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Managing menopause in women living with HIV: A survey of primary care practitioners

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Abstract

Objective: One in three women living with HIV (WLHIV) in the UK is aged 45–56, and therefore of potentially menopausal age. Little is known about the management of menopause in WLHIV in primary care. We aim to describe current knowledge and practice in the management of menopause in WLWH among primary care practitioners (PCPs).
Methods: A questionnaire-based study of 88 PCPs attending two sexual and reproductive health conferences.
Results: Almost all respondents (n = 87, 99%) routinely managed women with menopause-related symptoms; however, only 18 (20%) reported having managed menopause in WLHIV. Over 95% (n = 85) reported being confident in managing menopause in general, whereas less than half (n = 40) reported confidence in managing menopause in WLHIV ($p < 0.001$). The majority of respondents (n = 84) felt that menopause should be routinely managed in primary care, whereas just over half thought that menopause in WLHIV should be managed in primary care (n = 50, $p < 0.001$). Almost all respondents (n = 85) reported concerns about managing menopause in WLHIV.
Conclusion: PCPs reported limited experience of and low levels of confidence in managing menopause-related symptoms in WLHIV. Nearly all PCPs had concerns about managing menopause-related symptoms in WLHIV, many stating that this should be managed outside primary care. Development of national guidance and specialised training, coupled with good liaison between HIV services and PCPs, may improve confidence in this area.

Keywords
HIV, menopause, primary care, women

Introduction

The widespread availability of antiretroviral therapy (ART) has transformed HIV from a life-limiting condition to one which is chronic with normal life expectancy for many. HIV care today predominantly involves managing co-morbidities, drug interactions and the effects of HIV on ageing. Consequently, the impact of HIV on ageing has emerged as an important area of research interest, with attention focused on cardiometabolic disease and neurocognitive impairment.

Increasing numbers of older women are living with HIV, with one in three women living with HIV (WLHIV) attending for HIV care in the UK in 2014 estimated to be aged 45–56 years,[1] and therefore of potentially menopausal age. We anticipate that clinicians will be likely to see increasing numbers of WLHIV with menopause-related symptoms. However, little is known about the menopause in this population.

Menopausal symptoms are common in the general population and experienced by 85% of women.[2] They persist for a median duration of seven years[3] and have been shown to adversely affect quality of life and role-functioning in work and personal relationships.[4,5] Management options for menopausal symptoms include (but are not limited to) lifestyle modification, cognitive behavioural therapy and hormone replacement therapy (HRT). Recently published UK guidance by the National Institute for Health and Care

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Excellence (NICE) recommends that HRT be discussed and offered to women with menopausal symptoms.[6]

A recently published review paper concluded that WLHIV are likely to experience menopause earlier than their HIV-negative counterparts and that they may experience more symptoms.[1] Furthermore, data suggest that symptoms of menopause are often misattributed by both patients and clinicians to HIV-related illness or side effects of ART.[7] Finally, WLHIV are at risk of poor mental health and social marginalisation,[8] which may add further complexity to their menopause experience.

In the UK, menopause is currently mainly managed within primary care. However, healthcare providers within primary care may see small numbers of people living with HIV, and are therefore likely to have limited experience of managing comorbidities and drug interactions in this population. In contrast, healthcare providers within HIV specialist services may lack experience of managing menopause. It is therefore unsurprising that a recent qualitative study has found that WLHIV find themselves caught between primary and tertiary care services, with their menopausal symptoms not being addressed.[9]

Although integrated clinics combining HIV and menopause care are a welcome service development for this patient group, provision of this type of service is extremely limited in the UK. Specialist gynaecology-led menopause services largely see patients who have contraindications to HRT, who have symptoms that do not respond to treatment, or are experiencing significant side effects from treatment.

There is a paucity of data on how menopause in WLHIV is managed within primary care. In this paper, we describe, for the first time in the UK, knowledge and practice regarding management of the menopause in WLHIV amongst primary healthcare providers.

Methods

In October–November 2015, we conducted a questionnaire-based study of primary care practitioners (PCPs) with a special interest in reproductive and post-reproductive health. The questionnaire covered three key areas: respondent demographics; management of menopausal symptoms in HIV-negative women and management of menopausal symptoms in WLHIV.

The questionnaire was piloted amongst a small group of general practitioners (GPs) prior to being administered to respondents to inform the conduct of the study. The outcome of the pilot resulted in shortening of the survey and changes to the wording of a few questions. We subsequently conducted a further pilot study at the annual Royal College of General Practitioners conference in 2015; unfortunately, we achieved a 1% response rate. Following this low response rate, we decided to target PCPs attending two sexual and reproductive health meetings aimed at healthcare providers with an interest in this area.

Self-completed paper questionnaires were distributed to PCPs attending two sexual and reproductive health meetings in London. Data were entered into Excel and analysed using Stata 14.0 (StataCorp. 2015. Stata Statistical Software: Release 14. College Station, TX: StataCorp LP).

