 25% are clinically significant to require intervention. Fibroids are the leading indication for hysterectomy.

Expectant management is appropriate for asymptomatic women or for those who do not want intervention. Surgery was the traditionally preferred treatment. Novel drugs have widened the ambit of medical management. Medical co-morbidities preventing safe surgery also warrant medical management. For those who are symptomatic and wish to have treatment, the options are varied. Choice of therapeutic modality depends on several factors – age, parity, desiring fertility, size, number and location of myomas, proximity to menopause and risk of malignancy.

The basket of choices for **medical management of fibroids** are:

1. Combined oral contraceptives are effective in reducing Heavy Menstrual Bleeding (HMB) in short term and may prevent the development of fibroids.
2. Tranexamic acid can be considered for AUB-L.
3. For short-term therapy, GnRH agonist with or without add-back hormonal therapy are recommended for AUB-L in women awaiting menopause or surgery.
4. Oral GnRH antagonist with add-back therapy can be considered for treatment for AUB-L for 2 years.
5. LNG-IUD reduces menstrual blood loss and uterine volume in women with HMB and fibroids.
6. Danazole reduces HMB and uterine volume by 20%. Androgenic side effects can be troublesome in the long run.
7. Aromatase inhibitors: Letrozole reduced fibroid volume by 46% after 12 weeks of treatment.

8. SPRM:
    a. Mifepristone has an antagonistic effect on progesterone target tissue - significantly reducing uterine and myoma volume (47.91%) and alleviating symptoms. Dose: 10mg daily / 25mg daily / 50 mg biweekly for 3 to 12 months.
    b. Ulipristal exhibits antiproliferative effect on myoma cells and endometrium. Endometrial changes are benign and reversible. Ulipristal was banned due to reports of liver failure. On November 17th, 2020, it was permitted to treat uterine fibroids in premenopausal women for whom surgical procedures including uterine fibroid embolisation are not appropriate or have not worked. Counselling of patient and monitoring of liver function tests are mandatory.
9. The new drugs on the cards is Relugolix 40mg with 1 mg Estradiol and 0.5 mg Norethisterone Acetate, proposed by NICE in April 2021 in a final appraisal document for treating moderate to severe symptoms of uterine fibroid.

    Hence, medical management is offered to a midlife woman with fibroid, if indicated. There is improved quality of life and relief of symptoms.

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4. NICE guidelines – NG88
5. NICE Health Technology Appraisal, April 2021
6. Bleeding problems in midlife – GLOWM

STEM CELL THERAPY FOR PREMATURE OVARIAN INSUFFICIENCY

Prof. N Hephzibah Kirubamani
MD, DGO, FICOG, FRCOG, ACME, PhD, D.Sc
President Chennai Menopause Society

POI is a condition that can seriously affect female reproductive health and endocrine balance and is one of the main causes of female infertility.

Approximately 1% of women under the age of 40 suffer from premature ovarian failure, with some estimates ranging up to 10% of women in recent years.

Premature ovarian failure (POF) is a devastating condition for women of childbearing age with serious health consequences, including distress, infertility, osteoporosis, autoimmune disorders, ischemic heart disease, and increased mortality. In addition to the mainstay estrogen therapy, stem cell therapy has been tested as the result of rapid progress in cell biology and reprogramming research. The potential etiologies of POI include chromosomal abnormalities and genetic mutations, autoimmune factors, and iatrogenic causes, including surgery, chemotherapy, and radiation therapy. A major association is suggested to exist between reproductive longevity and the DNA damage pathway response genes. DNA damage and repair in ovarian granulosa cells is strongly associated with POI. Depletion of oocytes with damaged DNA occurs through different cell death mechanisms, such as apoptosis, autophagy, and necroptosis, mediated by the phosphatase and tensin homolog (PTEN)/phosphoinositide 3-kinase (PI3K)/protein kinase B (AKT)/forkhead transcription factors 3 (FOXO3) pathway. Mesenchymal stem cells (MSCs) are characterized by the ability of self-renewal and differentiation and play an important role in the regeneration of injured tissues.

