Nice guidelines menopause

I'm not robot!

A woman's relationship with the menopause is complicated…

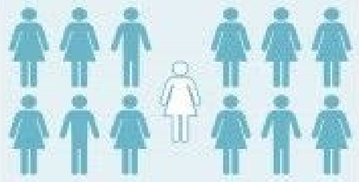
Three quarters of women* in the United Kingdom say that the menopause has caused them to change their life and more than half say it has had a negative impact on their lives.**

Work can be a struggle

45% of women say they feel their menopause symptoms have had a negative impact on their work

47% who have needed to take a day off work due to menopause symptoms say they wouldn't tell their employer the real reason

Social lives can take a back seat



Over **33%** of women feel less outgoing in social situations

32% of women feel they are no longer good company

23% of women feel more isolated

Sex can be off the menu

51% of women say that their menopause had affected their sex lives

42% of women also say they just didn't feel as sexy since experiencing the menopause

Partners are left feeling helpless

38% of partners say they feel helpless when it comes to supporting their partner through the menopause

28% of partners say they often end up having arguments "because they don't understand what she is going through"

* Either currently experiencing menopausal symptoms OR have experienced menopausal symptoms within the last ten years

** When menopause symptoms strongly affected their life

About the findings in this infographic: On behalf of the British Menopause Society, Edelman Intelligence conducted online interviews with 1,000 adults in the UK (698 women and 302 men) who were aged 45+ and either peri-menopausal, menopausal or post-menopausal or partners of those who are in a relationship with a woman who is either peri-menopausal, menopausal or post-menopausal, nationally representative of the online population in terms of regional spread.

For further information and support, including our telephone and email advisory service – please visit:

www.womens-health-concern.org

www.womens-health-concern.org
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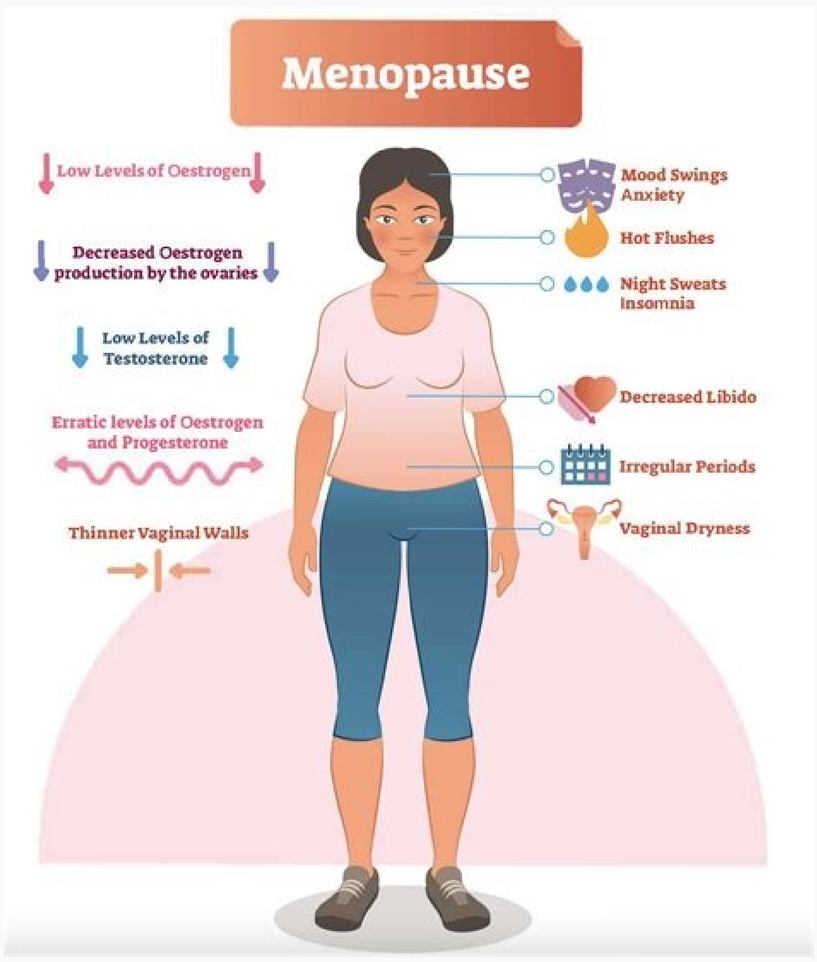
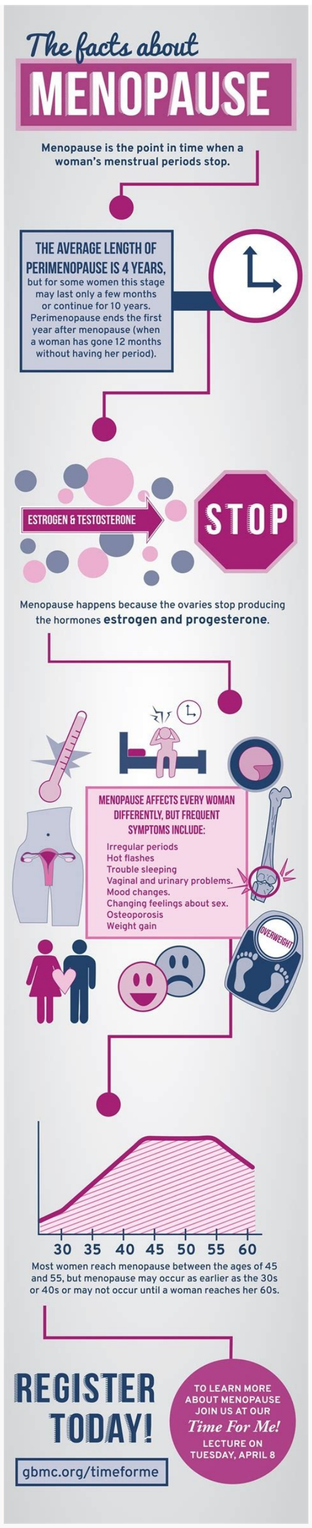
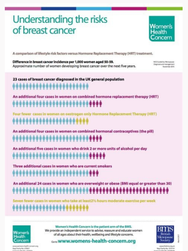
October 2017



