NAMS Practice Pearl

Clinical Considerations for Menopause and Associated Symptoms in Women With HIV

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Worldwide, more women with HIV are aging and entering menopause. Although a limited number of evidenced-based care recommendations are published, formal guidelines for the management of menopause in women with HIV are not available. Many women with HIV receive primary care from HIV infectious disease specialists, without any detailed assessment of menopause. Women's healthcare professionals specializing in menopause may have limited knowledge regarding the care of women with HIV. Clinical considerations for menopausal women with HIV include distinguishing menopause from amenorrhea because of other etiologies, early assessment of symptoms, and recognizing unique clinical, social, and behavioral comorbidities to facilitate care management.

Globally, 20.2 million women and girls are living with HIV, comprising more than half of persons with HIV worldwide.[1] About 1.2 million US persons are living with HIV, of which 263,900 are women.[2] In 2019, an estimated 36,801 US persons were diagnosed with HIV; 19% (6,999) were women; and most were women of color. Midlife women aged 45 years and older accounted for 35% (2,471) of new US HIV diagnoses. Although trends of new infection rates remained relatively stable between 2015 and 2019 in women across most age groups, rates were up 7% in women aged 55 years and older.[2] In other regions, including the United Kingdom and Canada, similar numbers of women are living with HIV or newly diagnosed with HIV at age 50 years or older have been reported.[3,4] The growing population of older women with HIV (WWH), coupled with the upward trend of midlife women newly diagnosed with HIV, has resulted in increasing numbers of WWH entering menopause.

Age of onset of menopause in women with HIV. Prior studies suggest that WWH may experience an earlier age of menopause onset (mid to late forties), whereas other studies found WWH begin menopause at a similar age as women without HIV (age 52).[5] The reason for these conflicting findings is multifactorial and related to 1) limitations with existing assessment criteria to confirm menopause status in WWH; 2) challenges with deciphering whether cessation of menses is related to true menopause versus amenorrhea related to HIV factors, including hypothalamic amenorrhea because of history of low weight, poor immune function, and low-nadir CD4 count; and 3) clinical

and behavioral factors such as substance-use disorder and use of psychotropic medications and methadone.

Recommendations for WWH from the British Menopause Society endorse baseline assessment of menstrual cycles with annual review and concurrent assessment of menopause symptoms in WWH aged older than 45 years (or postmenopausal).[3] Similarly, the Association of Medical Microbiology and Infectious Disease of Canada recommends routine screening of menstrual cycles in WWH beginning at age 40.[4] Both groups support counseling and education on the menopause transition for WWH. In particular, it is recommended that WWH learn of their potential risk for earlier onset of menopause or primary ovarian insufficiency compared with women without HIV that may be related to clinical and sociobehaviorial factors associated with HIV that can influence menstrual patterns. Elucidating the age of onset of menopause in WWH, specifically whether menopause occurs at an earlier age, is essential for early risk identification of burdensome symptoms, cardiovascular disease, and bone loss.[5]

Hot flashes and mood symptoms in women with HIV. Although findings are conflicting among studies evaluating menopause hot flashes in WWH, research suggests that WWH experience more frequent and severe hot flashes that interfere with quality of life compared with women without HIV.[6] Further, studies of WWH provide support that hot flashes negatively affect cognitive function and are associated with elevated depressive symptoms and reduced adherence to antiretroviral therapy and clinic visits.[7,8]

Treatment of hot flashes and other menopause symptoms in WWH with hormone therapy (HT), nonhormone medications (selective serotonin reuptake inhibitors; serotonin-noradrenaline reuptake inhibitors), and nonpharmaceutical interventions (cognitive behavioral therapy; homeopathic and lifestyle interventions) has not been investigated in interventional trials in menopausal WWH. For reasons including provider and patient uncertainty, few WWH are prescribed HT. In addition to the approved indications and recommendations for the use of HT in women without HIV, summaries of general principles and perspectives on the use of HT and nonhormone and nonpharmaceutical treatments in WWH have been outlined.[3,4]

Mood symptoms are observed during the menopause transition. Of concern, many premenopausal WWH experience depression and anxiety that can potentially worsen during menopause. Baseline and 12-month comparisons of depressive symptoms and anxiety in perimenopausal WWH and women without HIV revealed that WWH reported greater depressive and anxiety symptoms that persisted over 1 year compared with women without HIV. Baseline differences in mood and anxiety were significant, controlling for smoking, substance use, and antidepressant use. Other studies found WWH exhibit a disproportionate number of affective symptoms during menopause, and collectively, menopause symptoms associate with psychological distress in this population.

The British Medical Society recommendations support screening for mental health symptoms as part of routine consultations in WWH approaching or experiencing menopause.[3] Assessment of new, persistent, or elevated affective symptoms, specifically depression or anxiety, is essential, and initiating or adjusting current psychological health treatment regimens may help reduce adverse downstream consequences that may affect well-being.

Special considerations for the care of menopausal women with HIV. Considering the interplay between HIV-related and menopause symptoms, it is important for clinicians to assess symptoms associated with menopause in the context of HIV-related symptom burden, which can be challenging.[9] A novel investigation examined the influence of menopause on HIV symptom burden and found postmenopausal WWH, compared with premenopausal WWH, reported greater HIV symptom-related burden, including muscle aches/joint pains, sleep disturbance, and fatigue, controlling for relevant covariates. Similarly, WWH have described challenges with distinguishing HIV symptoms from menopause symptoms, resulting in anxiety.[3] Thus, educating WWH and healthcare professionals specializing in HIV on menopause symptoms, and educating women's healthcare professionals specializing in menopause on HIV symptoms, would be highly beneficial.

Another critical component to providing care to WWH during menopause is utilizing a trauma-informed approach.[10] Discussion pertaining to reproductive health may serve as a trigger, given the increased prevalence of domestic violence, sexual abuse, and trauma experienced by WWH. Providing equitable, culturally sensitive care to WWH from diverse ethnic backgrounds is essential to addressing their biopsychosocial health needs.

Pearls. Assessment of menstrual cycles should occur annually in women with HIV (beginning between the ages of 40 and 45 y) in addition to a comprehensive medical, social, and behavioral health history; medication use; and detailed HIV health history to confirm true menopause- versus amenorrhea unrelated to menopause. Women with HIV experience burdensome hot flashes that may negatively affect adherence to antiretroviral therapy and clinic appointments. Screening for mood symptoms should be included in the routine assessments of WWH approaching or experiencing menopause. Initiating or adjusting current psychological health treatments may improve overall well-being and care engagement. Interventional trials evaluating HT for management of menopause in WWH are needed.

Including comprehensive education on menopause to women with HIV during clinical encounters can help women differentiate symptoms of menopause and symptoms of HIV, reduce anxiety, and foster participation in treatment decisions. In order to effectively address the unique care needs of midlife WWH, education on assessment and management of menopause would be beneficial for healthcare professionals specializing in HIV, and education on HIV care of midlife WWH would be beneficial for women's healthcare professionals specializing in menopause.

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Disclosures

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