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Evaluation of a Shared Decision Making Intervention between Patients and Providers to Improve Menopause Health Outcomes: Issue Brief

Key Findings

- Tablet technology can be successfully incorporated into primary practices for patient-reported data collection and patient education. Patient-specific information and education can be used to enhance shared decision making (SDM); however, statistically significant differences were not realized in this study when tools designed specifically for menopause health were incorporated into tablet technology. Ideally, data collected would be auto-populated into the Electronic Health Record (EHR).
- Rates of menopause diagnosis and menopause medications (e.g., hormone therapy) increased for women 45-65 years when tablet technology was incorporated at the point of care during provider visits; however, these increased rates were not statistically significantly different between control and intervention groups.
- Women 45-65 years are very satisfied with their provider across several domains of the Ambulatory Care Experiences Survey (ACES) including: communication, interpersonal treatment, patient trust, whole person orientation and health promotion. Providers rated themselves lower than their patients in all domain areas. A majority of patients (88-93%) in control and intervention groups indicated complete satisfaction with the SDM process.
- Most women 45-65 years had discussions with their provider about menopause (72-77%), breast cancer risk (64-65%), and lifestyle modification (84-88%); however, there were no differences between the control and intervention groups.
- Half of the women completing the Menopause Rating Scale survey (127/252; 50.4%) indicated at least one severe to very severe somatic, psychological, and/or urogenital symptom. The most prevalent symptoms with >40% of women reporting moderate, severe, or very severe symptoms included muscular pain, sleep issues, depression, exhaustion and sexual symptoms. Moderate, severe, or very severe hot flashes/sweating were noted in only 32.3% of women.
- Most women (84-85%) indicated they enjoyed using the tablet, but it did not change their understanding of menopause symptoms and treatment.

Rationale and Design

Approximately half of all women 45-60 years of age experience at least one menopausal symptom or a combination of symptoms, yet only one-third of women talk about treatment options with their provider. Further, 45% of women say information about managing and treating symptoms of menopause is confusing. Hormone therapy (HT) has been proven to be the most effective treatment for vasomotor symptoms and is an acceptable option among many women up to 59 years of age; however, long-term use appears to impose greater risks than benefits. Therefore, it is equally important to ensure that women between the ages of 60-65 years discontinue HT, unless deemed appropriate by her clinician using a shared decision approach. Breast cancer risk increases with age and risk-reduction medications are recommended for women at higher risk; however, use of these medications remains low. Other treatments, including non-prescription therapies, may be more appropriate for individual situations. Women coming in and out of the menopause transition require individualized evaluation and management strategies.

The broad goal of this study was to promote SDM through the use of tablet technology among health care providers and women age 45-65 years regarding menopause, HT use and breast cancer risk. Women in the control group used tablet technology to complete surveys regarding demographics and SDM during the provider visit. Women in the intervention group used tablet technology to complete surveys regarding demographics, menopause symptoms, breast cancer risk, and SDM during the provider visit.

Primary outcomes were to:

1) Evaluate changes in documented diagnosis of menopause and
2) Evaluate patient and provider satisfaction with the SDM process.

Secondary outcomes were to:

1) Evaluate implementation success of validated health risk appraisal tools for menopause;
2) Determine rate of all prescriptions used to treat menopausal symptoms over a specific time period;
3) Determine rate of HT discontinuation in women age 60-65 years;
4) Determine rate of patients age 45-59 years that discussed menopause or menopausal symptoms with their provider;
5) Determine rate of counseling regarding breast cancer risk prevention and lifestyle changes in women age 45-65 years;
6) Determine rate of counseling regarding lifestyle changes (e.g., diet, exercise, alcohol) in women age 45-65 years; and
7) Evaluate provider knowledge regarding menopause.

Please see Appendix A: Summary table of the outcomes, hypotheses, methods and results.
Please see Appendix B: Patient demographics.

