NAMS
THE NORTH AMERICAN MENOPAUSE SOCIETY

Menopause *e*-Consult®

Volume 11, Issue 1 (January 2015)

This clinical e-newsletter from The North American Menopause Society (NAMS) presents questions and cases commonly seen in a menopause specialist's practice. Recognized experts in the field provide their opinions and practical advice. Chrisandra L. Shufelt, MD, the Editor of *Menopause e-Consult*, encourages your suggestions for future topics. Note that the opinions expressed in the commentaries are those of the authors and are not necessarily endorsed by NAMS or Dr. Shufelt.

Question:

Proper immunization can reduce morbidity and mortality from a variety of infectious diseases. Given the effect of preventive immunization, what are the major vaccines recommended for women around the time of menopause?

Commentary by:

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There are excellent guidelines in Canada and in the United States for immunization. However, in both countries there remains a significant immunization gap. The US National Vaccine Advisory Committee (NVAC) updated its recommendations in 2014[1] and acknowledged the barriers to adult vaccination, including the lack of knowledge by patients and providers, medical management of acute illness taking priority over preventive services, complicated payment issues such as out-of-pocket costs, and the fact that patients see multiple providers who may not be immunizers, thus complicating coordination of care.

To respond to these issues, NVAC has made a number of recommendations, including:

1. All providers should incorporate immunization needs into every clinical encounter.

2. Providers who do not offer immunizations should establish referral relationships with providers who offer immunizations.

3. Providers who offer immunizations should assess immunization in every patient encounter, strongly recommend the appropriate vaccines, and maintain appropriate records.

Thus, the responsibility for immunization is widespread and includes nurses, pharmacists, and public health personnel, as well as specialists and primary care providers.

What are the current recommendations for menopausal women?[2-4] In the United States, the major guidelines are from the Advisory Committee on Immunization Practices (ACIP), whereas in Canada, the guidelines are from the National Advisory Committee on Immunization (NACI). Both committees set the national standard of care for immunization.

1. **Influenza**. The recommendation for both countries remains an annual immunization. There are various vaccine choices, including trivalent inactivated vaccine, a new quadrivalent inactivated vaccine, a live attenuated influenza vaccine, and a vaccine with an adjuvant for stimulating a better response in older patients.

2. **Tetanus, diphtheria, and acellular pertussis** (Td, Tdap). A one-time dose of Tdap (Boostrix by GlaxoSmithKline or Adacel by Sanofi Pasteur) is recommended for all adults who have not received Tdap previously or for whom vaccine status is unknown, to replace one of the 10-year Td boosters. There are specific recommendations for pregnant women at more than 20 weeks' gestation, adults (regardless of age) who are close contacts of infants younger than 12 months, and all healthcare personnel.

3. **Zoster vaccine** (Zostavax, Merck). This vaccine is recommended for patients aged 60 years and older, based on the Shingles Prevention Study, which showed a 51% reduction in incidence of disease and a 66% reduction of postherpetic neuralgia. Currently, a single dose of this live virus vaccine is recommended for immunocompetent patients. The vaccine is approved for patients aged 50 years and older by FDA, and per the NACI guidelines it can be used for patients in this age range. Remote diagnosis of shingles is not a contraindication for immunization. With a recent episode of shingles, most experts suggest waiting a minimum of 1 year before vaccination.

4. **Pneumococcal vaccine**. (Pneumovax 23, Merck or PCV13/Prevnar 13, Pfizer) All patients aged 65 years and older should be immunized for pneumococcal disease. Although there are changing guidelines as to when to use each vaccine, there are various differences: Pneumovax 23 is a polysaccharide vaccine that covers 23 subtypes of the bacteria, and PCV13 is a conjugate vaccine that covers 13 subtypes. In general, polysaccharide vaccines given once as booster doses are not effective. Polysaccharide vaccines stimulate immunoglobulin M antibodies. Conjugate vaccines stimulate immunoglobulin G antibodies, with long-lasting immunity. The most recent ACIP guidelines recommend that:
    a. Adults aged 65 years and older who have not had pneumococcal vaccine should receive PCV13 first, followed by Pneumovax 23 no sooner than 8 weeks later.
    b. Adults aged 65 years and older who have already had Pneumovax 23 should receive a dose of PCV13 1 year later.
    c. Pneumococcal vaccine is recommended for those aged younger than 65 years, depending on their individual risk factors for disease and underlying immune status.