Recent advances in stem cell therapy are likely to be translated to new therapeutic options bringing new hope to patients with POI. Stem cell therapy can result in recovery of hormonal levels, follicular activation, ovarian angiogenesis, and functional restoration. study of molecular pathways revealed that the function of stem cells mainly depends on their paracrine actions, which can produce multiple factors for the promotion of ovarian angiogenesis and regulation of cellular functions

Current medical treatments include hormone replacement therapy (HRT), psychological support therapy, androgen-dependent therapy, dehydroepiandrosterone therapy, and puberty induction. However, HRT can only improve symptoms but does not increase ovarian

reproductive function, because of the failure of current traditional treatments, different options have been evaluated, one of them is the use of mesenchymal stem cells (MSCs)

Several studies have shown that MSCs can directly differentiate into oocyte-like cells, and transplantation of MSCs is conducive to restoring ovarian function and reproductive capacity

Stem Cell Therapy Clinical Study

The injections were performed intraoperatively into the ovaries via laparoscopy. The team found an increase in the volume of about 50% in the treated ovaries in comparison with the contralateral control ovaries that persisted to the end of 1year.The team also observed an increase in the serum levels of estrogen of 150% compared with preoperative levels. Both patients had an episode of menses and reported a marked improvement in their menopausal symptoms for the whole year of study. No reported side effects were reported. Another study by Igboeli and colleagues reported two cases of Caucasian women with premature ovarian failure who resumed ovarian estrogen production and menses 7 months following an intraovarian application of autologous bone marrow-derived MSCs.

Conclusion

Animal studies have shown good results and hold promise for the treatment of premature ovarian insufficiency. Showing recovery of ovarian function and fertility stem cell therapy has shown a great potential for the reversal of POF. Stem cells have self-renewal and regeneration potential; hence they can be very effective in the treatment of ovarian failure and consequently infertility

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MENOPAUSAL WEIGHT GAIN

Dr. Vijayalakshmi Seshadri
MS, FICOG, FICMCH.,
Senior Consultant (OBGYN) Sundaram Medical Foundation, Chennai.

With advancing age, maintaining the body weight becomes more difficult for women, and, invariably they seem to add on 5-8% of their baseline body weight in 1-2 Yrs after menopause and typically around the midsection, popularly called as “menopausal belly”. To relate it to hormonal variations occurring around menopause, with estrogen depletion and androgen prominence, even if it is not true change in weight, the redistribution of fat centrally with increase in intra-abdominal fat causes ANDROID OBESITY in contrast to the gluteofemoral or gynoid obesity. Independent of menopausal factor too, middle aged women gain about 0.55kg/ yr.(Kuller etal1992).Cross sectional study (Lamboni etal 1992) and longitudinal study (Bjorkeland et al 1996)have established the association of menopause with increase in waist to hip ratio and total body fat .Reduced physical activity, lowered maximal oxygen consumption (VO2max),reduced exercise capacity and activity in this group of women leads to reduced lean body mass and increased central adiposity .Lean muscle mass reduces by 30-40 % relative to total body mass. Increased fat mass and loss of fat free mass and muscle mass evidence the sarcopenia. Increased insulin resistance is both cause and effect and hence, signifies the preponderance of Metabolic Syndrome comprising of Hypertension, Hyperuricemia and Hyperlipidaemia. Waist circumference of more than 88 cm (35”) has a strong correlation to insulin and leptin levels, and small dense LDL particles predisposing to the cardiovascular risk elevation in these women. The dress that is worn shows up as bad fitment and women oriented to their good body shape feel the difference.

It is not just the hormonal play but genetics, depressive moods, the sedentary lifestyle, the pre-existent diabetic and hypertensive states, the medications used, the dietary components, smoking and alcohol intake –all play significant roles in this fat redistribution.

Managing and controlling the belly fat at and around menopause can be significantly done by focussing on several modalities. Regular exercise and weight bearing movements at least for 20 mts every day, at least for three days a week takes away the excess fat to a large extent. Menopause does not lower her ability to alter her body composition favourably. The ideal body weight kept in mind as 100 lb+5 lb for every inch above 5 feet height or BMI of 20-25, or Waist Hip Ratio of less than 0.8 is very important. Visceral adipocytes respond more quickly to exercise induced weight loss.