HRT=hormone replacement therapy; LNG=levonorgestrel-releasing intrauterine system; SSRI=selective serotonin reuptake inhibitor.





Nice guidelines menopause testosterone. Nice guidelines menopause 2022. Nice guidelines menopause checklist. Nice guidelines menopause symptoms. Nice guidelines menopause pdf. Nice guidelines menopause antidepressants. Nice clinical guidelines menopause. Nice cks guidelines menopause.

See guidance for the public on "Menopause: diagnosis and management" (NG23) from the National Institute for Health and Care Excellence (NICE). Treament for symptoms of the menopause See our patient information leaflet on Treatment for symptoms of the menopause. Menopause hub Our information hub about menopause and women's health in later life brings together a range of resources that will help you find out more. The ‘scope’ of the menopause guideline, published on Friday 27 May, sets out new areas of evidence which NICE will look at and consider either making new recommendations or updating existing ones. The following areas have been identified for inclusion in the scope: Managing menopausal symptoms. Cognitive behavioural therapy to manage symptoms associated with the menopause. Interventions to manage genitourinary symptoms associated with the menopause. Effects of hormone replacement therapy on overall health outcomes. The surveillance and scoping process did not identify any substantive new evidence on using testosterone beyond the current recommendations in the NICE guideline for using testosterone for altered sexual function. NICE discussed the need for evidence in this area with the National Institute for Health and Care Research (NIHR) who have agreed to scope new research. Dr Gail Allsopp, NICE interim chief medical officer said: “We recognise the profound impact, both physically and psychologically that menopause can have and the need for updated guidance. We are working at pace on this guideline update to ensure that its impact can be realised as soon as possible. “We work closely with our stakeholders at the interface of health and care, and after highlighting the gap in the evidence for the use of testosterone, I am delighted that our partners at NIHR have agreed to scope further research into whether testosterone helps to manage menopausal symptoms beyond altered sexual function.” Minster for Women’s Health Maria Caulfield said: “Most women will experience menopausal symptoms – some of these can be quite severe and have a significant impact on their everyday activities. “It’s crucial these can be managed effectively to enable women to continue living their lives and this step forward will ensure healthcare professionals continue to have access to the most up to date evidence and recommendations on menopause care. “Women’s health is a priority for this government, and we will set out our plans in the first ever government-led Women’s Health Strategy to level up women’s health.” Professor Lucy Chappell, Chief Executive Officer for the National Institute for Health and Care Research said: “We welcome this work by NICE to evaluate new evidence that relates to management of the menopause, and the opportunity to address gaps in the evidence base through timely research. We know that this topic is of high importance to many women and healthcare professionals, and this update should provide high-quality recommendations on best practice, not just on menopausal symptoms but also on wider health outcomes.” While we have identified a need for further research into testosterone, there are a number of areas of new evidence identified that could affect existing menopause recommendations and these will now be looked at by an independent committee of experts. The new evidence looked at in the guideline update will cover women, non-binary and trans people with menopause aged 40 and older, this will include perimenopause and postmenopause. No new evidence was identified about people with premature ovarian insufficiency, so the existing recommendations will remain in the updated guideline. It will also look at inequalities relating to protected characteristics or other characteristics that might impact people's access to care, their experience of care and their menopause process, such as age, disability, ethnicity, socioeconomic status, and gender identity. To view the scope please visit Menopause: diagnosis and management update page It’s amazing how often executives are stymied by their inability to influence others. The typical scenario involves a talented, change-oriented leader who gets a shot at a more visible role. In the process of getting stuff done, he steps on a few (very influential) toes. Over a couple of years, the executive racks up some impressive accomplishments but finds that his success is hindered by the organizational minefields his actions have sown over the years. As a result, the executive tires of the level of effort required