Results

We administered a total of 500 questionnaires, with a response rate of 19% (95 out of 500). Seven questionnaires were excluded because they were incomplete or completed by health professionals not currently working in primary care. This analysis is therefore based on data from 88 respondents.

Demographics of respondents

The median age of respondents was 47 years (interquartile range: 34–61 years) and the median year of qualification was 1996 (Table 1). Most respondents were female (n = 82, 93%) and working as GPs (n = 81, 92%). Nearly 90% of respondents worked in medium–large sized practices. Approximately half worked in practices in England (but outside London) and 39% (n = 33) were based in London.

Consultations

Almost all respondents reported that they managed menopause in their primary care service (n = 87, 99%), with 75% seeing women for menopause-related consultations 'often' (Table 2). Two-thirds (n = 57) reported having seen WLHIV for general consultations in their practice. A significantly higher proportion of respondents from London reported having seen WLHIV for general consultations compared with respondents from other geographical regions (79% vs. 60%, $p < 0.05$). One-fifth (n = 18) reported having managed menopause-related symptoms in WLHIV; 60% of these respondents were based in London.

Managing menopause

Almost all respondents (n = 85, 97%) reported confidence in managing menopause in general, whereas less than half reported being confident in managing menopause in WLHIV (47%, $p < 0.001$). There was no association between confidence in managing menopause in HIV and respondent gender, age, clinical role, practice size or region (all $p > 0.05$).

Table 1. Participant and practice characteristics.

Demographics	Number of participants, n (%)
Professional role	
General practitioner	81 (92)
Practice nurse	3 (3)
Other	4 (5)
Age	
Median	47 years (IQR: 34–61 years)
Gender	
Female	82 (93)
Male	6 (7)
Year of qualifying	
<1990	28 (32)
1990–1999	24 (28)
≥2000	35 (40)
Practice size	
Small: <5000 patients	9 (10)
Medium: 5000–10,000 patients	36 (42)
Large: >10,000 patients	39 (46)
Practice region	
London	33 (39)
England (outside London)	45 (54)
Wales, Northern Ireland or Scotland	4 (5)
Other	2 (2)

IQR: interquartile range.

Table 2. Respondent experience of managing women with and without HIV.

	Number of participants, n (%)
How often do you see women with menopause-related issues?	
Often	66 (75)
Occasionally	21 (24)
Never	1 (1)
How often do you see women living with HIV for general consultations?	
Often	2 (2)
Occasionally	55 (63)
Never	31 (35)
How often do you see women living with HIV for menopause-related issues?	
Often	0
Occasionally	18 (20)
Never	70 (80)

Nearly all respondents thought that menopause in HIV-negative women should be managed in primary care (n = 84, 96%). However, only half (n = 40) thought that menopause in WLHIV should be managed in primary care. Instead, just over a fifth (22%) thought WLHIV with menopausal symptoms should be managed in specialist menopause clinics, with a further 24% believing that menopause-related care should be provided HIV specialist teams.

Concerns about managing menopause in WLHIV

Almost all respondents (n = 85, 99%) expressed concerns about managing menopause in WLHIV (based on a clinical scenario). This contrasts with 81% (n = 71) who stated that they had concerns about managing menopause in general ($p < 0.001$). Key concerns identified by respondents (Figure 1), included potential drug–drug interactions (n = 68, 79%) and fear of missing an HIV-related illness (n = 44, 51%). Almost half reported having the same concerns as they would have when managing menopause in women without HIV.

There was a particular emphasis in the free text section of the questionnaire on a lack of knowledge and experience in this area and the likely underuse of HRT in WLHIV.

One-fifth of respondents did not identify any further training needs, mainly because they did not routinely see WLHIV in their clinical practice. However, three-quarters (n = 68) stated that they would benefit from further training in menopause and HIV.

Discussion

This small questionnaire study reveals that less than half of PCPs surveyed lacked confidence in managing menopause in WLHIV, in contrast to high levels of reported confidence in managing menopause in women without HIV. This is of particular concern for PCPs working in London, who are more likely to see WLHIV because of the higher prevalence of diagnosed HIV.[10]

The management of menopause in WLHIV may sometimes (but not always) involve considering alternative HIV-related diagnoses and potential drug–drug interactions. Both were identified as key concerns by our respondents. Similar concerns have been found in previous studies among GPs exploring barriers to managing comorbidities in people living with HIV.[11,12]

A significant proportion of respondents believed that menopause in WLHIV should be managed in tertiary services (either within specialist menopause clinics or by HIV specialist teams), reflecting a lack of confidence and knowledge in this area. Three-quarters