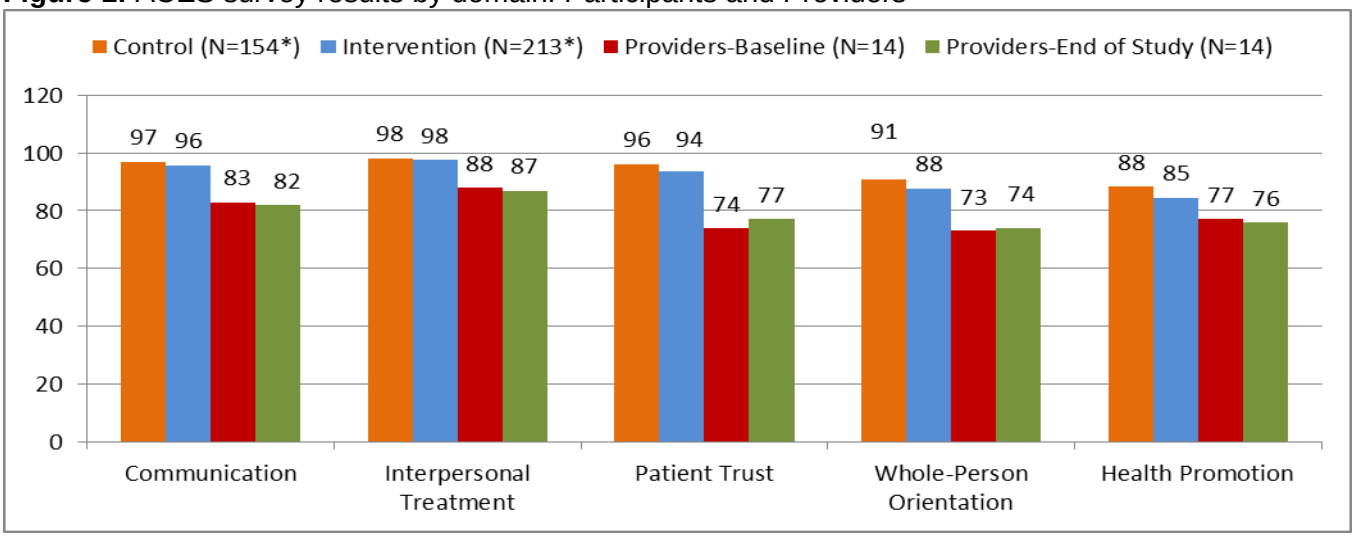
Results

Nine primary care practices and 14 healthcare providers completed the study and were included for analysis. Practices were located in Massachusetts, Pennsylvania, Georgia, Ohio, Virginia, Iowa, Connecticut, and California, and in various geographic areas: rural (2), suburban (5), and urban (2). A total of 438 unique participants completed 408 full datasets for evaluation. Patients were given the option to not answer survey questions which accounts for some differences in patient responses. *See Appendix B: Patient Demographics*

Primary Outcome 1: *Evaluate changes in documented diagnosis of menopause*
Based on the Electronic Health Record (EHR) data extraction of women 45-65 years among eligible practices (n=7), the rate of diagnosis a baseline was 8.7/100 women and at the end of the study was 10.5/100 women. The total number of women with a diagnosis of menopause was 42.8 per clinician at baseline and 70.5 per clinician at study completion (27.7 mean increase, 95% CI: (-55.2-111.4), p-value=0.44).
For practice-specific data, see practice outcomes report: Chart 1.

Primary Outcome 2: *Evaluate patient and provider satisfaction with the SDM process*
A modified version of the Ambulatory Care Experiences Survey (ACES) was used as a proxy for SDM to evaluate patient and provider experiences across the following domains: communication, interpersonal treatment, patient trust, whole person orientation and health promotion. Overall, women in the control and interventions groups rated providers very high across all five domains (range 85-98 out of 100). There were no significant differences between women in the control and intervention groups. Providers completed the ACES at three times points: baseline, six and 12 months. Providers scored themselves lower across time for each of the domains of the ACES compared with patients. See Figure 1 below.
For practice-specific data, see practice outcomes report Table A and Chart 2.

Figure 1: ACES survey results by domain: Participants and Providers



Note: *Control/Intervention population numbers are an average of respondents. Provider data is the mean of all providers at baseline and at study completion.

For patients responding to specific questions about satisfaction with the SDM process, most patients in the control and intervention groups were *completely* satisfied (143/154, 92.9% and 189/214, 88.3% respectively, p=0.15 between groups). All other patients were *somewhat* satisfied. No patients were dissatisfied.

Secondary Outcome 1: *Evaluate implementation success of validated health risk appraisal tools for menopause*

All practices were able to view the menopause health assessment report at the point of care. Practices were able to view the report by a practice staff printing the health assessment or downloading it from a secured server and directly on the tablet. Most women indicated they enjoyed using the tablet, but it did not change their understanding of menopause symptoms and treatment. The limited number of views of the videos received made it difficult to discern if videos played a major role in SDM, but warrant further consideration and research. Overall, results of survey questions related to tablet technology are shown in Table 1 below.