to move things forward and decides that it’s time to move on. Getting others to do what you want them to do because they want to do it is the ultimate test of leadership skill. It’s hard to face the fact that others don’t like working with you (and it always boils down to this very personal sentiment, doesn’t it?) but once the tears, anger and denial are over, two questions remain: Is it too late to salvage these relationships, and how can I do that? It’s rarely too late to try again, although it does take a lot of time and effort because it’s easier to create impressions than change them. It may seem easier to start over at a new company, but the only sure way to put the issue to bed is by winning back those who have walked away. I have a couple of clients in this situation and, the fact is, they can change organizations but they won’t change the outcome. No matter where they go, there they are; you can change organizations, but unless you change your behavior, you’ll find yourself in a new place facing the same old problem. It’s easier to outline what to do than it is to muster the courage to get it done. The first steps require eating a lot of humble pie. Start by facing the truth of how your actions got you into trouble. Everybody has a tendency to, at first, place the blame on others. Accepting accountability requires explaining the past without using the phrases “He said…,” “She should…,” “I told them…,” “I tried…,” and so on. Next, reach out to would-be colleagues by communicating three things. First, say that you are sorry for past actions. Tell them you would like to restart the relationship. Then ask for their help in doing so. The combination of apologizing and asking for help is powerful in that it disarms the listener and asks him to verbally (and therefore, psychologically) commit to being a partner in your success. If the other party is unwilling to let go of the past, focus your efforts elsewhere. Finally, you need to learn how to understand and serve the needs of others in order to find the win-win solutions that define effective collaboration. To do so, you will need to: Understand your stakeholders. Understand the motivators of key stakeholders by discovering their current objectives, concerns and longer-term goals. Determine how to collaborate effectively by understanding their communication, decision making, and conflict management styles using tools such as the Myers-Briggs Type Indicator. Listen more empathetically. When people are emotional, they need to be heard. People hate know-it-alls who spout off with advice-giving statements that start with “you should…,” “you ought…,” “what about….” When approached with an issue, respond by reflecting the content and emotion of the other party two times (for example, “I bet that it was frustrating when you had worked so hard…”) before asking “when,” “what,” “how” type questions to understand the situation further. Avoid using “why” questions because they put others on the defensive. If conversations get heated, take a break and reconvene later—in person if possible. Uncover underlying rationale. People have a tendency to advocate their point of view (“We should use this vendor”) without providing the underlying rationale regarding information and interpretations—particularly when they are emotional. Don’t counter with your own advocacy statements (“The current system can be enhanced…”). Instead, use inquiry to understand their how they reached their conclusions (for example, “What do the customers think?” “What are the key issues?” “How will we measure success?”). Shift into productive advocacy once you have all the facts by presenting your recommendation and underlying rationale, and inviting comments or critiques (“What am I missing here?”). Apply the psychology of persuasion. In a Harvard Business Review article entitled Harnessing the Science of Persuasion, Robert Cialdini outlines six psychological principles that can help strengthen relationships and tip the scales in your favor. The principle of reciprocity, for example, discusses how important it is to give what you want to receive. Although “Do unto others” is hardly a new concept, what’s interesting is the fact that you will compel others to repay in kind if, and only if, you give something unexpected and relevant and respond to their gratitude by saying, “I’m sure you would do the same for me” rather than the more typical response, “No problem” or “My pleasure.” The remaining principles include liking, social proof, consistency, authority and scarcity, and they are useful to any leader, regardless of the circumstances. My clients, like most executives in similar circumstances, are having trouble getting off first base because of the ego hit involved with taking accountability for their actions and asking others for help. Ultimately they will be successful because they understand that is it impossible to move on without staying put and delivering against the acid test of turning around negative impressions. Susan Cramm is founder and president of Valuedance, an executive coaching firm in San Clemente, Calif. You can e-mail feedback to susan@valuedance.com. 1.4.1 Adapt a woman's treatment as needed, based on her changing symptoms. 