5. **Hepatitis A and B**. These vaccines are recommended because mortality from hepatitis increases with age. Furthermore, given the issues of weight gain and subsequent diagnosis of fatty liver and metabolic syndrome in women around the time of menopause, there is significant benefit in decreasing the risk of this viral infection.

6. **Human papillomavirus (HPV) vaccine**. In Canada, HPV vaccine has been recommended for women aged older than 26 years who are at risk for the disease. Though approval of the vaccine by Health Canada is for those aged 9 to 45 years, NACI has not set an upper age limit for women at risk of acquiring HPV. The vaccine is also recommended in those who have had cervical disease, for a reduction in risk of recurrence, as well as a decreased potential risk of other genital cancers and anal cancer.

Ultimately, it is a provider recommendation that will have the most effect in patient uptake of vaccine. If the provider does not strongly recommend vaccine, the patient is poorly informed and may think it is not essential. With adult vaccines, we must understand that the goal is not to eradicate disease, as we do with childhood vaccines, but rather to attenuate the disease, decreasing morbidity and mortality. Thus, the public and the physician need to understand that if, for example, influenza is targeted by the vaccination, a person may still

experience a flu-like illness; however, the likelihood of hospitalization or death from influenza is dramatically reduced. Realistic expectations will help increase public confidence in this ongoing effort and excellent preventive process.

Disclosure: Dr. Brown reports: Consultant/Advisory Board: Merck, Bayer, Novartis, Novo Nordisk, Pfizer. Grant/Research Support: Bayer, Novartis. Speaker's Bureau: Merck. Speaking Fee/Stipend: Merck, Bayer, Novartis, Novo Nordisk, GlaxoSmithKline, Pfizer.

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Case:

A 51-year-old low-income patient without insurance seeks relief for hot flashes. How would you advise her?

Management Issues by:

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In caring for this patient, the evaluation of risk factors should be undertaken through careful history and physical examination. Treatment options should be chosen according to risk factors and the ability to afford therapy. The North American Menopause Society (NAMS) offers online patient information and handouts, including *MenoNotes*, which are free of charge. They include discussions of lifestyle changes, nonprescription remedies, and prescription drugs, all of which may be useful in lessening vasomotor symptoms associated with menopause.[1] Guidelines established recently by NAMS,[2] as well as the new *MenoPro* smartphone app, may be useful in making treatment recommendations. In particular, it may be useful to counsel women regarding smoking cessation for management of symptoms. If there is a history of childhood abuse or neglect, which increase the risk of vasomotor symptoms as well,[3] a woman may need help in arranging psychological counseling.

Should medication options be offered to our patient, there are low-cost choices. The costs of commonly used medications that are approved by FDA are listed below (some are off-label medications). These prices from the Philadelphia area were found at Goodrx.com, a free app that gives the price range of medications at local pharmacies. Prices shown here are for a 30-day supply or one package (prices include free online coupons and exclude offerings from membership pharmacies). The lowest price for each medication given is shown (as of December 14, 2014):

Type	Drug name and dose	Cost
Generic Climara	Estradiol 0.05 mg patch	$36.58
Brand name	Combipatch 0.05 mg/ 0.14 mg	$91.28
Generic Estrace	Estradiol 1.0 mg tablet	$4.00
Brand name	Premarin 0.625 mg tablet	$114.28
Brand name	Menest 0.625 mg tablet	$48.83
Brand name	Prempro 0.625 mg/ 2.5 mg tablet	$125.03
Generic Activella	Estradiol 1 mg/ norethindrone 0.5 mg	$57.77
Generic Provera	Medroxyprogesterone acetate 2.5 mg	$4.00
Generic Prometrium	Progesterone 100 mg	$30.21
Brand name	Duavee	$122.58
Brand name	Brisdelle 7.5 mg	$145.00
Generic Paxil	Paroxetine 10 mg tablet	$4.00