Adequate and balanced diet with more of fruits and vegetables, nuts, low fat and lower glycaemic index foods, whole grains, with good amount of dietary micronutrients-magnesium, calcium, potassium, zinc, vanadium, chromium-should form the cornerstone of dietary

management. It is easy to take in more calories than is required, and hence avoiding those extra calories is important every day.

Reducing stress and anxiety, focussing on relaxations and hobbies, feeling good with leisure activities are, anyway, important management of menopausal symptoms. Cutting out on caffeine, alcohol and smoking are sure welcome steps.

Menopausal Hormone therapy can be used as indicated.

Some women resort to Tummy tucking, CoolSculpting and Liposuction but target needs to be consistent and persued incessantly.

LIFESTYLE Modification is the golden rule that can be achieved to attain a satisfactory control on the menopausal weight gain and the shift of body fat.

Being watchful without getting perturbed and accepting the limitations that surround oneself – and getting help of nutritionist, dietitian, exercise guides and doctors as and when required, will give a wholesome solution to maintaining the physiology and cosmesis of the advancing age.

PROBIOTICS IN VAGINAL HEALTH IN MENOPAUSE

Prof. K. Kalaivani
MD, DGO, FICOG.,
Director ISO-KGH, Joint Secretory Of OGSSI.

The health of vaginal tissues is directly linked to oestrogen levels, and as these levels drop during perimenopause and then menopause, so the tissues of the vagina become less protected and less well 'nourished'.

Research suggests that rather than lowered oestrogen directly causing vaginal changes, it may be that lowered oestrogen is simply causing a reduction in probiotic bacteria in the vagina, which then in turn leads to vaginal dryness, atrophy and the potential for vaginal infections Probiotic bacteria modulate the immune system and interfere with the inflammatory cascade. Less inflammation means less tissue damage. Studies show that probiotic therapy can support the vaginal 'ecosystem' and prevent reductions to the protective vaginal flora

PRO-BIOTIC=PROMOTING+ LIFE

Definition

"LIVE MICRO ORGANISMS WHICH WHEN ADMINISTERED IN ADEQUATE AMOUNT CONFERS BENEFICIAL EFFECT TO HOST."
CONCEPTUALISED BY A SOVIET ZOOLOGIST - NOBEL LAUREATE Élie Metchnikoff

Probiotics

According to WHO "Probiotics are live microorganisms which when administered in adequate amounts confer a health benefit on the host"

Prebiotics

Food ingredients that appear to stimulate the growth of beneficial bacteria in the intestinal tract." e.g. fructosoligosaccharide

Symbiotic

A product that contains both probiotics and prebiotics

Normal Vaginal Flora

Lactobacillus predominant – 95%
Ratio of anaerobes to aerobes 2:1 to 5:1
Gardnerella vaginalis present in 5-37% of women
Mobiluncus present in 0-5% of women
Some H2O2 producing bacteria also present - potent natural microbicide
Maintain the vaginal pH and provide protection against infectious bacteria
Lactobacillus reuteri RC-14 & *Lactobacillus rhamnosus* GR-1 are the most common strains present in the vagina

Mechanism Of Action

Probiotics cause production of lactic acids and bacteriocins causes killing of viral pathogens → Microcolonies → Adherence to Epithelial cell receptors and physical barrier → stimulation of host defence mechanism against pathogenic organisms.

Common Infections

Urinary tract infections (UTIs) and bacterial vaginosis (BV) are very common in menopausal women, and this is likely due to the environment of the intimate area becoming less acidic, which makes it a perfect environment for bacteria to thrive

Urinary Tract Infections

Escherichia coli is the organism responsible for the largest proportion of symptomatic and asymptomatic UTIs in women. Depletion of lactobacilli or imbalance between lactobacilli and uropathogens has been documented in patients with UTI. Vagina is a key anatomical site in the pathogenesis of UTI, serving as a potential reservoir for infecting bacteria. Initial step in the pathogenesis of UTI is colonization of the vagina and periurethra with infecting uropathogens, followed by ascension of uropathogens via the urethra to the bladder and sometimes the kidneys to cause infection

