Remarkable reflections on midlife and menopause

26th Annual Australasian Menopause Society Congress

1-3 September 2023

www.menopause.org.au

AUSTRALASIAN MENOPAUSE SOCIETY
EMPOWERING MENOPAUSAL WOMEN

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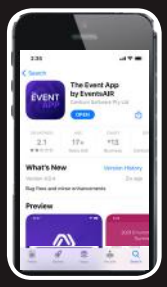

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Welcome to Congress 2023

On behalf of AMS it is my great pleasure to welcome you to the 26th Australasian Menopause Society Congress in Queenstown 1-3 September 2023.

We are delighted to welcome our keynote speaker Professor Nick Panay from Chelsea and Westminster Hospital, United Kingdom. He is immensely qualified for the role as Professor of Practice, Imperial College London, Director for the International Centre for Hormone Health and President of the International Menopause Society. His knowledge and authority of delivery has wide appeal. Delivery of knowledge requires passion and he hopes 'to achieve prioritisation of Women's Health globally, since being a neglected area, particularly to optimise quality of life and reduce the incidence of non-communicable diseases.' This needs addressing particularly urgently in women who go through early menopause and Premature Ovarian Insufficiency (POI). He would also like to see 'Premenstrual Syndrome/Premenstrual Dysphoric Disorder taken more seriously from societal and medical perspectives'.

The conference aims to update clinical knowledge with presentation of evidence, focus on the clinical concerns resulting from oestradiol fluctuations in the menopause, and give confidence in prescribing. Dr Ashley Makepeace as Chair of the Scientific Committee has an integrated programme of the latest scientific information, subjects and cases for debate.

We are thrilled that so many have come both from New Zealand and Australia to Queenstown, Kawarau, situated on lake *Whakatipu* with the Remarkables behind (2,319 m) and home to the NgāiTahu tribe. It is an adventure playground, the home of the bungy jump, at the Kawarau gorge. The main ski fields are Coronet Peak, Cardrona and the Remarkables. Scenic flights captivate the scenery of the Southern Alps going frequently to Milford Sound, weather dependent. Jet boating happens on the Rees, Dart and Kawarau river. The highest mountain in NZ – Mt Cook (Aoraki) 3,724 m is 275 km away from Queenstown on a stunning landscape road route – via the Crown Range, Wanaka, The Lindis Pass, Omarama, Twizel and Lake Pukaki.

Dr Sylvia Rosevear
Chair, Local Organising Committee

Welcome from the Scientific Program Committee

The 26th Annual Australasian Menopause Society Congress, to be held in Queenstown has already proven to be remarkable, with registrations reaching capacity, even before the early bird deadline. It reflects the surge in interest in the area of menopause and means that there will be a mix of those attending for the first time and others who have attended regularly, for the science and camaraderie expected of the AMS Congress. With that in mind, the aim has to been to provide a broad programme, from understanding the evidence but also the practical implications of delivering menopause health in our day to day practice.

We have enlisted many local experts from New Zealand but open the program with our keynote speaker, Dr Nick Panay, from the UK, speaking on premature ovarian insufficiency. There are updates on common areas in our clinical practice, including bone health, weight management, sleep, mood, vulval health and the lesser known impact of the menopause on epilepsy and eye health. We take a closer look at some of our routine investigations; bone density and breast screening and look at management of weight, musculoskeletal health and pelvic health. For the first time we have a session where we will learn more about the different preparations of menopausal hormone therapy. We will hear in depth about progestogens, and the more difficult areas of managing the menopause, including after breast cancer and will explore this further in the ask the expert session. As always we will finish with Sonia Davidson's update on what's new in menopause.

On behalf of the Scientific Organising Committee of Sylvia Rosevear, Sonia Davidson, Janice Brown and Christina Jang and some behind the scenes help from Anna Fenton, we hope that you find some things in this program to benefit your practice, and this and the camaraderie brings you back again.

Dr Ashley Makepeace
Chair Scientific Organising Committee

Sponsor Profiles

Diamond Partner

Diamond Partner, Congress App Sponsor, Commercial Symposia, Pre-Congress Update – Besins Healthcare

For more than 50 years, Besins Healthcare has discovered, developed and delivered healthcare solutions to help women successfully manage the often-unexpected issues related to the transition through menopause. Our products are prescribed by physicians in more than 100 countries worldwide.

Globally we are a major player in Menopausal Hormone Therapy (MHT), having developed a transdermal estradiol gel (Estrogel®), and a micronised natural progesterone in an oily formulation (Prometrium®) which is bioavailable by oral route of administration.

Besins remains committed to discovering additional innovations in menopause, gynaecology, fertility and obstetrics. In 2019 we were proud to be able to expand our MHT range of products for Australian women transitioning through menopause with the introduction of Australia's first MHT co-pack, Estrogel Pro – containing one pack of Estrogel plus one pack of Prometrium.

In addition to our MHT range of products, Besins Healthcare also provide Slinda® (drospirenone), an oral contraceptive, and Utrogestan®, (micronised progesterone, for luteal phase support in ART, for the prevention of Preterm Birth and the treatment of unexplained Threatened Miscarriage).

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Platinum Partner, Commercial Symposiua - Astellas

Astellas is a global pharmaceutical company, working at the forefront of healthcare change to turn innovative science into value for patients. Making a positive impact on patients' lives is the purpose behind everything we do. We are relentless in our pursuit of scientific progress and in tackling unmet medical needs. We work every day to leverage what sets us apart – our focus on patients, our pioneering spirit, our culture of innovation, and the passion of our talented people to pursue the best solutions for patients.

We focus our research and development on healthcare solutions that have the greatest potential to transform lives. Our Focus Area approach means that we approach drug discovery, research and development from multiple perspectives. At every level of Astellas, we put patients first to advance innovative early science into breakthrough treatments that can directly improve peoples' lives.

Silver Partner

Bayer is a global enterprise with core competencies in health care and agriculture. Our vision "Health for all, Hunger for none" with its focus on innovation and sustainability is based on values and behaviors that enable our employees to fulfill our purpose of "Science for a Better Life".

Business Partner

Exhibitors

AUSTRALASIAN MENOPAUSE SOCIETY
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Dr Janice Brown

Dr Ashley Makepeace

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Congress Organising Committee

Dr Sylvia Rosevear (Chair)

Dr Ashley Makepeace

Dr Janice Brown

Dr Samantha Newman

Dr Linda Dear

Scientific Program Committee

Dr Ashley Makepeace (Chair)

Dr Sylvia Rosevear

Dr Sonia Davison

Dr Janice Brown

Dr Christina Jang

AMS Membership

The Australasian Menopause Society brings together doctors, nurses and other allied health professionals who are keen to participate in communication and scientific discussions around the advancement of knowledge about the menopause.

If your work focuses on menopause and issues related to women's mid-life health, it's now more important than ever for you to become a Member of the AMS. Through AMS, you will be able to access information and resources which will inspire and guide improvements for your practice.

Members receive a monthly '*eChanges*' newsletter with clinical and AMS news updates as well as news on women's midlife health from around the world.

BENEFITS OF MEMBERSHIP

There are four main reasons to join AMS:

- Increase your confidence in menopause management by having access to up to date evidence-based information and resources;
- Gain CPD points by participating in education on the AMS eLearning website;
- Get discounts to Congress and other AMS education events;
- Advertise your practice on the Find an AMS Doctor website

To apply for AMS Membership please visit the AMS stand in the Exhibition area to complete an application form or alternatively apply online at www.menopause.org.au

Scientific Program

26th AMS ANNUAL CONGRESS

Remarkable reflections on midlife and menopause

THE MILLENNIUM, QUEENSTOWN, NEW ZEALAND • 1-3 SEPTEMBER 2023

Thursday 31 August		
17.30 – 18.00	**Pre-Congress Registration**	*Millennium Lobby*

Pre-Congress Menopause Essentials Program

All delegates attend at The Millennium, Galaxy I & II

Friday 1 September		
07.30 – 08.30	**Pre-Congress Menopause Essentials Registration**	*Millennium Lobby*
08.30 – 12.00	**Pre-Congress Menopause Essentials Update**	
	Chairs: Dr Elina Safro & Dr Carmel Reynolds	
08.30 – 09.15	Menopause consultation: A structured approach to decision-making	Dr Stella Milsom
09.15 – 10.00	Prescribing MHT: Evidence-base, tips, tricks and practice pearls	Professor Rodney Baber
10.00 – 10.30	**Morning Tea**	
10.30 – 11.15	Non-hormonal treatments for troublesome symptoms of menopause: What's the evidence?	Dr Sonia Davison
11.15 – 12.00	Contraception in the peri-menopause	Dr Amie Hanlon
12.00 – 13.00	**Lunch – for those attending both the Pre-Congress and Congress**	

Congress Program

Millennium Delegates - sessions are in Galaxy I & II
Copthorne Delegates - sessions are in Conference Room 1 & 2

