

SURGICAL MENOPAUSE

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Menopause occurs naturally for most women at an average age of 51, though it is considered normal from 45 onwards. Removing both ovaries (bilateral oophorectomy) before the biological menopause will cause a woman to enter menopause immediately, and is termed "surgical menopause".

The ovaries are located on either side of the womb (uterus). They produce eggs and make the hormones oestrogen, progesterone, and testosterone. The removal of only one ovary (unilateral oophorectomy) will not usually result in menopause, although it may cause it to occur slightly earlier than it otherwise would have.

WHY DO WOMEN HAVE THEIR OVARIES REMOVED?

Removal of both ovaries can occasionally take place at the same time as a hysterectomy (removal of the uterus and cervix) when treating non-cancerous conditions such as heavy periods or fibroids (non-cancerous tumours of the uterus).¹ This is not recommended routinely unless there is a specific reason to remove the ovaries, as it is associated with an increase in some health problems, and a lack of benefit for most women.

Removal of the ovaries is part of the surgical treatment for ovarian cancer, and they will often also be removed at the time of surgery to treat uterine (endometrial) cancer.

Other reasons for removing normal ovaries are to reduce the risk of developing ovarian cancer in the future for women with inherited gene faults (BRCA1, BRCA2, or Lynch syndrome)^{2,3} and in some women with strong family histories of ovarian cancer and inconclusive genetic testing.

Removal of both ovaries may be advised in premenopausal women with some types of breast cancer as part of their cancer treatment.

Generally speaking, the removal of both ovaries should only be considered when there is a distinct benefit to the individual woman.

You should discuss with your doctor whether it is the right treatment for you, as well as what other options are available.

POTENTIAL BENEFITS OF BILATERAL OOPHORECTOMY⁴

- Reduced risk of ovarian cancer in women with inherited gene mutations.
- Possible improvement in symptoms associated with chronic conditions such as chronic pelvic pain and endometriosis.

POTENTIAL NEGATIVE IMPACTS OF SURGICAL MENOPAUSE⁴

Early:

- Surgical complications
- Loss of fertility
- Sudden development of hot flushes, night sweats and sleep disturbance
- Vaginal dryness
- Impact on sexual function due to vaginal dryness and lower desire
- Lower libido
- Bone loss
- Mental health (anxiety / depression)
- Impaired cognition / "brain-fog"

Later:

- Genito-urinary Syndrome of Menopause
- Osteoporosis
- Increased risk of cardiovascular (heart) disease

WHAT IS THE DIFFERENCE BETWEEN MENOPAUSAL HORMONE THERAPY (MHT) AND HORMONE REPLACEMENT THERAPY (HRT)?

All hormone therapy for the treatment of menopausal symptoms used to be called hormone replacement therapy, or HRT. More recently, menopausal hormone therapy, or MHT, has become the preferred term in general. This is because menopause is a natural part of life during which levels of hormones such as oestrogen and progesterone are very low. Because it's normal to have low hormone levels at this time in life, we no longer consider hormone therapy to be replacing something that is missing, but rather to be a form of hormone treatment to manage the symptoms of a normal process.

In contrast, menopause before the age of 45 (whether surgical, as a result of medications, or natural) is considered premature.

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This is a time when the body would normally have high levels of oestrogen and progesterone, but these have dropped before they should. In this case, the treatment is being used to restore these hormones to appropriate levels (or “replace” them).

HRT for women going through menopause prematurely often requires higher doses and longer durations of treatment to maintain the health benefits that the ovaries would normally be providing. The risks and benefits are also quite different.

TREATMENT OPTIONS FOLLOWING SURGICAL MENOPAUSE

Regardless of the indication for surgery, it is preferable that women be reviewed by a menopause specialist BEFORE surgery to discuss the consequences of surgery and plan for both symptom management and long-term health.

It is recommended that all women who undergo surgical menopause before the age of 45 use MHT, provided it is medically safe for them to do so. This should continue until the average age of natural menopause (51 years) and then undergo review, although treatment should be individualised in discussion with your menopause specialist.⁵

Women who have a personal history of breast cancer should generally avoid MHT, as it is associated with an increased risk of cancer recurrence. Some studies have shown that MHT is safe for women who have surgical menopause due to being at high genetic risk of breast cancer (i.e. carriers of BRCA1 and 2).⁶

MHT is highly effective in treating hot flushes and sweats for most women, as well as maintaining bone mineral density. Women who retain their uterus require both oestrogen and progesterone combined. If women have had a hysterectomy, then oestrogen-only MHT is prescribed. The exception here is for those women who undergo surgical menopause to treat extensive endometriosis. Unopposed oestrogen may reactivate residual disease, so these women will often use combined MHT.

There are a range of non-hormonal options available to assist with symptom management for those women who either cannot or choose not to take MHT following surgery. They are generally less effective than oestrogen for managing menopausal symptoms, and do not address the other health concerns of an early menopause.

Further information visit:

- [Menopausal Hormone Therapy \(MHT\): The new HRT](#)
- [Non-hormonal options to MHT](#)
- [MHT and breast cancer](#)

WHEN TO START MHT

Women should start their MHT within the first week of surgery, provided it is medically safe to do so. Some patients who are at an increased risk of venous thromboembolism (blood clots) may be advised to delay the commencement of MHT, or use a transdermal preparation rather than an oral one. Follow up is generally arranged at 6–8 weeks to assess response to treatment and emerging concerns.

Testosterone may be added to MHT for those women who are bothered by a decline in their libido.⁷

Further information visit:

[Starting and stopping MHT](#)

FOLLOW-UP CARE

It is important to have regular follow up with a clinician who is experienced in the management of early menopause. Ongoing care will include regular reviews of general health, advice on optimising wellbeing, and investigations as required.

This can include:

- General healthy living advice includes attention to exercise (including weight-bearing exercise), smoking cessation, alcohol consumption, diet and maintaining a healthy weight
- Ensuring adequate calcium and vitamin D
- Monitoring bone density, which may include a bone mineral density scan
- Monitoring of risk factors for cardiovascular disease, such as blood pressure, cholesterol and glucose levels
- Supporting emotional wellbeing

Further information visit:

[Lifestyle changes](#)

Additional resources:

[Pink Hope](#)
[The Daisy Network](#)
[Ask Early Menopause](#)
[Cancer Australia](#)

References

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7. Martínez-García & S. R. Davis (2021) Testosterone use in postmenopausal women, Climacteric, 24:1, 46–50, DOI: 10.1080/13697137.2020.1796961.