Vaginal Infections

Bacterial vaginosis (BV) and complicated vulvovaginal candidiasis (VVC) are frequently occurring vaginal infections in postmenopausal women, caused by an imbalance in vaginal microflora.
Decreased estrogen secretion in postmenopausal women makes vaginal tissues thinner and less elastic, depletes lactobacilli and increases intravaginal pH, resulting in increased vaginal colonization by harmful microorganisms (e.g., *Enterobacter*, *Escherichia coli*, *Candida*, and *Gardnerella*).
Probiotics positively effects on vaginal microflora composition by promoting the proliferation of beneficial microorganisms, alters the intravaginal microbiota composition, prevents vaginal infections in postmenopausal.

Probiotics also reduce the symptoms of vaginal infections (e.g., vaginal discharge, odor, etc.), The best-known intravaginal beneficial probiotic species are in the *Lactobacillus* genus.

Probiotics Advantages Over Antibiotics

Probiotics maintains a Healthy Vaginal Ecosystem and Vaginal pH maintenance that confers a protective role Prevent adherence of pathogens to vaginal epithelium and help restore altered flora

Disadvantages

Probiotics cause harm either by interacting with drugs a person may be on for other medical conditions or may have long-term harmful effects on the body Less Commercial Availability Often unavailable or Less Effective in Oral routes Benefits are Uncertain and Compromised

Route

Oral supplementations of probiotic capsules are particularly alluring because of their ease of use and high satisfaction versus the use of creams and gels.

Vaginal

More Viable and Quicker in action, Direct delivery and Proven specific adhesion to Urogenital Epithelium

Products Available: EVA NEW, CTV-05, FEM-DOPHILUS, FLORAJEN, GYNOFLOR, INFEMIN, INTRAFR

Summary

- One of the most important considerations in a natural health protocol for menopause is microbiome support
- The importance of our natural microbiomes for good health has been well established
- Research regarding the vaginal microbiome and menopause has evolved over the last decade.
- Light microscopy and culture techniques revealed healthy vaginal microbiomes are dominated by *Lactobacillus* species
- Next- generation sequencing technology has allowed scientists to further categorize and understand the complexity and diversity of species that inhabit the vaginal cavity.
- Although effective antimicrobial treatments are readily available for UTI BV and VVC, concerns mount about antibiotic cost, overuse or overexposure, sensitivity, and sequelae, including antibiotic resistance
- Rationale for urogenital probiotics comes from the belief that replenishing the normal microbes will counter pathogens and lead to a return to the lactobacilli dominated state found in healthy women

CHOICE OF CONTRACEPTION AT 40s

Dr. VIJAYALAKSHMI GNANASEKARAN

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PROFESSOR OF OBG,

A.C.S. MEDICAL COLLEGE & HOSPITAL

Introduction

Women at age of 40 years is accompanied by important biological and psychosocial changes. This makes contraceptive counseling and care for this age group a challenge and, at the same time, offer an opportunity to contribute to these women's reproductive and general health as well as improve their quality of life. Choice of contraceptive methods for women in the perimenopause will depend on the efficacy, safety, tolerability, and potential benefit of each method in relation to the biopsychosocial profile of the individual woman

Do Women Over 40 Need Separate Guidance? YES

- Lower fertility but a relatively high rate of unintended pregnancies
- Increased rate of miscarriage, chromosomal abnormalities, ectopic pregnancies, preeclampsia, and postpartum hemorrhage
- Heavy menstrual bleeding and climacteric symptoms
- Age-related increased risks of cardiovascular diseases including venous thromboembolism (VTE)
- Age-related increased risk for cancer (breast, endometrial, and ovarian cancer)
- Age-related and hormone-related increased risk for osteoporosis
- Psychosocial challenges and changes, mental health risks, and sexual dysfunction.

All these tend to make these women a special group needing special contraceptive guidance.