11.30 – 18.00	**Registration**	*Millennium Lobby*
13.15 – 14.40	**Congress Opening & Plenary 1: Alice MacLennan Plenary**	
	Chairs: Dr Karen Magraith & Dr Sylvia Rosevear	
13.15 – 13.40	Official Congress Opening	
13.40 – 14.10	The Modern Management of Premature Ovarian Insufficiency (POI)	Prof. Nick Panay
14.10 – 14.40	POI – an Australian perspective	Clinical A/Prof. Amanda Vincent
14.40 – 15.10	**Afternoon Tea**	
15.10 – 17.10	**Plenary 2**	
	Chairs: Dr Christina Jang & Dr Marita Long	
15.10 – 15.35	Osteoporosis management in the peri- and early menopausal woman	Dr Susannah O'Sullivan
15.35 – 16.00	Bone density interpretation	Prof. Bronwyn Stuckey
16.00 – 16.25	Metabolic regulation and weight reduction with peptide therapy	Prof. Russell Scott
16.25 – 16.50	Exercise for musculoskeletal health in the menopause	Prof. Belinda Beck
16.50 – 17.10	Panel Discussion	
17.15 – 18.45	**Welcome Reception** ***Galaxy III & Gallery, Millennium (for all delegates)***	

Scientific Program

Congress Program

Saturday 2 September		
07.15 – 08.15	*Commercial Symposia hosted by Besins Healthcare	Breakfast* From Menopause to Menopeaks - Allie Pepper	**Conference Room 1 & 2, Copthorne** BESINS HEALTHCARE Innovating for Well-being
8.15 – 15.30	**Registration**	*Millennium Lobby*
08.45- 10.15	**Plenary 3**	
	Chairs: Dr Carmel Reynolds & Dr Kelly Teagle	
08.45 – 09.15	The modern management of PMS/PMDD	Prof. Nick Panay
09.15 – 09.45	Sleep and the menopause	Dr Kerri Melehan
09.45 – 10.15	Stress, Menopause and CEBT	Dr John McEwan
10.15 – 10.45	**Morning Tea**	
10.45 – 12.15	**Plenary 4**	
	Chairs: Dr Sonia Davison & Dr Stella Milsom	
10.45 – 11.15	Dry Eyes in Menopause – Frequently found, Frequently missed, Infrequently treated	Dr Andrew Logan
11.15 – 11.45	The complex interplay between epilepsy and menopause	A/Prof. Lata Vadlamudi
11.45 – 12.15	Individualising MHT: Australia and NZ Perspectives	Dr Elina Safro and Dr Janice Brown
12.15 – 13.15	**Lunch**	
13.15 – 14.35	**Plenary 5/Free Communications**	
	Chairs: Dr Ashley Makepeace & Dr Marita Long	
13.15 – 13.30	Health system utilisation and preferences: early trends from the inaugural VITAL peri-/menopause registry of Australia	A/Prof. Erin Morton
13.30 – 13.36	Role of psychology in the perimenopause and menopause. Greater collaborative care enhances patient outcomes	Ms Jacinta Grima
13.36 – 13.51	Medicinal Cannabis and Treatment of Menopause Symptoms	Prof. Kylie O'Brien
13.51 – 14.06	Lifestyle & Complementary medicine influence on cognition at Midlife	Ms Sandra Villella
14.06 – 14.21	The DHED prodrug selectively delivers 17-beta-estradiol to the brain-an alternative HRT approach for metabolic dysfunction?	Ms Celine Camon
14.21 – 14.27	Ovarian hyperthecosis and Leydig cell tumour presenting with virilisation and isolated increase in testosterone	Dr Kirsty Fisher
14.27 – 14.33	Case Study: Exploring perimenopause for a wahine Maori through a culturally safe lens	Dr Samantha Newman
14.35 – 15.30	**Afternoon Tea** *Galaxy III & Gallery, Millennium (for all delegates)*	
15.00	**AMS AGM** *Galaxy I & II, Millennium*	
18.00 – 22.30	**Congress Dinner** **The Heritage Queenstown** Coaches will depart the Millennium at 18.00	

Scientific Program

Congress Program

Sunday 3 September		
07.15 – 08.15	*Commercial Symposia hosted by Astellas	Breakfast* How well do you know Vasomotor Symptoms (VMS)? **Chairs: Dr Sonia Davison** **Speakers:** Professor Rodney Baber & Professor Bronwyn Stuckey	**Conference Room 1 & 2, Copthorne** astellas
8.15 – 13.00	**Registration**	*Millennium Lobby*
08.45 – 10.50	**Plenary 6**	
	Chairs: Clinical A/Prof. Amanda Vincent & Dr Karen Magraith	
08.45 – 09.15	Progestogens	Prof. Rodney Baber
09.15 – 09.45	Breast screening at the menopause	Prof. Mary Rickard
09.45 – 10.15	Management of Menopause in Breast Cancer Survivors	Dr Stella Milsom
10.15 – 10.45	**Ask the Expert** Panelists: Prof, Nick Panay, Prof. Rodney Baber, Dr Stella Milsom	
10.45 – 10.50	Invitation to the World Congress on Menopause in Melbourne 2024	
10.50 – 11.15	**Morning Tea**	
11.15 – 13.00	**Plenary 7**	
	Chairs: Dr Ashley Makepeace & Dr Sylvia Rosevear	
11.15 – 11.45	Vulval conditions in the menopause	Dr Amanda Oakley
11.45 – 12.15	Pelvic Health at Menopause	Dr Olivia Smart & Niamh Clerkin
12.15 – 12.45	Sonia's Snippets	Dr Sonia Davison
12.45 – 13.00	**Congress Close**	

Social Program

Welcome Reception

Welcome to the 26th Annual Australian Menopause Society Congress 2023. The Welcome Reception is your first social opportunity to catch up with colleagues, sponsors and exhibitors of the Congress. The Welcome Reception also provides a great opportunity to meet delegates who are attending the Congress for the first time.

Date: Friday 1 September
Time: 5:15pm – 6:45pm
Venue: Galaxy III & Gallery, Millennium
Dress: Neat casual

Congress Dinner

Join us at The Heritage Hotel Queenstown for the 2023 Congress Dinner! Enjoy the view of the Remarkables mountain rage, rising from the waters of Lake Wakatipu, the dinner is your chance to dress up and catch up with your colleagues, new friends, sponsors and exhibitors, while dancing the night away!

Date: Saturday 2 September
Time: 6:00pm – 10:30pm (Coaches will depart the Millennium at 6pm)
Venue: The Heritage Queenstown
Dress: Neat casual

FRIDAY 1 SEPTEMBER

Plenary 1: Alice MacLennan Plenary

The Modern Management of Premature Ovarian Insufficiency (POI)

Professor Nick Panay

Consultant Gynaecologist: Queen Charlotte's & Chelsea Hospital
Professor of Practice: Imperial College London

BIOGRAPHY:

Consultant Gynecologist, Subspecialist in Reproductive Medicine

Imperial College Healthcare NHS Trust and Chelsea & Westminster Hospital NHS Foundation Trust, London

Professor of Practice, Imperial College London

President, International Menopause Society

Guest Professor, Beijing Obstetrics and Gynecology Hospital, Capital Medical University.As director of the Menopause & PMS Centres at Queen Charlotte's and Chelsea & Westminster Hospitals, Nick leads a busy clinical and research team which publishes widely, presents at scientific meetings and trains health professionals at all levels. He set up his Gynaecological Endocrinology (Gynae Endo) Research Unit within the Women's Health Research Centre of Imperial College Healthcare NHS Trust. He also runs a research programme at Chelsea and Westminster Hospital (C & W). He and his team of research fellows and research nurses run an active research programme consisting of translational, clinical and pharmaceutically sponsored research in menopause, premature ovarian insufficiency (POI), premenstrual syndrome, androgens and contraception.

Nick has authored more than 200 peer reviewed publications with more than 7000 citations to date and has a Google Scholar h index of 46. He has presented at numerous national and international conferences, as an invited key note and plenary speaker.

Through his work with a number of societies, councils and women's groups he campaigns actively for women's health issues both nationally and internationally. His affiliations include:

Board Member and President, International Menopause Society,

Past Chairman of The British Menopause Society (BMS),

Medical Advisory Council Member, BMS

Chairman of The National Association for Premenstrual Syndromes,

Clinical Advisory Board Member, International Association for Premenstrual Disorders,

Patron of Daisy Network

Past Honorary Director of Conferences, RCOG,

Past President and Council member, Royal Society of Medicine (O & G Division).

ABSTRACT:

The presentation will use as its basis the European Society of Human Reproduction and Embryology 2015 POI guidelines which are currently being updated and the International Menopause Society (IMS) 2020 White paper on POI. A summary of key POI guidelines from the IMS White Paper is shown below.

Demographics / etiology / pathophysiology of POI

Terminology and diagnostic criteria should be standardised to avoid confusion about diagnosis.

Full understanding of etiology / pathophysiology will facilitate efficient diagnosis and management e.g., global registry / biobank.

Global, ethnic and cultural variations in prevalence, presentation require clarification.