1.4.2 Offer women HRT for vasomotor symptoms after discussing with them the short-term (up to 5 years) and longer-term benefits and risks. Offer a choice of preparations as follows: oestrogen and progestogen to women with a uterus oestrogen alone to women without a uterus. 1.4.3 Do not routinely offer selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) or clonidine as first-line treatment for vasomotor symptoms alone. 1.4.4 Explain to women that there is some evidence that isoflavones or black cohosh may relieve vasomotor symptoms. However, explain that: multiple preparations are available and their safety is uncertain different preparations may vary interactions with other medicines have been reported. 1.4.5 Consider HRT to alleviate low mood that arises as a result of the menopause. 1.4.6 Consider CBT to alleviate low mood or anxiety that arise as a result of the menopause. 1.4.7 Ensure that menopausal women and healthcare professionals involved in their care understand that there is no clear evidence for SSRIs or SNRIs to ease low mood in menopausal women who have not been diagnosed with depression (see the NICE guideline on depression in adults). 1.4.9 Offer vaginal oestrogen to women with urogenital atrophy (including those on systemic HRT) and continue treatment for as long as needed to relieve symptoms. 1.4.10 Consider vaginal oestrogen for women with urogenital atrophy in whom systemic HRT is contraindicated, after seeking advice from a healthcare professional with expertise in menopause. 1.4.11 If vaginal oestrogen does not relieve symptoms of urogenital atrophy, consider increasing the dose after seeking advice from a healthcare professional with expertise in menopause. 1.4.12 Explain to women with urogenital atrophy that: symptoms often come back when treatment is stopped adverse effects from vaginal oestrogen are very rare they should report unscheduled vaginal bleeding to their GP. 1.4.13 Advise women with vaginal dryness that moisturisers and lubricants can be used alone or in addition to vaginal oestrogen. 1.4.14 Do not offer routine monitoring of endometrial thickness during treatment for urogenital atrophy. 1.4.15 Explain to women that the efficacy and safety of unregulated compounded bioidentical hormones are unknown. 1.4.16 Explain to women who wish to try complementary therapies that the quality, purity and constituents of products may be unknown. 1.4.17 Advise women with a history of, or at high risk of, breast cancer that, although there is some evidence that St John's wort may be of benefit in the relief of vasomotor symptoms, there is uncertainty about: appropriate doses persistence of effect variation in the nature and potency of preparations potential serious interactions with other drugs (including tamoxifen, anticoagulants and anticonvulsants). 1.4.18 Discuss with women the importance of keeping up to date with nationally recommended health screening. 1.4.19 Review each treatment for short-term menopausal symptoms: at 3 months to assess efficacy and tolerability annually thereafter unless there are clinical indications for an earlier review (such as treatment ineffectiveness, side effects or adverse events). 1.4.20 Refer women to a healthcare professional with expertise in menopause if treatments do not improve their menopausal symptoms or they have ongoing troublesome side effects. 1.4.21 Consider referring women to a healthcare professional with expertise in menopause if: they have menopausal symptoms and contraindications to HRT or there is uncertainty about the most suitable treatment options for their menopausal symptoms. 1.4.22 Explain to women with a uterus that unscheduled vaginal bleeding is a common side effect of HRT within the first 3 months of treatment but should be reported at the 3-month review appointment, or promptly if it occurs after the first 3 months (see recommendations on endometrial cancer in the NICE guideline on suspected cancer). 1.4.23 Offer women who are stopping HRT a choice of gradually reducing or immediately stopping treatment. 1.4.24 Explain to women that: gradually reducing HRT may limit recurrence of symptoms in the short term gradually reducing or immediately stopping HRT makes no difference to their symptoms in the longer term. 1.4.26 Offer menopausal women with, or at high risk of, breast cancer: information on all available treatment options information that the SSRIs paroxetine and fluoxetine should not be offered to women with breast cancer who are taking tamoxifen referral to a healthcare professional with expertise in menopause.

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