

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/advances-in-womens-health/diagnostic-workup-menopause/67536/>

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The Diagnostic Workup for Menopause

Announcer:

You're listening to *Advances in Women's Health* on ReachMD. On this episode, we'll hear from Dr. JoAnn Pinkerton, who's the Women's Midlife Help and Mamie Jessup Professor of Obstetrics and Gynecology at the University of Virginia. She also serves as Division Director for the Midlife Health Center at UVA and is the Emeritus Executive Director and past President of The Menopause Society. She'll be walking us through the diagnostic workup for menopause. Here's Dr. Pinkerton now.

Dr. Pinkerton:

When a woman comes in, we start with our history: looking at menstrual frequency, duration, and flow, whether or not they're having vasomotor symptoms like hot flashes or night sweats, sleep disturbances, mood shifts, emotional lability, genitourinary changes like vaginal dryness, loss of libido, or weight gain. We look at age, because the diagnosis is fairly straightforward in women age 45 and older who have typical symptoms and late menopause cycle irregularity. So blood testing—such as an FSH or estradiol—is not usually required for standard cases over 45, but are sometimes used to confirm menopause in a complicated case.

Sometimes we'll get a TSH—thyroid stimulating hormone—or a blood count to rule out mimics like thyroid dysfunction or anemia, and sometimes pregnancy tests, depending on the scenario. Sometimes we'll get prolactin levels. But the FSH—follicular stimulating hormone—is the diagnostic marker for ovarian failure, and a level of more than 30, in most labs, is generally accepted as diagnostic of menopause, especially if you've got a year of amenorrhea.

You don't need to do an LH to make this diagnosis. Women, however, who have elevated but not postmenopausal FSH levels are still at risk for pregnancy, and contraception needs to be discussed if needed until the FSH levels remain in the postmenopausal range.

We do have markers of ovarian aging. This includes the Anti-Müllerian hormone—AMH—produced by the granulosa cells of all the follicles. Assessment of AMH may be the earliest and most effective way of measuring progress towards menopause, but at present, the testing's not sufficiently developed to be a standard of care. And the major endocrine changes are really the increase in FSH, decrease in estradiol, and inhibin.

For women with heavy bleeding, I'll often do a ferritin level. We'll do a physical exam that's going to need to include the thyroid, a breast exam, and a pelvic exam. And then, if we have abnormal patterns of bleeding, we might do a transvaginal ultrasound or consider an endometrial biopsy if the bleeding's abnormal or the lining of the uterus is thickened. We sometimes do hysteroscopy to use a thin lighted camera into the uterus so we can do a visually guided biopsy and remove any focal lesions.

Sometimes I check vitamin D, because bone loss begins about 18 months before the last period. I'm always encouraging calcium and vitamin D.

And then the important group is, if they come in with early menopause or primary ovarian insufficiency, we need labs to document menopause and identify medical issues. And we're going to look at thyroid, autoimmune reasons, and genetic components. So we'll start with an FSH and an estradiol, a thyroid, a prolactin, do a karyotype chromosome analysis, fragile X testing, and screen for adrenal antibodies because ovarian antibodies are not a good test. And we'll often do an AMH.

Announcer:

That was Dr. JoAnn Pinkerton talking about how to confirm menopause. To access this and other episodes in our series, visit *Advances in Women's Health* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!