Table 1: Tablet Technology Implementation Outcomes	**Control (n=156)**	**Intervention (n=213)**
Participants strongly/somewhat agreed they enjoyed using the tablet	133 (85%)	179 (84%)^
Found the surveys easy to understand and answer	153 (98%)	201 (94%)^
Participants strongly/somewhat agreed they left their appointment less confused about menopausal symptoms and treatment options	106 (68%)	131 (62%)^
Early Exit Had trouble using the tablet Reported study took too long and appointment was over No longer wish to participate Feel uncomfortable with questions	4 1 (25%) 0 (0%) 1 (25%) 2 (50%)	7 2 (25%) 2 (25%) 3 (38%) 0 (0%)
Those presented opportunity to view at least one video Found the videos helpful (regarding SDM process) Complete or partial viewing of all videos offered	*N/A* *N/A* *N/A*	127/253 (50%) 43/83 (52%) 41/221 (19%)

^No statistically significant difference between control and intervention group (p>0.2).

Secondary Outcome 2: *Determine rate of all prescriptions used to treat menopausal symptoms over a specific time period*
Many women were receiving treatment for various menopausal symptoms at the time of study enrollment. (*See Appendix B: Patient Demographics*) The rate of prescriptions used to treat menopausal symptoms (e.g., HT, SSRI) increased over time among eligible practices (n=7): baseline: 6.1/100 women compared with end of study: 9.2/100 women. When looking at the rate per clinician (rather than per 100 women), the number of medications prescribed for menopause also increased with baseline at 59.2/clinician and end of study at 94.3/clinician (35.1 mean increase; 95% CI (-5.5, 66.9); p-value=0.085). Medication changes for menopausal symptoms were reported by 11/177 (6.25%) women in the control group and 27/231 (11.25%) women in the intervention group, indicating a trend toward significance (p=0.06) when the Menopause Rating Scale (MRS) data was available at the point of care. Other medication changes such as calcium and vitamin D, and allergy medication were noted, but not considered in the analysis regarding medications for menopause.
For practice-specific data, see practice outcomes report: Chart 1.

Secondary Outcome 3: *Determine rate of HT discontinuation in women age 60-65 years*
Given that all medication changes were either substitutions (e.g., discontinue oral contraceptive and initiate HT) or additions, no discontinuation of HT occurred for women age 60-65 years. Of 93 women in this cohort, only 3 women (3.2%) were taking an estrogen containing medication.

Secondary Outcome 4: *Determine rate of patients age 45-59 years that discussed menopause or menopausal symptoms with their provider*
Women age 45-59 years in the control and intervention groups reported having frequent discussions about menopause: Control: 79/106; 74.5%; Intervention: 112/142; 78.9%. There was no statistical difference between groups; p-value=0.42. Among all enrolled women (45-65 years-includes post-menopausal aged women), the majority also reported having frequent discussions about menopause: Control: 105/145; 72.4%; Intervention: 143/187; 76.5%. There was no statistical difference between the groups (p-value=0.40). See Table 2 below.
For practice-specific data, see practice outcomes report: Chart 3.

For women in the intervention group, the MRS survey and breast cancer risk assessment were presented prior to the other surveys so this health assessment report would be available at the point of care. For this reason, 252 women completed the MRS survey and 127/252 (50.4%) indicated at least one severe to very severe symptom in one of three categories: somatic, psychological, and/or urogenital. Specifically, 87/252 (34.5%) had at least one somatic severe to very severe symptom, 65/252 (25.8%) had at least one severe to very severe psychological symptom, and 69/252 (27.4%) had at least one severe to very severe urogenital symptom. The most prevalent symptoms with >40% of women reporting moderate, severe, or very severe included muscular pain, sleep issues, depression, exhaustion and sexual symptoms. *See Appendix C: Individual Symptoms*.

Secondary Outcome 5: *Determine the rate of counseling regarding breast cancer risk prevention and lifestyle changes in women age 45-65 years*
Most women 45-65 years reported having frequent discussions with their providers about breast cancer: Control: 109/167; 65.3%; Intervention: 146/187; 63.5%. There was no statistical difference between the groups (p-value=0.71). See Table 2 below.
For practice-specific data, see practice outcomes report: Chart 3.

Women (n=225) in the intervention group took the National Cancer Institute's Breast Cancer Risk Assessment Tool. The mean five-year risk was 1.61% (standard error 0.07) with a range of 0.47%-8.20%. Women with a five-year risk of 1.67% or higher are classified as "high-risk"; this score is the cut-off for the FDA guidelines recommending a risk-lowering drug (tamoxifen or raloxifene) for patients to reduce breast cancer risk.