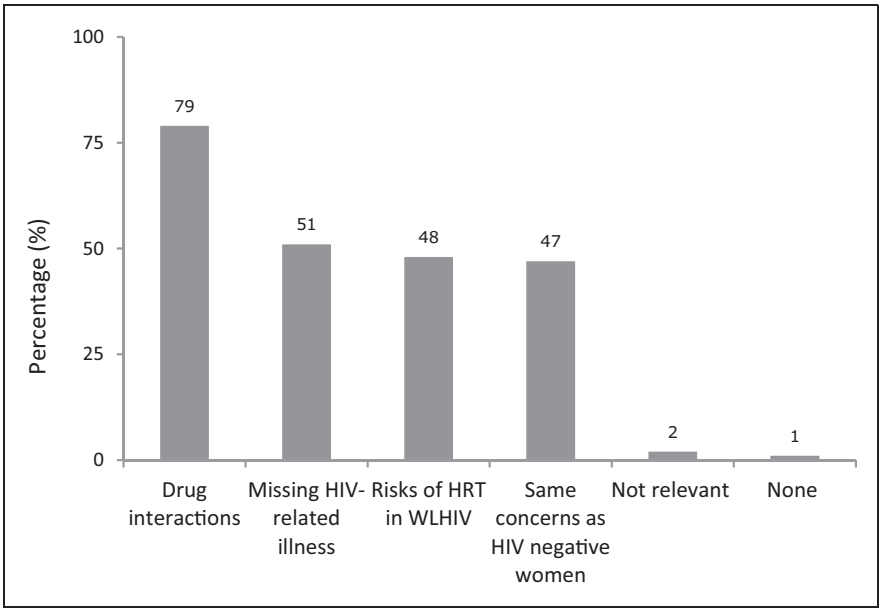

Figure 1. Concerns about managing menopause in women living with HIV.

of respondents stated they would benefit from further training on menopause specifically in the context of HIV.

It is reassuring that over half of our respondents believed that menopausal symptoms in WLHIV should be managed in primary care. It is likely that primary healthcare providers are best placed to manage menopause in this group given their experience in managing menopause more generally and their ability to integrate menopause care with broader preventative healthcare measures as women get older. There is no reason why WLHIV should necessarily be managed differently to women without HIV, or indeed women with other chronic medical conditions, by virtue of their HIV status alone. Where concerns arise regarding drug interactions, alternative diagnoses or psychosocial complexity, close liaison and joint management with HIV specialists is essential to support PCPs to deliver the best care for these patients.

Providing training will be key in developing confidence and competence amongst primary care practitioners to manage WLHIV with menopausal symptoms. This could be in the form of specialist training for those managing menopause by means of e-learning, or lectures within existing training packages.

As identified by some of participants, the development of specialist guidance on managing the menopause in WLHIV would be valuable. We therefore welcome the inclusion of a section on menopause in the forthcoming British Association of Sexual Health and HIV guidelines on the reproductive healthcare of people living with HIV. This will help build consensus on the management of menopause in this population.

Where there are existing specialist menopause clinics within tertiary care, referral pathways should be encouraged for complex HIV-positive patients who cannot be managed in primary care. However, should menopause care for this group be restricted solely to tertiary care, it is unlikely that the majority of women will receive the care they require. Instead, it is imperative to foster close liaison between HIV services and primary care, so that PCPs feel supported in managing menopause in WLHIV.

Limitations

This was a small study with a low response rate which limits the generalisability of our results. We recruited practitioners who were attending sexual and reproductive health meetings and who therefore had a particular interest in reproductive and post-reproductive health. This is a group of predominantly middle-aged women who were regularly managing menopause in their current practice and are therefore likely to be particularly knowledgeable in this area. Two-fifths of participants were based in London; this will introduce bias as participants practicing in London (where there is a higher prevalence of HIV) would be more likely to see WLHIV for general and menopause-related consultations. Their experiences and knowledge around HIV and menopause are likely to differ from those practicing in areas of lower HIV prevalence. Consequently, these findings represent 'a best-case scenario' of primary care practitioners' knowledge of managing menopause in WLHIV and may not reflect the wider population of PCPs (whose knowledge and confidence may be even more limited).

Due to the nature of this survey, we were limited in our scope to interrogate participants' concerns regarding the management of menopause in WLHIV in detail.

Conclusions

To the best of our knowledge, this is the first study in the UK (and one of the first internationally) to explore the management of the menopause in WLHIV amongst PCPs. There is a growing population of WLHIV reaching menopausal age and therefore increasing clinical need. Despite the limitations introduced by sampling, sample size and respondent characteristics, our data provide some useful insights. We found low confidence amongst PCPs in managing menopause in WLHIV, despite half of our participants indicating primary care as the most appropriate setting for the management of menopause in this population. Developing training and specialist guidance on HIV and menopause, and formulating clear care pathways for onward tertiary referral when needed, is likely to be key in developing confidence and knowledge in this emergent area, supporting PCPs to deliver high-quality care to WLHIV transitioning through the menopause.

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Ethical approval

Ethical approval was not required for this study as it was deemed service evaluation.

Guarantor

ST.

Contributorship

ST conceived the study. RM, CG, MC and ST were involved in the study development, and CG and RM carried out the pilot study. MC analysed data analysis, supervised by ST. MC wrote the first draft of the manuscript. All authors reviewed and edited the manuscript and approved the final version.

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