Diagnosis of POI

Personal e.g., menstrual health and family history are very important in making the diagnosis.

The diagnosis should not be made on the basis of only one FSH level.

AMH testing is only required if there is diagnostic uncertainty.

A baseline DEXA scan should be offered to all women diagnosed with POI.

Management of POI

Management of women with POI should ideally be multidisciplinary and include patient advocacy groups.

Lifestyle, diet exercise should be optimised.

Hormone replacement at least until average age of menopause should be first line treatment unless contraindicated or if rejected by the woman after careful counselling.

There are very few data for the benefits and risks of CAMS and non-hormonal bone sparing agents in POI.

Replacement can be with the COC initially if contraception is required or because of personal preference, but in the long-term HT is recommended to optimise bone and metabolic health.

Key Research priorities in POI

Global POI registry collaboration / expansion / biobanking. e.g. https//: poiregistry.net

Further determination of etiology of POI, especially genetic.

Discovery of reliable biomarkers for predicting POI.

Impact of hormonal interventions e.g. HT v COC, types of HT / COC on

Quality of Life

Psychological/psychosexual aspects

Bone, cardiovascular and cognitive health.

Role of androgen supplementation for QOL, cardiovascular, bone, cognitive health and fertility.

Differential impact and management of iatrogenic and spontaneous POI.

POI as part of an aging syndrome v aging following POI due to hormone deficiency.

Confirmation of efficacy and safety of fertility enhancing techniques.

Further clarification of role and division potential of human oogonial stem cells.

FRIDAY 1 SEPTEMBER

Plenary 1: Alice MacLennan Plenary

POI – an Australian perspective

Clinical Associate Professor Amanda Vincent

Clinical Associate Professor Amanda Vincent, MBBS (Hon), B. Med Sci (Hon), FRACP, PhD
A/ Prof Amanda Vincent MBBS, BMed Sci, FRACP, PhD
Monash Centre for Health Research and Implementation (MCHRI), Sub-Faculty of Clinical and Molecular Medicine, Monash University
Endocrinologist, Menopause Clinic, Monash Health, Clayton, Victoria, Australia

BIOGRAPHY:

Clinical Associate Professor Amanda Vincent is a clinician researcher combining clinical practice in menopause with menopause related research, translation and education. She is lead endocrinologist in the Menopause, Early menopause and Menopause Oncology clinics, Monash Health, Clayton, Victoria, Australia with over 20 years experience providing clinical care and undergraduate/ post-graduate education in menopause management. She is Head of Early Menopause Research, Monash Centre for Health Research and Implementation https://mchri.org.au/), Monash University and co-leads the Early menopause stream, NHMRC Centre for Research Excellence in Women's Health in Reproductive life (https://whirlcre.edu.au/). She has publications and successful grant funding in projects, including the Healthtalk Australia Early menopause digital resource and Ask Early menopause App (www.askearlymenopause.org), and currently co-chairs the international guideline group to update the European Society of Human Reproduction and Embryology premature ovarian insufficiency guideline. Clinical A/Professor Vincent is Past President of the Australasian Menopause Society and current board member of the International Menopause Society.

ABSTRACT:

Premature ovarian insufficiency (POI), loss of ovarian function before age 40 years, and early menopause (EM), menopause age 40-44 years, affects almost 4% and 12% of women respectively. POI or EM occurs spontaneously or secondary to medical treatment. Over the past 15 years our mixed methods research has explored POI/ EM in Australia. We highlighted:

Women:
Low POI/EM awareness, dissatisfaction with the diagnostic process, multiple disabling symptoms with predominately negative perceptions regarding POI/EM, significant physical/ psychological /social impacts, difficulty communicating with health professionals, uncertainty about health impacts and treatment, and difficulty accessing care.

Impaired musculoskeletal health including reduced osteoporosis knowledge, bone density, trabecular bone score and measures of skeletal muscle mass.

EM due to medical treatment is associated with an increased risk of death compared to women without EM. The risk of other health problems varies according to the cause of EM.

Health professionals:
Current POI/ EM guidelines varied in quality with significant deficiencies seen.

Knowledge gaps and variation in clinical care depending on the type of specialist or general practitioner.

Translation:
In response to these findings, we co-designed digital tools for women and health professionals including:
- ASK Early Menopause App
- Healthtalk Australia early menopause digital resource

FRIDAY 1 SEPTEMBER
Plenary 2

Osteoporosis management in the peri- and early menopausal woman

Dr Susannah O'Sullivan

FRACP, PhD
Endocrinologist, Greenlane Clinical Centre, Auckland, New Zealand

BIOGRAPHY:

Susannah O'Sullivan is a general and reproductive endocrinologist working at Greenlane Clinical Centre, Te Whatu Ora (Auckland). Following her clinical training, she completed a PhD in Medicine with the Bone and Joint Research Group at the University of Auckland. She has published a number of peer reviewed articles, and has been invited to submit review articles and book chapters for publication. She has given research and invited speaker presentations at local and international clinical and scientific meetings. Her current research focuses on bone metabolism and bone diseases, functional hypothalamic amenorrhoea, and management of thyroid dysfunction in pregnancy. She has previously served as a board member for the NZ Endocrine Society, Osteoporosis NZ and the ANZBMS Professional Affairs Committee, and is a current member of the NZ Endocrine Society, the Australasian Menopause Society and the Female Athlete Triad Coalition.

ABSTRACT:

Osteoporosis and fracture can be a major health problem for women in later post-menopausal life. Younger post-menopausal women are generally considered to be at low risk of developing these conditions, however bone loss may begin in the menopause transition (peri-menopause) and predispose women to development of osteoporosis and fracture later in life. Studies have shown that the peri-menopause and early post-menopause are characterised by rapid bone loss and changes in bone micro-architecture, both of which may contribute to increased bone fragility. In women at risk of developing osteoporosis, prevention of loss of bone density and skeletal integrity may reduce the chances of developing this condition, and the associated increased risk of fracture. In addition to conventional risk factors for osteoporosis, the presence of low peak bone mass, and early and rapid menopausal bone loss, might aid in identifying candidates for treatment in the peri-menopause or early post-menopause. Menopausal hormone therapy (MHT) offers a treatment option that increases bone density and prevents fractures, and could be employed as part of a long-term osteoporosis management strategy. In those for whom MHT is not an option, an alternative strategy that has been studied in older post-menopausal women is the use of periodic administration of intravenous bisphosphonate. In those at high risk of fracture, potent anti-resorptive or anabolic treatments should be considered.

FRIDAY 1 SEPTEMBER
Plenary 2

Bone density interpretation

Professor Bronwyn Stuckey AM

Medical Director, Keogh Institute for Medical Research

BIOGRAPHY:

Professor Bronwyn Stuckey is a clinical endocrinologist with a special interest in reproductive endocrinology.

She is a consultant physician in Endocrinology and Diabetes at the Sir Charles Gairdner Hospital in Perth, Western Australia, Medical Director of the Keogh Institute for Medical Research and Clinical Professor in the Medical School, University of Western Australia. She is a Past President of the Australasian Menopause Society and a Life Member of the Endocrine Society of Australia.

Her clinical and research interests, and that of the Keogh Institute, lie within the interface between hormones, particularly reproductive hormones, and metabolism.

ABSTRACT:

In clinical practice we usually trust the providers of pathology and radiology to provide accurate reports. When it comes to bone density, so much of the decision to either institute anti-resorptive treatment or change treatment depends on the bone density or reported change in bone density. Often we receive the report but not the scanning image, and sometimes the comment on the report is generated by the machine, not by the person who signs it. It is worthwhile taking the time to check the quality control of the bone density scan image, rather than just read the report. This is especially the case if the report states there is a significant change in bone density which may prompt a change in treatment.

In this presentation I will show what bone density scanning images should look like, detail what we should expect from a quality bone density report, and include examples of errors and artefacts that should be taken into account in interpreting bone densitometry.

"A picture is worth a thousand words"

FRIDAY 1 SEPTEMBER
Plenary 2

Metabolic regulation and weight reduction with peptide therapy

Professor Russell Scott

MB ChB BMedSci FRACP PhD (Monash)
Clinical Professor of Medicine, Christchurch, NZ
Clinical Investigator, NZ Clinical Research OpCo, Christchurch division.

BIOGRAPHY:

Russell is a physician at Christchurch Hospital, New Zealand. His qualifications are MB, ChB BMedSci from the University of Otago in NZ, and PhD from Monash University Australia. He is a Fellow of the Royal Australasian College of Physicians. He is Clinical Professor of Medicine, Christchurch School of Medicine and Health Sciences, University of Otago, New Zealand.
He is also involved in the acute internal medicine service at Christchurch Hospital and runs a private specialist clinic in the areas of diabetes, endocrinology, metabolic disorders and lipidology. He has been involved in clinical research since the mid 1980's and is currently an investigator with NZ Clinical Research. His main research interests are prevention and treatment of type 1 DM, new technologies for diabetes mellitus, lipid disorders and cardiovascular disease, triglyceride regulation and clinical trials of new medications for diabetes and lipid disorders. He has been an investigator for 248 studies, from phase 1 through to long term CVD outcome trials. He has published 12 book chapters and 248 refereed articles in the areas of diabetes, atherosclerosis, and lipid disorders.

