Is it a mood disorder or menopause?

Uzma Anwer, MD, Elizabeth M. Tully, MD, FAPA, Antonio L. Garcia, MD, FACOG, and Kurt R. Finberg, MD, FACOG

Educate patients about the impact of menopausal changes on mood and treat disabling hormonal dysregulation symptoms

Consider the neuroendocrinology of menopause when evaluating midlife women for new or worsening mood symptoms. The risk of depression increases during perimenopause, even in women with no history of depression.[1] Fluctuating estrogen levels can cause vasomotor symptoms (VMS) and depression, presenting diagnostic and treatment challenges. In addition to conducting a comprehensive psychiatric evaluation, our collaborative rotation between the UCLA-Kern Psychiatry Residency Program and the department of obstetrics and gynecology uses the following approach for women age >40.

Obtain a menstrual history

Ask your patient when her last menstrual period was and if her periods are irregular, heavy, light, or missing. Menopausal transition begins when the length of the menstrual cycle varies and ends with the final menstrual period. Perimenopause begins early in the transition and ends 12 months after the last menses. During this time VMS and mood instability may worsen.

Ask about menopausal symptoms

Hot flashes typically begin as a sudden sensation of heat centered in the upper chest and face that rapidly generalizes. Flashes last 2 to 4 minutes and often are accompanied by profuse perspiration and occasional palpitations. VMS can occur several times during the day and night. Hot flashes—the most common symptom associated with menopausal transition—peak during the 12 months surrounding the last period and can commonly persist up to 5 years or more. Hot flashes affect a woman's sense of well-being and often are the reason women seek medical attention during midlife.

Insomnia. Sleep disturbance during the menopausal transition is common, sometimes severe, and may be related to nocturnal hot flashes and night sweats. Hot flashes and awakenings are sometimes followed by chills, shivering, anxiety, or panic.

Mood instability. Dysregulation of monoaminergic neurotransmitter systems caused by fluctuating estrogen levels may cause both depression and VMS.[2] Perimenopausal women with VMS are more likely to be depressed than those who do not have VMS. VMS may signal the onset or recurrence of major depression.

Sexual changes. Estrogen deficiency may lead to vaginal dryness and urogenital atrophy, resulting in infection, painful intercourse, or decreased sexual desire.

Body aches. Many perimenopausal women complain of stiffness, joint pain, breast pain, menstrual migraines, bladder discomfort, and impaired balance.

Memory changes. Complaints of forgetfulness may reflect aging and effects of sleep disturbance.[3]

To read more about depression in women, see **"Sex-related differences in antidepressant response: When to adjust treatment"** pages 25-30

Dr. Anwer is a staff psychiatrist, department of psychiatry, Contra Costa County, CA. Dr. Tully is chief, child and adolescent psychiatry division, University of California, Los Angeles-Kern Medical Center, Bakersfield, CA and assistant clinical professor, department of psychiatry and biobehavioral sciences, David Geffen School of Medicine at UCLA. Dr. Garcia is director, obstetrics and gynecology residency, and Dr. Finberg is an attending physician, obstetrics and gynecology, Kern Medical Center.

Diagnostic workup

Perimenopause can be diagnosed before clinical symptoms appear if the follicle stimulating hormone (FSH) level is >25 IU/L and estrogen is <40 pg/mL during the early follicular phase (day 3 of the menstrual cycle).[3] In women age <45 with irregular bleeding and menopause symptoms, check serum beta human chorionic gonadotropin (to rule out pregnancy), prolactin, thyroid-stimulating hormone, and FSH.

Women of any age with estrogen deficiency—such as those undergoing chemotherapy for breast cancer, treatment with gonadotropin-releasing hormone agonists for endometriosis or in-vitro fertilization, premature ovarian failure, or who have undergone oophorectomy—might experience VMS and other perimenopausal symptoms.

Women age >45 with 12 months of amenorrhea may be diagnosed with menopause clinically without further testing.

Treatment strategies

Fewer women are choosing hormone replacement therapy (HRT) (estrogen alone or estrogen and progesterone) after the landmark Women's Health Initiative (WHI) study in 2002.[4] Reports that HRT may increase the risk of breast cancer and offers no cardiac protection prompted many women to forego or discontinue HRT use. Subsequent interpretation of the WHI data has reduced many of these concerns.[5] As a result, estrogen alone currently is the most effective and only FDA-approved treatment for VMS.[5] Because of overlap between VMS and depression, treatment for these 2 conditions could be combined. Theoretically, treating VMS could prevent a major depressive episode in vulnerable women and may improve the chance of full remission of depression.[1]

Although results of studies of HRT for depression are mixed, estrogen alone may be effective for mild depression during perimenopause but not postmenopause. Estrogen also may be appropriate during perimenopause if a depressive disorder represents a first-onset episode of mild to moderate severity.[6] Estrogen is not FDA-approved for treating perimenopausal depression. As with all medications, counsel patients on the risks and benefits and administer the medication at the lowest dose and for the shortest time period to effectively treat symptoms.

Consider antidepressants when HRT is contraindicated or declined. Selective norepinephrine reuptake inhibitors such as venlafaxine, desvenlafaxine, and duloxetine have demonstrated efficacy for VMS and depression.[2] Selective serotonin reuptake inhibitors (SSRIs) are effective in women age <40 but show inconsistent efficacy for VMS and depression in women age >50. SSRIs combined with estrogen therapy may be useful in postmenopausal women.[2]

Biopsychosocial factors

Psychosocial attitudes about aging, sexual attractiveness, and children leaving home may contribute to depression during perimenopause. However, many women welcome the freedom from menstrual periods and pregnancy worries.

Some women may not be aware of the impact of menopausal changes on mood. Educating patients with a mood disorder about what to expect and identifying and treating disabling hormonal dysregulation symptoms is an ideal opportunity to enhance the quality of life for patients during menopause and beyond.

References

1. Cohen LS, Soares CN, Vitonis AF, et al. Risk for new onset of depression during the menopausal transition: the Harvard study of moods and cycles. Arch Gen Psychiatry. 2006;63(4):385-390.
2. Thase ME, Entsuah R, Cantillon M, et al. Relative antidepressant efficacy of venlafaxine and SSRIs: sex-age interactions. J Womens Health (Larchmt). 2005;14:609-616.
3. Aloysi A, Van Dyk K, Sano M. Women's cognitive and affective health and neuropsychiatry. Mt Sinai J Medicine. 2006;73(7):967-975.
4. Rossouw JE, Anderson GL, Prentice RL, et al. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. JAMA. 2002;288:321-333.
5. Santoro N. Symptoms of menopause: hot flushes. Clinical Ob Gyn. 2008;51(3):539-548.
6. Joffe H, Soares CN, Cohen LS. Assessment and treatment of hot flushes and menopausal mood disturbance. Psychiatr Clin N Am. 2003;26:563-580.