BARRIER CONTRACEPTION

Efficacy: Higher due to lower fertility of perimenopausal women

Special consideration for perimenopausal women – Nil

Copper Intrauterine Devices

Efficacy: failure rate is less than 1%; effective for a long period of time (between 5 and 12 years); independent of user adherence

Special considerations Higher incidence of heavy menstrual bleeding during perimenopause can be a limitation for the use of copper IUDs

Combined Hormonal Contraceptives

- **Efficacy:** highly effective when used correctly but due to the necessity of regular intake they are prone to a higher risk of user failure

Special considerations in perimenopausal women

- Age alone is not a contraindication to COC use
- Due to the age-related increase of cardiovascular complications, medical eligibility criteria should be considered and women with additional cardiovascular risk factors (smoking, obesity, and hypertension) should be excluded.

Progestogen Only Contraception
(ORAL PREPARATIONS, INJECTABLES, IUDS, AND IMPLANTS)

Efficacy: Failure rate is <1%

Special considerations

- For those women who have had previous VTE, it is important to know that the benefits of using progestogen-only methods outweigh the risks.
- Women with a history of ischemic heart disease or stroke can initiate POPs, implants, or the LNG-IUS; however, the risks of initiating a progestogen-only injectable outweigh the benefits.

Medical Eligibility Criteria For The Use Of Contraceptive Methods In Older Women

Method of contraception	Age group, yr	Medical eligibility criteria
Estrogen-containing method	≥ 40	Benefits outweigh risks
Progestin-only pill	≥ 40	No restriction
Progestin implant	≥ 40	No restriction
DMPA	≥ 40 to 45	No restriction
	> 45	Benefits outweigh risks
Copper IUD	≥ 40	No restriction
Levonorgestrel-releasing IUD	≥ 40	No restriction

Note: DMPA = depot medroxyprogesterone acetate, IUD = intrauterine device.

When Should Contraception Be Stopped?

- In general, all women can cease contraception at the age of 55 as spontaneous conception after this age is exceptionally rare even in women still experiencing menstrual bleeding.
- If a woman age 55 or over does not wish to stop a particular method, consideration can be given to continuation providing the benefits and risks for her as an individual have been assessed and discussed with her.
- IUCD should not be left *in situ* indefinitely after it is no longer required as it could become a focus of infection.

Can Hormone Replacement Therapy Be Used Alongside Or In Place Of Contraception?

- Women using sequential hormone replacement therapy (HRT) should be advised not to rely on this for contraception.
- Women may use a Mirena levonorgestrel intrauterine system (LNG-IUS) with estrogen for up to 5 years for endometrial protection as part of an HRT regimen. Women using Mirena for this purpose must have the device changed every 5 years.

- At the present time, POP, IMP and DMPA are not licensed for and cannot be recommended as endometrial protection with estrogen-only HRT.
- All progestogen-only methods of contraception are safe to use as contraception alongside sequential HRT.
- COC can be used in eligible women under 50 as an alternative to HRT for relief of menopausal symptoms and prevention of loss of BMD.

Conclusion

- Perimenopause per se does not exclude any contraceptive method available
- Health-care provider should help the woman to find the method which best suits her needs
- Take into account the medical and psychosocial profile of the woman
- Use the evidence-based knowledge about the efficacy, health risks, side-effects, and benefits of all methods

DANCING THROUGH MENOPAUSE

Dr. S Geetha

Happy to share the benefits of dance in peri and post menopausal women.

The tendency to gain weight is more after menopause.

Joint stiffness adds on to this and makes us more sedentary and gain more weight.
Dance prevents weight gain.

Regular gentle less -intense dance moves helps post menopausal women to overcome mood-swings , increase endorphins and promotes mood elevation.
Dance movement help to free the joint and increase the flexibility.

It helps us gain balance and stability.

It increases the vagal tone thereby reduces the basal heart rate which in turn reduces the risk of cardio vascular events.

It reduces the adrenaline rush and prevents rhythm disturbances in the heart.

An Australian study with 4800 british people fould that moderate intensity dancing is linked to a lower risk of cardiovascular diseases.

Dancers were found to have 46% lower risk of cardiovascular death compared with those who rarely or never danced.

It increases the melatonin level and helps in sound sleep.

Resistance - training increases the muscle mass there by improving insulin sensitivity and maintains metabolic health.

While dancing different part of our body moves is a co-ordinated way, this activates several parts of the brain. A study published in new england journal of medicine even found that dancing was the only physical activity associated with a lower risk of dementia.