ABSTRACT:

Obesity is prevalent in NZ and Australia. With ageing, there is an increase in fat mass and decrease in lean muscle mass and is an issue with menopause. Lifestyle and diet changes are typically used with disappointing outcomes. Traditional pharmacotherapeutic agents seldom achieve useful weight reduction beyond 1 year. The glucagon-like peptide-1 (GLP-1) analogue Exenatide was first used around 1995 (mainly in T2DM) and a long-acting version also was developed. Dose-dependent gastrointestinal side effects limited their use. Newer agents such as Liraglutide, dulaglutide and semaglutide (the latter not in NZ) are funded for type 2 DM and can deliver reasonable metabolic results while titrating for side effects. The attraction for use in type 2 DM, is cardio renal benefit. Guidelines rank them as the next medication option after metformin in those with obesity/insulin resistance. They are being used increasingly in other metabolic situations such as sleep apnoea, insulin resistance, menopause, NASH.

Other gut, pancreatic and brain peptides such as glucagon, oxyntomodulin, peptide YY (PYY), and glucose-dependent insulinotropic peptide (GIP) are emerging key targets for medications to improve metabolics and reduce obesity. Novel dual agonists for GLP-1/glucagon and GLP-1/GIP have been / and are being developed. Tirzepatide is registered in Australia, not available in NZ. Triagonists (GLP-1/GIP/glucagon) show initial favourable clinical trial results. However, the track record of weight regulators uncomfortable with market withdrawal being a repeated feature over the last 30 years; the most recent being lorcaserin (cancer risk). The claims for the 'latest and greatest' dominate 2023 medical news with pharma giants competing for position.

The talk will focus on the role of newer medications that improve metabolic issues associated with high body weight. It will also profile those emerging.

FRIDAY 1 SEPTEMBER
Plenary 2

Exercise for musculoskeletal health in the menopause

Professor Belinda Beck

FACSM, FESSA, FASMF
School of Health Sciences and Social Work

BIOGRAPHY:

Belinda Beck is a Professor at Griffith University (Gold Coast, QLD) and the Menzies Health Institute Queensland. She founded The Bone Clinic, a translational research facility and clinical practice providing evidence-based exercise for patients with osteoporosis. She graduated from The University of Queensland (BHMS[Ed]) and the University of Oregon (MSc and PhD) and completed a postdoctoral research fellowship in the Stanford University School of Medicine (CA, USA). Her work, primarily related to the effects of mechanical loading on bone, has involved both animal and human models, from basic to clinical research. Her particular focuses have been exercise interventions across the lifespan for the prevention of osteoporotic fracture, and the management of bone stress injuries in athletes and military recruits. Recent projects have included the LIFTMOR clinical trials, the findings of which inform the Onero exercise program implemented at The Bone Clinic and licensed for delivery by exercise physiologists and physiotherapists around the world.

ABSTRACT:

Bone and muscle strength decline with age. Whether or not the process is purely an age-related phenomenon, or a manifestation of the reduction in mechanical loading across the lifespan is not well understood. What is known is that the rate of decline in bone and muscle accelerates markedly at menopause with the reduction in circulating oestrogen. The risk of low trauma fracture increases in parallel as not only are weaker bones less able to resist trauma, but weaker muscles are less able to prevent falls. While exercise prescription for muscle strength has long been well characterised, an effective exercise prescription to safely improve osteoporotic bone has only recently been established. Not all forms of exercise provide an equally effective stimulus for bone and some activities may be hazardous for an osteoporotic skeleton. Similarly, only very specific high-challenge balance training is likely to notably stimulate sufficient neuromuscular adaptation to reduce falls and fracture. A recent series of trials testing a highly targeted exercise program for osteoporosis observed excellent outcomes for both bone and functional outcomes in older adults at risk of low trauma fracture. This talk will address the principles of effective exercise for the prevention of low trauma fracture after menopause by improving muscle and bone mass, strength and function.

SATURDAY 2 SEPTEMBER
Plenary 3

The modern management of PMS/PMDD

Professor Nick Panay

Consultant Gynaecologist: Queen Charlotte's & Chelsea Hospital
Professor of Practice: Imperial College London

BIOGRAPHY:

Consultant Gynecologist, Subspecialist in Reproductive Medicine

Imperial College Healthcare NHS Trust and Chelsea & Westminster Hospital NHS Foundation Trust, London

Professor of Practice, Imperial College London

President, International Menopause Society

Guest Professor, Beijing Obstetrics and Gynecology Hospital, Capital Medical University.As director of the Menopause & PMS Centres at Queen Charlotte's and Chelsea & Westminster Hospitals, Nick leads a busy clinical and research team which publishes widely, presents at scientific meetings and trains health professionals at all levels.He set up his Gynaecological Endocrinology (Gynae Endo) Research Unit within the Women's Health Research Centre of Imperial College Healthcare NHS Trust. He also runs a research programme at Chelsea and Westminster Hospital (C & W). He and his team of research fellows and research nurses run an active research programme consisting of translational, clinical and pharmaceutically sponsored research in menopause, premature ovarian insufficiency (POI), premenstrual syndrome, androgens and contraception.

Nick has authored more than 200 peer reviewed publications with more than 7000 citations to date and has a Google Scholar h index of 46. He has presented at numerous national and international conferences, as an invited key note and plenary speaker.

Through his work with a number of societies, councils and women's groups he campaigns actively for women's health issues both nationally and internationally. His affiliations include:

Board Member and President, International Menopause Society,

Past Chairman of The British Menopause Society (BMS),

Medical Advisory Council Member, BMS

Chairman of The National Association for Premenstrual Syndromes,

Clinical Advisory Board Member, International Association for Premenstrual Disorders,

Patron of Daisy Network

Past Honorary Director of Conferences, RCOG,

Past President and Council member, Royal Society of Medicine (O & G Division).

ABSTRACT:

Many women experience mild physical and emotional PMS symptoms which are not particularly troublesome. However, when severe these symptoms can lead to a breakdown in interpersonal relationships and interference with normal activities. These symptoms can be particularly troublesome in the late reproductive and perimenopause years due to increasing hormonal fluctuations which can trigger symptoms in genetically predisposed, hormonally vulnerable, women. When PMS in severe, it may satisfy the American Psychiatric Association DSM-V criteria for premenstrual dysphoric disorder (PMDD). The International Society for Premenstrual Disorders (ISPMD) has made recommendations for a new classification with core (typical, pure or reference disorders associated with spontaneous ovulatory menstrual cycles) and variant premenstrual disorders (such as symptoms of an underlying psychological or somatic disorder significantly worsening premenstrually). PMS/PMDD continues to be poorly understood and in many cases inadequately managed. It can be the cause of considerable morbidity and at time even mortality. It is imperative that a consensus on definition is reached globally and that properly conducted research continues to be funded. It is through this work that clinicians will be able to practice in an evidence-based way to effectively treat this condition.

The alternatives to traditional therapy, such as agnus castus, red clover and St John's Wort, are showing promising results in randomized studies but more data are needed. Data on natural progesterone remain controversial, although many women derive considerable benefit from this preparation. Progestogens should not be used as they are good at reproducing the symptoms of PMS/PMDD! The more established therapies for which randomized controlled data exist are the combined "fourth" generation pills (e.g. the 24/4 or flexible regimen 20mcg ethinylestradiol / 3mg drospirenone), transdermal estradiol, selective serotonin re-uptake inhibitors and the GnRH analogues with add back HRT. Hysterectomy with BSO and adequate HRT remains an important option for severely afflicted women whose family is complete and have not responded to other therapies. The presentation will follow the UK RCOG Green Top Guideline No 48 on the Management of Premenstrual Syndrome https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/premenstrual-syndrome-management-green-top-guideline-no-48/.