Generic Effexor	Venlafaxine XR 75 mg tablets	$14.36
Generic Lexapro	Escitalopram 20 mg tablets	$11.50

In the Study of Women's Health Across the Nation, there were significant increases in vasomotor symptoms among women with incomes less than $20,000 annually compared with other women. There were also more vasomotor symptoms in women with fewer years of education and who expressed greater difficulty in paying for basic needs.[4]

Out-of-pocket costs for visits to healthcare providers can be significant, especially for those with limited resources. If a woman lacks health insurance or has a budget plan that doesn't fully cover gynecologic examinations, she can expect to pay at least $125 for a basic office visit with a Papanicolaou test and pelvic examination. Additional services or tests will increase this fee accordingly.[5] Free clinics and Planned Parenthood may offer sliding-scale payments.

Access to menopause-related information may be limited in low-income women as well. Before the Women's Health Initiative, it was reported that three-quarters of a sample of US postmenopausal women aged 50 to 65 years said that they had been counseled about hormone therapy. However, women with the lowest socioeconomic status and those who did not have a primary care provider were least likely to have received counseling. The findings suggest that special efforts are necessary to provide menopause education and counseling to underserved women.[6]

We are assuming that this patient lives in the United States. If she lived in Canada, she would find that Canada's universal single-payer healthcare system covers about 70% of costs and that the Canada Health Act requires that all insured persons be fully insured, without copayments or user fees, for all medically necessary hospital and physician care. A total of 99% of total physician services are financed by the public sector.[7]

Unfortunately, our patient's options are more limited in the United States. According to the Henry J. Kaiser Family Foundation, people without insurance coverage have worse access to care than people who are insured.[8] Baseline estimates show that more than 41 million people in the United States were uninsured in 2013, before the start of the major Affordable Care Act (ACA) coverage provisions. Under the ACA in 2014, Medicaid coverage was granted to nearly all adults with incomes at or below 138% of poverty in states that adopted Medicaid expansion, and tax credits were made available for people who purchased coverage through a health insurance marketplace. Affordable access to health care will increase as more states adopt Medicaid expansion.

Enrollment data show that as of July 2014, Medicaid enrollment has grown by 8 million people since the period before open enrollment (which began in October 2013). People of color, people living in the South,[9] and people living in rural areas are especially at risk of being left out of ACA coverage expansions.[10] Gaps in coverage are experienced by a disproportionately high share of low-income women and women of color. For low-income women, the gaps in coverage are considerable, with 40% reporting that they were uninsured at the end of 2013. Twenty-two percent of black women and 36% of Hispanic women were also uninsured. Although 82% of women with private insurance go to a doctor's office for routine care, this share drops to 66% of women with Medicaid and 45% of uninsured women. Medicaid beneficiaries (23%) and uninsured women (28%) have much higher reliance on clinics than privately insured women (7%). Approximately 19 million women are uninsured. Compared with women with insurance, uninsured women have lower use of important preventive services and are 2 to 3 times as likely to forgo medical services because of cost.[11] Nevertheless, with the

exception of depression, uninsured and insured adults have similar prevalence rates of chronic illness.[12]

This patient may have a higher risk for vasomotor symptoms than a woman with a higher income. She may have higher out-of-pocket expenses for her office visit and medications than a woman with health insurance. She may also receive a lower quality of care than a woman with health insurance.

Disclosure: Dr. Steiner reports: none.

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What are your clinical challenges with immunizations? Post on our Member Forum (www.menopause.org/member-login?ReturnUrl=%2fforum) to discuss the topics from January *Menopause e-Consult*.

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