Another north american menopause society study suggests that women who are post menopausal lower their cholesterol level ,improve their fitness and self esteem just by dancing.

It is a great way for post menopausal women to reenter the fitness journey.

It has physical benefits on our bodies but also mentally makes us happier.

It is also fun filled when done in groups,it helps us to meet more people from all walks of life.

However intense dance movements should be avoided to prevent any age related damage to the ligaments and bones.

It is advisable to do stretching pre and post dancing sessions to prevent injury .

let us dance our way back to health.

In HOT FLASHES

World's No. 1

℞ Shield

Estro G-100

1 Tablet BID

Available in more than 90 Countries

100 YEARS OF TRUST

Me-No-Pause

By U.S, Canada, Korea & Europe

Health Canada NPN License | US FDA NDI | HFFI | efsa European Food Safety Authority

Contains Bio Actives,

- Cinnamic Acid
- S Methyl Ester
- Decursin & Decursinol

• Effective • Safe • Non Estrogen

In Itch, White Discharge & Odor associated with Bacterial Vaginosis

℞ TOTALEES

1st DCGI Approved

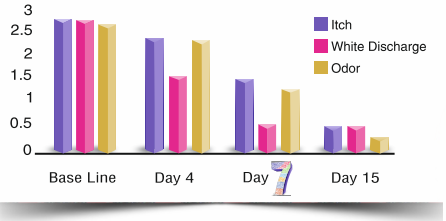
Powered by 7 Vaginal Specific Strains of Indian Genome

Right concentration
Total Count 10 billion CFU

Composition	Type	CFU
L. acidophilus	UBLA-34	2.0 Billion
L. rhamnosus	UBLR-58	2.0 Billion
L. reuteri	UBLRu-87	2.0 Billion
L. plantarum	UBLP-40	1.0 Billion
L. casei	UBLC-42	1.0 Billion
L. fermentum	UBLF-31	1.0 Billion
Bifidobacterium bifidum	UBBB-55	1.0 Billion
Fructo Oligosaccharides		100 mg

Indian clinical trial demonstrated

Severity of symptoms disappeared on day 4 & Significant disappearance on day 7 [3]



Recurrence reduction

Dosage
1 Cap BID for 14 days

TOTAL BLISS from Itch, White Discharge & Odor

3. Benef Microbes. 2012 Jun 1;3(2):151-5

For **Dysmenorrhea** with **Pain Abdomen**

Dysmegesic

Ursolic acid, Bromelain, Fenchone & Curcumin Tablets

Ursolic Acid

Bromelain

Fenchone

Curcumin

Relieves Pain & Spasm

Dosage: 1 tablet BID

Powerful like NSAID, yet Safe

For all your PCOS patients wanting to conceive

℞

APCOD Softule

Myo-Inositol 550 mg, D-Chiro-inositol 13.8 mg, Folic Acid 200 mcg (as dietary folate) Soft Gelatin Capsules

The **NEW AGE** Full Therapeutic In sitol

Patient Friendliness

No unpleasant taste[2]

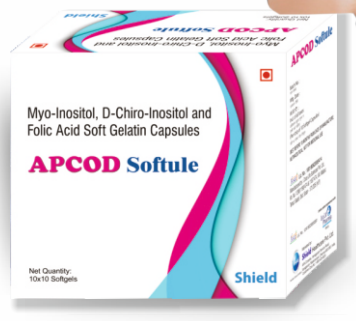
Pocket friendly

Technical Collaboration with Lo.Li. Pharma Italy

26 Clinical Trial Papers

131 Countries

FDA



Aug 5,6,7 IMS South Zone International Conference hosted by CMS on Holistic approach to Healthy Aging


CMS- On Independence Day Aug 15th NCD Health Camp was Conducted



Group Discussion on Menopause with Private Practionners



Awareness Programme for Newly joint Stanley P.Gs and K.M.C Pgs



World Sexual day-Public Awareness


Visit to old age Home
100 year old lady cutting the cake



Aging

Wear your years with pride like a bandage of honor, for you have conquered
You have thrived, you have survived!

You have to embrace getting older, Life is precious at Each Day is a GIFT