Support for patients and health professionals is available from the National Association for Premenstrual Syndrome https://www.pms.org.uk/

SATURDAY 2 SEPTEMBER
Plenary 3

Sleep and the menopause

Dr Kerri Melehan

BCom BAppSc MAppSc PhD RPSGT ACP (Sleep)
Accredited Clinical Physiologist (Sleep)

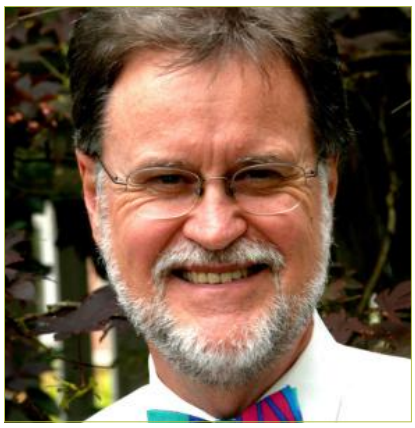
BIOGRAPHY:

Kerri has been a sleep scientist for more than 25 years, is an Accredited Clinical Physiologist (Sleep), and has worked in major teaching hospitals, private practice, education, and research. She completed her PhD in sleep in 2014 and has been teaching sleep medicine at the University of Sydney since 2015, while continuing clinical work as a sleep scientist at Royal Prince Alfred hospital in Sydney. Her research interests include sleep issues particular to women and the sexual function impacts of sleep apnoea (in men and women), as well as being involved in a variety of studies including sleep in the ICU, timing of exercise in sleep, efficacy of catch up sleep, REM sleep behaviour disorder, among others. She is an author on the Australasian commentary on the sleep scoring guidelines and is previous president of the Australia New Zealand Sleep Science Association

ABSTRACT:

Sleep, together with diet and exercise, is considered the third pillar of good health. The many functions of sleep are becoming more apparent due to findings of on-going research. These include aspects of hormone release, memory, immune function, and metabolite clearance. The regulation of several hormones rely on active processes which occur during sleep. Age is a significant factor which influences sleep architecture, timing, and consolidation. Both increased age and menopause cause changes in subjective sleep quality. Sleep disorders such as insomnia and obstructive sleep apnoea also become more frequent in menopausal women. This presentation aims to 1) provide an overview of sleep and the expected changes in sleep due to menopause, 2) highlight those sleep disorders which menopausal women are at risk of developing, and 3) provide a brief overview of behavioural strategies which may be used to assist with these expected changes in sleep quality, and treatment options for common sleep disorders seen in this population.

SATURDAY 2 SEPTEMBER
Plenary 3



Stress, Menopause and CEBT

Dr John McEwan

BIOGRAPHY:

A graduate of Auckland University and North Shore Teacher's College and known as "Dr Stress" John works with professionals facing Stress, Anxiety-Depression, Grief and Trauma. He was founding President of the New Zealand Chapter of the Australasian Critical Incident Stress Association, and has served as Australasian President. He is a full member of the NZAC, and has received the Mental Health Foundation "Respect Award", and a Life Time Achievement Award from the Australian Critical Incident Stress Foundation for his work in the field of Post Trauma education. A Retired Naval Reserve Lieutenant Commander, he is the author of the Naval History of the Volunteer Reserve of Auckland. He is also the author of a number of texts on Pastoral Leadership used in the toughest slums of the Third World. He is a counsellor for professional players in Cricket and Rugby as "Mental Skills Coach" and is excited about the application of Sports Psychology into the Clinical area.

ABSTRACT:

The application of Sports Psychology Tools and Techniques to empower women as they deal with adjusting to hormonal fluctuations through menopause's challenges, making it easier for them to defeat passivity with its health and addictive dangers. He draws on clinical work done over the last thirty years working with patients facing medical challenges and Athletes facing potentially game ending injuries.

The Primal Brain perceives all hormonal fluctuations as a threat to survival, and coming at any treatment plan from this angle gives the patient an empowering understanding of the internal conflicts they feel as body battles Primal Brain within.

The message has been, "Empower yourself through this time" – don't just roll over and relax into sugar, alcohol, drug taking, anxiety or depression. You can "do something here"! Active not passive! Using the well proven Sports Psychology tricks/tools we can "manage" our Primal Brain and give the message of power-control-strength-relaxation to empower/enhance.

I am going to suggest here today a way of using the Cognitive Behavioural technique in a manner that has proved to get great results with people facing the challenges of hormonal fluctuation on mind-body.

SATURDAY 2 SEPTEMBER
Plenary 4

Dry Eyes in Menopause – Frequently found, Frequently missed, Infrequently treated

Dr Andrew Logan

The Wellington Eye Centre

BIOGRAPHY:

Dr. Andrew Logan is the founder of Wellington Eye Centre and has been an ophthalmologist, for over 40 years. He qualified as a doctor with a Bachelor of Medicine (MB) and Bachelor of Surgery (CH.B) from Otago University in 1976, and completed his training as a specialist ophthalmologist in 1983. Dr Logan specialises in refractive surgery, anterior segment surgery and corneal conditions, although he now focuses on refractive laser surgery.

Dr Logan is proud to call himself an early adopter of new proven technology, and he has an unequalled record of introducing and pioneering new technology and procedures in New Zealand and Australasia. Including being the first surgeon in New Zealand to perform LASIK in 1996, as well as the first to have it carried out on himself. He stays at the forefront of this by attending seminars and training in New Zealand, Australia and the United States.

ABSTRACT:

Dry eyes are a frequent cause of ocular discomfort, unstable and poor quality vision and also of more significant eye pathology. They can occur at any age but appear to be more common in association with menopause. In addition, dry eyes can be associated with a number of systemic conditions, for which a presenting symptom may be that of dry eyes.

This talk will discuss the aetiology and diagnosis of dry eyes and management of the condition from the point of view of the non-ophthalmologist.

SATURDAY 2 SEPTEMBER
Plenary 4

The complex interplay between epilepsy and menopause

Associate Professor Lata Vadlamudi

Senior Staff Specialist Neurology, Metro North Clinician Research Fellow
Neuroscience Theme Leader UQCCR
University of Queensland Centre for Clinical Research (UQCCR)

BIOGRAPHY:

Associate Professor Lata Vadlamudi is a Senior Staff Specialist in Neurology at the Royal Brisbane and Women's Hospital; Epileptologist within the Comprehensive Epilepsy Program; Metro North Clinician Research Fellow; and Neurosciences Theme Leader at the University of Queensland Centre for Clinical Research.

Clinical interests include integrating genomics into the clinical care and management of women with epilepsy, through all stages of life from pre-conception to pregnancy and menopause. Current research projects include developing patient-specific brain organoid models to personalise epilepsy care with a current MRFF funded mission entitled Personalising Epilepsy Regimes with Stem cells and artificial Intelligence models for Superior Treatment outcomes (PERSIST); and developing a neuro-genomics service in Queensland.

Awards have included UQCCR Clinical Researcher of the year; Epilepsy Queensland Health Award for contributions to the medical care of people with epilepsy; and Leonard Cox Award for outstanding contribution to research in the field of Neurology.

ABSTRACT:

Epilepsy affects 1 in 10 people during their lifetime and is characterized by seizures. Seizures are the tip of the iceberg in terms of quality of life for people with epilepsy. There is a complex interplay between epilepsy, neuro-endocrine disruption and anti-seizure medications in the management of women with epilepsy. Menopause adds another layer of complexity to this network.

To manage women with epilepsy, an understanding of the neuro-endrocine system as well as the esotrogen:progesterone ratio, and how they influence seizure control, is critical to the understanding of catamenial epilepsy and hormonal impacts in pregnancy and menopause. Epilepsy itself is an endocrine disruptor adding more complexity to the equation. Finally, enzyme-inducing anti-seizure medications play a role in altering hormonal levels as well as direct impacts on vitamin D and bone turnover.

There is a multi-factorial increase in the risk of fractures in epilepsy, which is additive to the risks that menopause poses on bone health.

For optimal management of epilepsy and menopause, a holistic approach is required with balancing of risks and benefits of treatment for the individual patient. Management includes discussion on menopause-specific treatment in women with epilepsy, control of seizures, bone health, osteoporosis and fracture prevention.

There is an imperative need for longitudinal studies, to enable development of evidence-based preventive and treatment guidelines.

SUNDAY 3 SEPTEMBER
Plenary 6

Progestogens

Professor Rodney Baber AM

Clinical Professor of Obstetrics and Gynaecology, Faculty of Medicine and Health, The University of Sydney
Past President IMS, Editor in Chief, Climacteric, Associate Editor ANZJOG

BIOGRAPHY:

Rod Baber is Clinical Professor of Obstetrics and Gynaecology at The University of Sydney and is Head of the Menopause and Menstrual disorders clinic at Royal North Shore Hospital.

He is a Past President of The International Menopause Society and The Australasian Menopause Society and currently Editor in Chief of Climacteric, the journal of The International Menopause Society and an associate editor of The Australian and New Zealand Journal of Obstetrics and Gynaecology. His awards include membership of The Order of Australia for services to Obstetrics and Gynaecology in clinical medicine and research and The RANZCOG Distinguished Service medal.

ABSTRACT:

Progestogens are defined as substances which bind to the progesterone receptors and exert an agonistic response. They may be divided into two major categories: natural and synthetic.

Progesterone is the only natural progestogen. Synthetic progestogens, also known as progestins are derived from testosterone derivatives, hydroxyprogesterone derivatives and spironolactone.

The principal indication for the use of progestogens on MHT is to prevent estrogen induced endometrial hyperplasia and cancer.

The effect of progestogens on an estrogen primed endometrium depends on the dosage, duration of exposure and the type of progestogen chosen.

For commonly used, 'average' doses of estrogen there is clear evidence of the appropriate dose and duration of therapy required for different progestogens. However, for higher doses of estrogen the doses are less clearly defined.

Whilst progesterone binds almost exclusively to the progesterone receptors, synthetic progestins also bind to other steroid hormone receptors, an effect related to their origins.

