

Two approaches to enhancing patient care and job satisfaction in primary care

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For too many years, perimenopausal women have suffered in the absence of treatment, most likely due to embarrassment or fear of discredited treatments. In addition, medicine is seeing increasing numbers of patients with co-morbidities related to insulin resistance (IR), which incidentally also includes perimenopause.

I would like to describe two approaches addressing these conditions. The first is to advocate for menopausal hormone therapy (MHT). The second is a low carbohydrate diet (LCD) as a means of improving disorders related to IR. Both approaches are evidence-based and have reported improved medical outcomes and patient and doctor satisfaction.¹

Over 20 years ago, we were encouraged to advocate for hormone replacement therapy (HRT) at perimenopause. Then HRT was discredited, and it faded from our consciousness. So, I was recently surprised when asked if I would prescribe MHT for a patient. It became evident that if the necessary questions and safeguards were followed, then MHT could be safe and effective.² The Australian Menopause Society provide an excellent online resource.³ I designed a questionnaire (available on request) which lists common symptoms of perimenopause and asks relevant safety questions.

I got back to my patient, she completed the questionnaire, and we agreed to try MHT with planned follow-up after a few weeks. Subsequently, she reported a marked benefit from MHT. I next emailed all women of perimenopausal age in my practice, asking them to complete the questionnaire and consider consultation. There were a considerable number of consultations that followed. I received many positive responses from women reporting resolution of hot flushes, improved sleep and no further “brain fog”, to mention but a few symptoms. I have received comments like “I feel like I have got my life back,” and “I feel so much better”. The questionnaire has proved very useful in assessment and has assisted in joint decision-making.

Perimenopausal women can also develop central

obesity and find it very difficult to lose weight. Perimenopause is associated with IR, and it is suggested that MHT may facilitate weight loss and therefore reduce IR.^{4,5} MHT is unlikely to increase body weight. With improved symptoms, including mood, women might find the energy and motivation for lifestyle choices that might aid weight modification.

For several years I have personally adopted a LCD. I was introduced to this by a friend. It has been shown to be effective and safe, and improves many health parameters, including haemoglobin A1C, liver function and lipid profile, and is particularly good in combatting IR.^{1,6,7,8} I have been actively recommending this to patients who are overweight or have prediabetes, type 2 diabetes (T2DM), non-alcoholic fatty liver disease (NAFLD), hypertension and polycystic ovarian syndrome (PCOS), with some very positive and rewarding results.⁹ There is a growing body of evidence in support of low carbohydrate eating for management of T2DM for up to 5 years.⁸ Noakes described the scientific basis and practicalities behind a LCD.⁷ Suffice to say that there has been a good deal of patient and professional satisfaction as a result. Imagine seeing weight loss actually happen, reducing/stopping blood pressure medication and T2DM medication, witnessing T2DM reversal/remission, observing resolution of NAFLD and menstrual periods returning in PCOS, with pregnancy becoming a very real option. Patients are happy. The doctor is happy. I am more often treating patients with diet as an adjunct to or as a primary method for managing some disorders, and not just depending on drugs to improve “numbers”. I am now considering widening the approach to include a health coach in order to optimise the process and the results. It is often argued that low carbohydrate eating plans are not sustainable, but it is also obvious that this approach works for a significant number of people who can adopt it. With respect to other weight loss approaches, on a population level they do not appear to be any more sustainable, as evidenced by their apparent failure; obesity is

increasing, not decreasing.¹⁰

Being open to change is arguably quite difficult for some health professionals, and change can be daunting. I would have been as resistant as the next person about making these changes had the suggestion not come from “patient pressure” and a friend’s suggestion. Health professionals are often faced with time constraints and significant workloads that can make finding the time to research other treatments difficult. The easier path is most

likely to be chosen; therefore, that of no change. I would strongly urge all relevant health professionals to consider one or both of the therapeutic modalities described above. When I consider my retirement, I feel that I might continue working a few more years, now that these two approaches have reduced the “burden” of everyday practice by rewarding me and some of my patients with the positive feedback necessary to enhance patient care and increase job satisfaction.

COMPETING INTERESTS

Nil.

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