DEPRESSION
Making a psychiatric diagnosis during menopause is tricky

BY KARI OAKES

The notion that women in midlife are moody is so pervasive that entire Pinterest boards and Facebook pages are dedicated to menopause jokes. For physicians, however, it’s not always so easy to sort out when a patient who says she’s down, or short tempered, might really have major depressive disorder or another serious psychiatric diagnosis.

“The key point is that depressive symptoms are not the same as clinical depression,” said Hadine Joffe, MD, in an interview that recapped her recent presentation at the annual meeting of the North American Menopause Society (NAMS). “The causal factors and contributions to depressive symptoms and major depression are different.”

It’s not that clinical depression is a more severe extreme of milder depressive symptoms, but rather a distinct clinical entity, she said, and it’s sometimes a point that gets missed in a busy gynecology practice.

Practically speaking, this means two things. The first message is that treating common menopausal symptoms can have a positive impact on mood. However, it’s also true that clinicians must be educated and vigilant about more serious mood symptoms, and not expect major depression to lift when a patient starts hormone therapy, according to Dr. Joffe, a psychiatrist and director of the women’s hormone and aging research program at Brigham and Women’s Hospital, Boston.

Using a novel experimental model, Dr. Joffe and her coinvestigators recently completed work that examined the relationship among daytime and nighttime hot flashes, sleep disturbance, and mood changes. In a small study of 29 healthy premenopausal women, they tracked mood, hormone levels, and sleep fragmentation both before and after suppressing ovarian function with a gonadotropin-releasing hormone agonist. The study found independent and significant effects on mood for nighttime (but not daytime) hot flashes, as well as subjective sleep disturbance (J Clin Endocrinol Metab. 2016;101[10]:3847-53).

“We were struck by the fact that the nighttime hot flashes, separate from the sleep problems, contributed to mood symptoms,” Dr. Joffe said.

This study, though small, validates and extends the notion that multiple symptoms of the menopausal transition contribute to the mild mood symptoms that are common during this phase of a woman’s life, said Dr. Joffe. To date, most of the studies have been large epidemiologic studies, which while important, tend to assess people at one cross-sectional time point annually, and can’t always capture a nuanced and precise view of symptoms and how they relate to hormone levels, she said.

“Perimenopausal hormone changes are dynamic,” said Dr. Joffe, and have wide interindividual variation during the menopausal transition. Overall, though, she said, “clinical studies show that mood is better as ovarian activity is more normalized in perimenopausal women. Conversely, the more abnormal the hormonal profile, the worse the mood.”

Major depression is another story, said Dr. Joffe. “Menopause-specific factors have not, for the most part, been linked,” she said, noting that the best predictors for clinical depression in midlife that have been identified to date are a previous history of clinical depression or anxiety, as well as other traditional psychiatric risk factors such as low socioeconomic status and a low level of social support.

“People often present with all these symptoms all at once; they have mood disturbances, they have hot flashes, they have sleep disturbances. For the people experiencing these symptoms, it matters a lot to be able to have an explanation that’s credible, and defendable, and evidence based,“ Dr. Joffe said. “And it also has implications for treatment, of course.”

This real-world complexity inevitably intrudes during a clinical encounter, and it’s not an easy task, or a quick one, to tease apart the extent to which the menopausal transition is contributing to depressive symptoms when women have so many other potential stressors.

“At the same time that someone in her mid-40s...
to early 50s is starting to have vasomotor symptoms at night, poor sleep, fatigue, she also typically has an elderly parent making demands, a midlife partner who may be making demands, and it is highly likely that she has adolescent or young adult children who need help as well,” said Jan Shifren, MD, director of the Massachusetts General Hospital Midlife Women’s Health Center, Boston. When you add work to the mix, “this is a highly stressful time psychosocially,” she said.

While acknowledging that it’s very difficult to unpack this in a brief clinic visit, Dr. Shifren also emphasized that it’s critically important. For patients with mild depressive symptoms, hormone therapy or other treatment to address vasomotor symptoms, along with evidence-based treatment of sleep problems, can be of real help.

“That’s very different from women who come in with real depression,” Dr. Shifren said in an interview. “It’s very important not to say, ‘Oh, that’s just a little bit of perimenopause.'”

Owen Montgomery, MD, chair of the department of obstetrics and gynecology at Drexel University, Philadelphia, agreed. Many clinicians who provide care to women during the menopausal transition are not comfortable administering and interpreting objective measures of symptoms of depression – one of the most reliable ways to distinguish a woman who has depressive symptoms from one who’s clinically depressed,” he said.

“There is not enough education of general providers about the nuances of mood changes and mental health of women in midlife,” Dr. Montgomery said in an interview. “These are nicely dealt with in publications of the North American Menopause Society,” he said, also noting that the ob.gyn. residency curriculum at Drexel University includes specific modules to address the menopausal transition and menopause. “If you are going to be caring for women in transition, you probably should do a little deeper dive,” he said.

“My advice for clinicians is don’t do this alone,” Dr. Shifren said. If clinicians feel they lack expertise in diagnosing and managing mood disorders, they should establish collaborative relationships with colleagues in mental health. “We can still help with hormone management, sleep management, and keeping in touch with the patient,” she said.

One trick of the trade is to use your nursing staff to follow up with patients, Dr. Shifren said. She will ask a nurse to make a follow-up phone call 2-6 weeks after a patient visit to assess how the woman is faring with symptoms and any treatments that have been initiated or modified. The interval and intensity of follow-up can be modified based on feedback from this call, she said.

The bottom line for Dr. Montgomery is twofold: "Being menopausal does not make you depressed," he said. "True clinical depression is a rare event, but one that should not be missed."

Dr. Joffe reported consulting agreements with several pharmaceutical companies, and grant support from Merck for research related to vasomotor symptoms and insomnia. Dr. Montgomery reported no relevant financial disclosures. Dr. Shifren reported that she has a consulting agreement with the New England Research Institutes.

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