The consequence of progestins binding to other steroid receptors may be associated with adverse effects on cardiovascular and breast health.

These effects and an approach to appropriate use of progestogens will be discussed.

SUNDAY 3 SEPTEMBER
Plenary 6

Breast screening at the menopause

Dr Mary Rickard

Sydney Breast Clinic

BIOGRAPHY:

Dr Rickard trained as a radiologist and worked in hospital and private radiology practice before establishing a Sydney-based pilot mammography screening project in 1987. This and other pilot projects led to the establishment of BreastScreen Australia in 1990.

She has taken a keen interest in breast imaging technique and interpretation, in new technologies and in professional training, and is an Adjunct Professor at the University of Sydney.

She was State Radiologist for BreastScreen NSW from 2001 until 2006 when she joined Sydney Breast Clinic, a multidisciplinary screening and diagnostic service, where she is now Medical Director.

In 2002 she received an Order of Australia award, and in 2015 she was elected a Life Member to the Royal Australian and New Zealand College of Radiologists.

ABSTRACT:

Breast cancer is the commonest cancer in Australian women and is a disease of increasing age, with an approximate median incidence age of 61 years. The BreastScreen program, a mammography only screening program targeting women aged 50 to 74 years, aims to establish earlier diagnosis. While breast cancer mortality reduction has been seen since the introduction of the BreastScreen program, not all women have benefitted equally. Some women are at increased risk of developing the disease and for many, mammographic breast density, adversely affects mammographic sensitivity and specificity. Digital breast tomosynthesis, ultrasound examination, and contrast enhanced techniques of contrast enhanced mammography and magnetic resonance imaging all incrementally improve accuracy in screening and diagnosis. Good quality of imaging studies and their careful correlation with patient history and risk and clinical findings optimizes outcomes. The introduction of AI into imaging for image quality assessment, risk evaluation and image interpretation will further improve diagnostic accuracy.

SUNDAY 3 SEPTEMBER
Plenary 6

Management of Menopause in Breast Cancer Survivors

Dr Stella Milsom

MB ChB, Dip Obs, FRACP
Department of Reproductive Medicine at National Women's Hospital

BIOGRAPHY:

Stella Milsom graduated from University of Otago, followed by post graduate training in Christchurch and Auckland, doctoral studies with Professor Peter Gluckman at the University of Auckland and post-fellowship training at the University of Utah, USA and Middlesex Hospital and St Bartholomew's Hospitals, London.

She is currently the senior reproductive endocrinologist in the Department of Reproductive Medicine at National Women's Hospital, leader of the Reproductive Endocrine group at Fertility Associates, Auckland and also a clinical senior lecturer in the Department of Obstetrics and Gynaecology at the University of Auckland.

Stella is on the Boards of Osteoporosis New Zealand and Human Fertility UK, is past Chair of Endocrinology training in New Zealand for the Royal College of Physicians, is a member of the National Health Committees formulating guidelines on hormone replacement therapy and fertility preservation and an advisor to Pharmac. Her clinical and research interests include lactation physiology, ovulatory disorders such as polycystic ovary syndrome, and hypothalamic amenorrhea, and modern menopause management. She is involved in numerous Australasian educational initiatives in reproductive endocrinology and has been the recipient of several awards for research and clinical leadership including the Kaye Ibbertson award of 2021.

ABSTRACT:

In general, hormone therapy (MHT) is first line pharmacological management for women with significant menopausal symptoms. There are relatively few contraindications to MHT when compared with synthetic hormones. However, the use of MHT is strongly discouraged by the majority of professional organisations in breast cancer survivors.

Survival rates after breast cancer with modern therapy now exceed 85%. This is reflected by an increasing number of women with a breast cancer history presenting to primary care for management of menopausal symptoms. These are often severe and debilitating, regardless of whether the aetiology of menopause is spontaneous, induced by therapies used to treat breast cancer, or in association with adjuvant endocrine therapies (AET). These women may have a significantly reduced quality of life and management needs to be effective and individualised.

While the pathway to resolution of menopausal symptoms is not as straightforward as in a woman without a history of breast cancer, and the use of AET may complicate decision making, there are a number of current and emerging evidence based non hormone options that potentially will alleviate symptoms.

These will be discussed and their efficacy reviewed, along with situations where MHT may still be considered.

SUNDAY 3 SEPTEMBER
Plenary 7

Vulval conditions in the menopause

Dr Amanda Oakley

BIOGRAPHY:

Dr Amanda Oakley is a Dermatologist at Te Whatu Ora Waikato. She is a Fellow of the International Society of the Study of Vulvovaginal Diseases and was the President of the Australian and New Zealand Vulvovaginal Society from 2011 to 2013. She has held vulval clinics for 35 years. Publications about vulval diseases are included in her list of 306 publications on ORCID. Other academic interests include teledermatology and teledermoscopy. She was a Founder of DermNet and was its Editor in Chief for 25 years, for which she has received many awards, including Companion of the New Zealand Order of Merit and Honorary memberships of several professional organisations.

ABSTRACT:

Te Whatu Ora Waikato

Women commonly present with vulval skin diseases and conditions at menopause due to intermittent or persistent itch, pain, dyspareunia, a rash, or a lesion of concern. The history should explore previous skin diseases, incontinence, comorbidities, medications, and vulval treatments. Evaluate symptoms using a verbal or written 10-point Likert scale, and their impact by completing the vulval life quality index (VLQI). The vulval examination includes the mons pubis, groin creases, introitus, perineum, hair-bearing, glabrous, and perianal skin. Relevant inflammatory diseases may be found in the scalp, ears, flexures (psoriasis); shoulders, breasts, abdomen, and buttocks (lichen sclerosus); shins, lower back, wrists and oral mucosa (lichen planus); and feet and toenails (tinea). Atrophy and resorption of vulval skin can be due to lichen sclerosus (skin only), lichen planus (skin and mucous membranes), or oestrogen deficit. Inflammatory skin diseases may be red or white bilateral and symmetrical plaques, whereas neoplasia is unilateral and focal. Dermoscopy assesses structural pigmentary symmetry (benign melanosis) or asymmetry (potentially malignant). Baseline photographs are important for monitoring disease and the effect of treatment. Investigations may include vaginal swabs (abnormal discharge), scrapings (scaling of buttocks or thighs), and biopsies (diagnostic uncertainty or potential malignancy).

SUNDAY 3 SEPTEMBER
Plenary 7

Pelvic Health at Menopause

Dr Olivia Smart

BIOGRAPHY:

Olivia is a specialist gynaecologist based in Christchurch New Zealand. She obtained her medical degree from University College London and undertook post graduate studies at Imperial College before relocating to New Zealand to complete her fellowship training in Obstetrics and Gynaecology in 2005,

"Gynaecology is a diverse field of medicine covering many aspects of women's health through their reproductive and post reproductive years. What I see over and over again in my practice is that women are not receiving sufficient education and support around menopause transition and how to mitigate the long- term health impacts.

I am passionate about all aspects of wellbeing and wish to inspire others to take steps that promote vitality to live a long, happy and enjoyable life.

This requires a holistic approach looking at preventative steps that can significantly alter health outcomes."

Olivia lives in Christchurch with her two children and tries to keep herself fit. When she is not plunging into an ice bath, Olivia enjoys orienteering and adventure racing.

Niamh Clerkin

Bsc Hons Physiotherapy, PG Dip Sports Medicine
Pelvic Health Physiotherapist , Director Mna Pelvic Health

BIOGRAPHY:

Niamh is a Pelvic Health Physiotherapist originally from Ireland. She completed her BSc Hons in Physiotherapy in the UK and went on to complete a postgraduate diploma in sports medicine in New Zealand, her home since 2004. Niamh has been working as a Physiotherapist in Women's Health for over 12 years now and set up Mna Pelvic Health in Christchurch in 2021. She works out of Oxford Womens' Health alongside Dr Olivia Smart, plus a wide range of other medical and allied health team members.

"I believe working collaboratively across our professions, adopting a truly holistic approach that meet the needs of women from midlife to postmenopause is paramount to best practice"

My role is to help women find solutions to their pelvic health conditions, help them live and achieve their goals. My passion is in pelvic floor rehabilitation, exercise prescription, management of GSM, prolapse and incontinence conditions.

We can truly empower women to navigate this journey by educating them , helping them priorise their own health and , regain confidence and the skills at living positively throughout this phase of life.

SUNDAY 3 SEPTEMBER
Plenary 7

Sonia's Snippets

Dr Sonia Davison

Monash University and Jean Hailes for Women's Health

BIOGRAPHY:

Dr Sonia Davison MBBS FRACP PhD, is an Endocrinologist with a special interest in Women's Health.

She is a Clinical Fellow at Jean Hailes for Women's Health and has an adjunct appointment at the Women's Health Research Program, Monash University, Victoria, Australia. Sonia is in private practice at the Melbourne Endocrine Clinic, Malvern, and at Jean Hailes for Women's Health. Her PhD and postdoctoral research examined sex steroid physiology in women, including measurement of androgens and their relationships with age, mood, sexual function and cognition. Sonia is Past President of the Australasian Menopause Society and former editor of its newsletter, 'Changes'.

ABSTRACT:

A summary of the latest clinical trials in the area of menopause/women's midlife health will be presented.

Health system utilisation and preferences: early trends from the inaugural VITAL peri-/menopause registry of Australia

***A/Prof. Erin Morton*[1]**, *Dr Kelly Teagle*[2], *Dr Linda Dear*[3], *Dr Emma Rees*[4], *Johanna Wicks, Naomi Reeves, Dr Maria Alejandra Pinero de Plaza*[1], *Katie Harris*[5], *Dr Liz Buckley*[1], *A/Prof Murthy Mittinty*[1], *Gillian Mason*[6], *Janey Barrow*[1], *Dr Laura Edney*[1]

[1]*Flinders University, Bedford Park, Australia*

[2]*Wellfemme – Women's Health Services, Weston , Australia*

[3]Menodoctor, Bethlehem, NZ

[4]*Femma, Perth, Australia*

[5]*Zebra Research, Sydney, Australia*

[6]*University of Newcastle, New Lambton Heights, Australia*

BIOGRAPHY:

A/Prof Morton is an internationally renowned researcher with >20 years' experience in clinical trials, health data, & ANZ clinical quality registries, with impact on international guidelines in 3 disciplines to date. Upon developing lived experience of peri-/menopause, she brought together a national stakeholder consortium of >250 experts to advise on her VITAL inaugural peri-/menopause registry concept; this particular project includes Clinicians Kelly Teagle, Linda Dear & Emma Rees; consumer representatives Naomi Reeves & Johanna Wicks, digital health experts Gillian Mason, Alejandra Pinero de Plaza, & Janey Barrow, & researchers & analysts Katie Harris, Murthy Mittinty, Liz Buckley, & Laura Edney.

ABSTRACT:

Aims: To evaluate early trends in Australian health system utilisation and consumer preferences for peri-/menopause care, as reported via the inaugural Virtual reglstry of perl-/menopause in AusTrALia (VITAL).

Methods: VITAL was designed by a researcher with >20 years' clinical trials & ANZ registry expertise, with lived experience of peri-/menopause, to collate consumer feedback on peri-/menopause experiences, treatment preferences, & priorities. Enhanced by a stakeholder consortium of >250 experts, VITAL recently launched to national dissemination via innovative methodologies & cutting-edge technology, surpassing ACSQHC clinical quality registry guidelines. VITAL collates information not just on the clinical diagnosis & treatment pathways experienced, but also on the pathways consumers prefer.

Results: Analysis of VITAL registry data collected to date will include current self-reported health system utilisation and health service preferences by demographics, as advised by VITAL's peri-/menopause community.

Key Conclusions: VITAL is the inaugural Australian peri-/menopause registry, and world-first consumer-led, consumer-driven, & consumer-directed registry, to enable early insight into how well we, as clinicians & researchers, are responding to the needs & wants of our Australian peri-/menopause community. Preliminary evidence presented here provides the first evidence for health care utilisation and preferences for this cohort.

Role of psychology in the perimenopause and menopause. Greater collaborative care enhances patient outcomes

***Ms Jacinta Grima*[1]**

[1]Private Practice, Australia

BIOGRAPHY:

Jacinta Grima has over fifteen years experience as a clinical psychologist working across the lifespan including children, adolescents and families in urban, regional and rural locations.

She has trained in various psychological therapies and takes a family systems and attachment perspective. She understands that good formulation considers all relevant biopsychosocial considerations and supervises and teaches a range of psychologists, including registrars.

She is a member of the Australian Clinical Psychology Association, the Australian ADHD Professionals Association and an Associate Member of the Australasian Menopause Society. Jacinta has held academic appointments as an Adjunct Fellow Academic with Western Sydney University.

ABSTRACT:

The perimenopause and menopause are largely misunderstood in terms of symptoms that can arise. Greater awareness of the biological changes and wider psychosocial issues for woman juggling multiple demands at this time of biological change are needed.

Aims: Psychologists can assist in providing support, differential diagnosis, and enhancing awareness of putting the 'bio' in biopsychosocial models. Cases will be discussed with respect to how an understanding of this period can enhance treatment outcomes for woman and the wider family system.

Conclusion: The need for enhanced collaborative care with medical professionals is considered.

Medicinal Cannabis and Treatment of Menopause Symptoms

Prof. Kylie O'Brien[1,2]

[1]*NICM Health Research Institute, Western Sydney University, Westmead, Australia,*

[2]*Torrens University, Adelaide, Australia*

BIOGRAPHY:

Kylie has had a strong academic career in Chinese medicine, integrative medicine and since 2018 medicinal cannabis (MC), previously holding senior leadership positions in the Australian university and private education sector. One of Australia's leading MC educators, she led an observational study investigating the effectiveness/safety of MC in Australians with chronic pain, anxiety, PTSD and MS, and has published two books to date: O'Brien & Blair, Medicinal Cannabis and CBD in Mental Healthcare (Cham: Springer, 2021) and O'Brien and Sali, A Clinician's Guide to Integrative Oncology: What You Should Be Talking About with Cancer Patients and Why (Cham: Springer, 2017).

ABSTRACT:

Cannabis sativa has had a long history of use in many cultures throughout the world, including for women's health problems. An ancient Chinese medicine text, the Shen Nong Ben Cao Jing, contains one of the oldest medical records of medicinal cannabis (MC) in China, and one of the indications for MC mentioned is female reproductive tract disorders. In the US in 1889, Dr John W Farlow wrote of the use of cannabis suppositories to mitigate menopause symptoms. Surveys of perimenopausal and menopausal women indicate they are using MC to alleviate menopause-related symptoms, including sleep disturbance, depression and anxiety. MC has over 540 constituents, with key phytocannabinoids being cannabidiol (CBD) and tetrahydrocannabinol (THC), and over 200 terpenes isolated. The physiological basis for why MC may work is our endocannabinoid system (ECS), an important neuroregulatory and immunoregulatory system responsible for homeostasis of most bodily systems. Components of the ECS are found in the brain, organs including female and male reproductive organs, immune cells and more. This presentation will explain the ECS and examine some of the scientific evidence that suggests MC may be useful in addressing some of the symptoms associated with perimenopause and menopause.

Lifestyle & Complementary medicine influence on cognition at Midlife

Ms Sandra Villella[1]

[1]*Jean Hailes For Women's Health, East Melbourne, Australia*

BIOGRAPHY:

Sandra Villella has been practicing as a naturopath for three decades in private practice and has been the consultant naturopath at Jean Hailes for women's health since 1999. She works as part of a collaborative health care team with general practitioners, medical specialists and other allied health professionals, and she is responsible for the development of educational resources on complementary medicine and therapies for women, for the website, national magazine, webinars and seminars, for both the general public and health professionals. She also creates recipes for the "Jean Hailes kitchen" which provide health based nutritional educational messages.

ABSTRACT:

Changes in cognitive function are commonly reported during the menopausal transition, and impact quality of life. Concern is often expressed about whether these changes may be signs of more serious cognitive disorders.

Exploration of the evidence for lifestyle factors, diet, herbal medicines, nutraceuticals to address cognitive decline will be explored. A review of the literature for soy isoflavones (SIFs) impact on cognitive function, particularly memory will be presented. SIFs are selective oestrogen receptor modulators with a selective binding to oestrogen receptor Beta, which are highly expressed in the brain. Research demonstrates benefit particularly in those who are equol producers and suggests a window of opportunity in initiating SIFs use.

Midlife conversely, is also the ideal time to address the modifiable risk factors for dementia. Interventions to address these risk factors are associated with significant decreased dementia risk. More recently hyperhomocysteinemia, psychological stress and heavy drinking have been associated with elevated dementia risk. Higher adherence to the Mediterranean diet is associated with decreased risk of dementia.

A snapshot of the research will help inform of the lifestyle, diet and complementary factors that influence cognition during the menopausal transition.

The DHED prodrug selectively delivers 17-beta-estradiol to the brain-an alternative HRT approach for metabolic dysfunction?

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BIOGRAPHY:

Final year PhD candidate in the Centre For Neuroendocrinology and Department of Anatomy at the University of Otago. Research interests include estrogen delivery in metabolism and ageing, alternative hormone replacement therapy agents in menopause and the neuroendocrine control of metabolic dysfunction.

ABSTRACT:

Hormone replacement therapy (HRT) is prescribed for menopausal symptoms including hot flushes and weight gain and contains estrogens such as 17-beta-estradiol (17βE2). However, estrogen receptor activation by HRT can increase reproductive cancers and cardiovascular event risk in some patients. As protective metabolic effects of 17βE2 are mediated through the arcuate nucleus of the hypothalamus, restricting 17βE2 actions to the brain could serve as a safer mechanism of HRT.

10β,17B-dihydroxyestra-1,4-dien-3-one (DHED) is a prodrug of 17βE2 which is enzymatically converted to estradiol exclusively within the brain. DHED has demonstrated positive benefit in rodent models of hot flush, cognitive decline and stroke. We hypothesise that DHED treatment in female mice will act within the hypothalamus to provide the same beneficial metabolic effects as 17βE2, while avoiding peripheral actions.

Female mice on a high fat diet (to induce metabolic dysfunction) were split into either control, DHED, or 17βE2 treatment groups. Body weight, uterus weight and glucose tolerance was recorded along with estrogen and progesterone receptor expression in the brain. Findings to date indicate that DHED does not elicit the same protective metabolic effects of 17βE2, suggesting that further drug dosage optimisation is required to assess DHED's potential to improve metabolic dysfunction.

Ovarian hyperthecosis and Leydig cell tumour presenting with virilisation and isolated increase in testosteronet

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[3]*PathWest Laboratory QEII, Nedlands, Australia*

BIOGRAPHY:

Dr Kirsty Fisher is an Advanced Trainee in Endocrinology in Western Australia. She completed her medical degree at the University of Otago before moving to Western Australia in 2009. She completed her Advanced Training in General Medicine but was drawn to Endocrinology and has returned to training. She enjoys all aspects of general endocrinology and has an interest in reproductive endocrinology and metabolic medicine.

ABSTRACT:

A 46-year-old female was referred with a 2-year history of weight gain, irregular menstruation and progressive virilisation. History included atypical endometrial hyperplasia, polycystic ovarian syndrome, fatty liver, impaired fasting glycaemia, and morbid obesity. Serum testosterone level was 19.3nmol/L (<2.0) with otherwise normal androgens. Luteinizing hormone (LH) and follicle stimulating hormone (FSH) were within normal pre-menopausal reference range, oestradiol 154 pmol/L, progesterone <1 nmol/L. Pelvic ultrasound reported a displaced Mirena, a 5mm myometrial cyst, ill-defined endometrium, and normal ovaries. Computed tomography (CT) abdomen and pelvis was normal. Given the endometrial abnormalities, symptom severity, and patient being within menopausal age, bilateral salpingo-oophorectomy and hysterectomy was considered the best management option. Testosterone rapidly normalised post-operatively. Histopathology revealed dual pathology; bilateral ovarian stromal hyperthecosis and ovarian Leydig cell tumour.

Hyperandrogenism requires careful consideration, particularly with rapid onset symptoms, features of severe androgen excess, overt virilisation, very high androgen levels, or severe insulin resistance. The diagnosis of ovarian androgen-secreting tumours can be difficult, with significant overlap in biochemical and clinical parameters when compared to non-tumour ovarian, adrenal, or metabolic-associated hyperandrogenism. In addition, they are frequently radiologically occult. Although commonly benign, they are associated with significant morbidity and are curable with surgical resection.

Case Study: Exploring perimenopause for a wāhine Māori through a culturally safe lens

Dr Samantha Newman[1,2,3]

[1]*FemaleGP, Napier, New Zealand*

[2]*Honorary Lecturer, University of Auckland, New Zealand*

[3]*Adjunct Associate Researcher, University of Monash, Australia*

BIOGRAPHY:

Samantha runs a Womens Health Practice, FemaleGP in Napier, NZ and is an Honorary Lecturer of the University of Auckland, an Adjunct Research Associate at Health and Research Centre at the University of Monash, is an Accredited Forensic Examination for MEDSAC and does a couple of tenths of General GP at a local practice.

Samantha loves being able to integrate hormonal health into General Practice concepts.

ABSTRACT:

Case Study: Exploring the experience of perimenopause for a wāhine Māori through a culturally safe lens.

Aim: This case explores the experience of perimenopausal hormone treatment in a wāhine Māori.

Background: There are studies about menopause symptom management of women in New Zealand and reviews on the need for cultural safety rather than cultural competence, but there is limited data on how cultural safety can be integrated into menopause management for wāhine Māori .

Methods: Patient case study method was used. The case is presented and contextualised in menopause medicine in Aotearoa New Zealand.

Findings: Four aspects relating to the patient's experience demonstrate the value of cultural safety in menopause medicine. These are menopause as a part of the whole health journey of life, whanau [family] involvement, equal power balance between clinician and patient, and knowledge and understanding of the health experience. Concepts are discussed in the context of patient experience, medical practice and the literature on cultural safety.

Conclusion: Cultural safety should be integrated into menopause management. There is a complex interplay between Māori culture, personal experience of own culture, and health beliefs. The open exploration of the biopsychosocial model by the clinician can facilitate patient led care.

Symposia

Breakfast Symposium:
Sponsored by Besins Healthcare

Saturday 2 September
0715 – 0815

Topic: From Menopause to Menopeaks

Speaker: Allie Pepper

Breakfast Symposium:
Sponsored by Astellas

Sunday 3 September
0715 – 0815

Topic: How well do you know Vasomotor Symptoms (VMS)?

Speaker: Professor Rodney Baber & Professor Bronwyn Stuckey

General Information

CONGRESS VENUES

Millennium Hotel Queenstown - 32 Frankton Road, Queenstown 9300, New Zealand
Copthorne Hotel and Resort Queenstown Lakefront

REGISTRATION DESK

The registration desk will be located in the Millennium Lobby at the Box Office on the ground level from the following times. The desk will be attended at all times through the congress. Delegates should collect their satchel and name badge on arrival. Admission to all sessions, catering and Welcome Reception is by name badge only.

Friday 9 September: 7.30am

Saturday 10 September: 8:15am

Sunday 11 September: 8:15am

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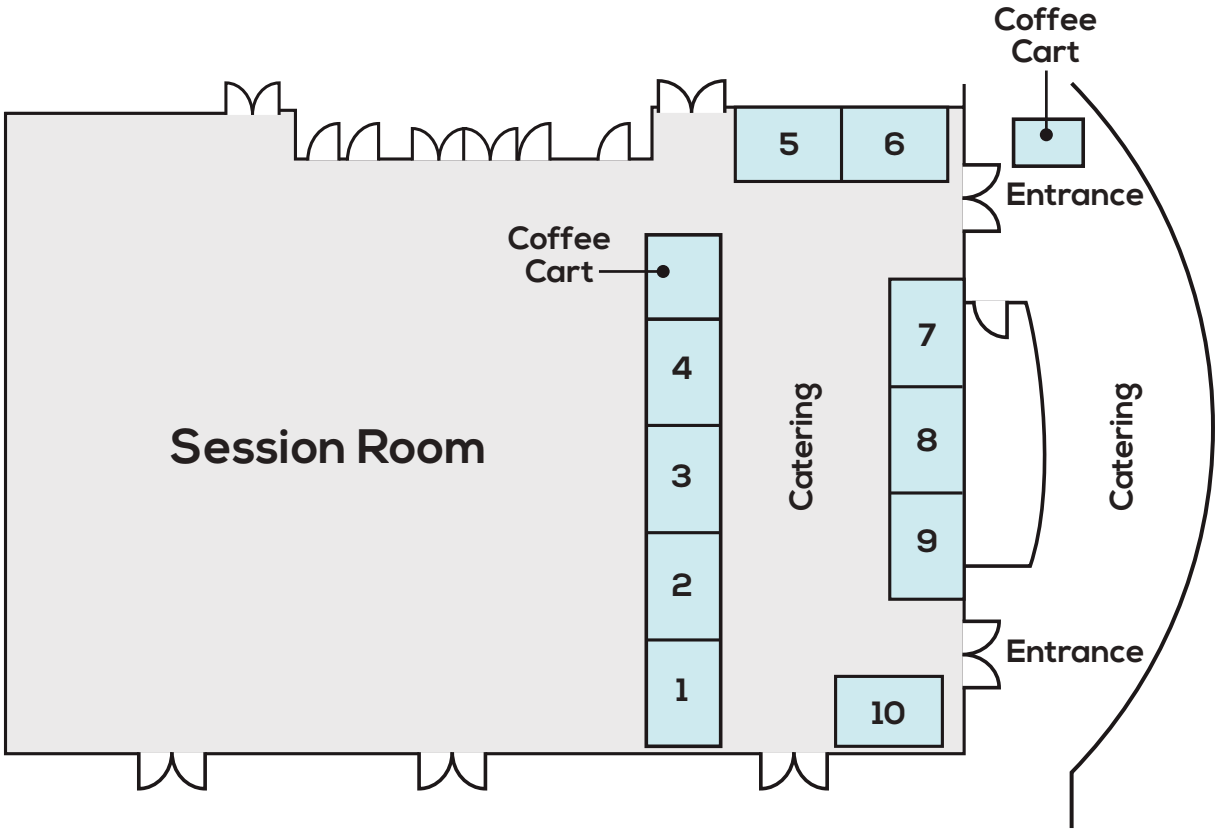

Booth	Organisation
1	Australasian Menopause Society
2	Promensil
3 & 4	Astellas Pharma Australia
5	Orion Pharma
6	Novo Nordisk
7 & 8	Pharmaco
9	Lawley Pharmaceuticals
10	Bayer