Secondary Outcome 6: *Determine the rate of counseling regarding lifestyle changes (e.g., diet, exercise, alcohol) in women age 45-65 years*
All women (45-65 years) in control and intervention groups had very frequent discussions about lifestyle, but there was no statistical difference between groups: Control: 151/179 (84.4%); Intervention: 225/255; 88.2%; p-value=0.25. See Table 2 below. *For practice-specific data, see practice outcomes report: Chart 3.*

Table 2: Discussions between participants and providers.

Topic	Control	Intervention	P-value
Menopause (45-59 years)	79/106 (74.5%)	112/142 (78.9%)	0.42
Menopause (45-65 years)	105/145 (72.4%)	143/187 (76.5%)	0.40
Breast Cancer Risk	109/167 (65.3%)	146/187 (63.5%)	0.71
Lifestyle Modification	151/179 (84.4%)	225/255 (88.2%)	0.25

Secondary Outcome 7: *Evaluate provider knowledge regarding menopause*
Providers (n=14) completed a pre- and post-test assessment of an educational webinar designed to increase provider knowledge and impact clinical practice. There was an insufficient sample size to detect a difference, but the trend indicated improved knowledge on this assessment of 14 multiple choice questions (mean correct: pre=66%, post=74%, mean difference=0.07; 95% CI -0.008-0.16; p-value=0.07).
For provider-specific data, solo providers please see practice outcomes report: Table B. For practices with more than one participating provider, pre-post test results will be sent via email.

Discussion and Conclusions

Integration of tablet technology improves SDM opportunities to ensure higher quality medical decisions and focus health care on patients' personal values and preferences. This study evaluated the impact of improved information collection and SDM among health care providers and women age 45-65 years regarding issues of menopause, postmenopause, hormone therapy, and breast cancer risk. We aimed to improve how we assess menopausal symptoms by integrating tablet technology to measure menopause health assessment, ambulatory care experiences, and various aspects of the patient-provider visit. Questions concerning menopause, sexual health, genitourinary symptoms, and breast cancer risk are commonly asked on intake forms for annual exams; however, they are not standardized or tied to an educational intervention or treatment plan. Tablet technology is one tool that was used to facilitate this person-centered care.

Although the number of women diagnosed with menopause or postmenopause improved with the intervention, it still represented a minority of women 45-65 years and was not different between control and intervention groups. This is likely because most providers did not include a diagnosis unless women had been prescribed a medication related to menopause. We would assert that having this diagnosis readily apparent in the EHR helps to ensure re-assessment of menopausal symptoms and appropriate medication use on a routine basis.

Overall, patients reported high satisfaction with provider-patient interactions across several domains; clinician perceptions were lower. A majority of patients reported complete satisfaction with the SDM process. Providers discussed lifestyle, menopause, and breast cancer risk most of the time with their patients. This is important given that half of these women had severe or very severe menopause symptoms. In this cohort of women, the most prevalent symptoms were not hot flashes, but >40% of women experienced moderate, severe, or very severe symptoms of muscular pain, sleep issues, depression, exhaustion, and sexual symptoms. Medication use for menopause symptoms increased for patients in the intervention compared with the control group, but the difference was not statistically significant.

This study successfully integrated tablet technology into practices to assess menopause health outcomes for women age 45-65 years. It would be ideal for patient care, monitoring, and follow-up if the assessment tools within the tablet technology could readily be integrated into the EHR. This study demonstrated that tablet technology can provide effective SDM between providers and women age 45-65 years to deliver individualized and specific information regarding issues related to menopause. Future research could evaluate effective use of tablet technology for SDM processes in other medical conditions and medication use.

Appendix A: Outcomes, Hypotheses, Methods and Results

Primary Outcomes	Hypothesis	Method for Assessment	Results
1. Evaluate changes in documented diagnosis of menopause or postmenopause state	Documented diagnosis of menopause or postmenopause state will increase after physician education intervention and health risk tools discussed with patient. (Baseline: 16%; Post-intervention: 36%)	Pre- and post-intervention assessment via query of EHR for diagnosis of menopause or postmenopause in women age 45-65 years.	Rate of diagnosis of menopause increased across eligible practices (n=7): Baseline: 8.7/100 women; End of study: 10.5/100 women Total number of women with a diagnosis of menopause: Baseline: 42.8/clinician; End of study: 70.5/clinician (27.7 mean increase, 95% CI: (-55.2-111.4), p-value=0.44) *See practice level outcomes report: Chart 1.*
2. Evaluate patient and provider satisfaction with the shared decision making (SDM) process	Women and physicians will be very or completely satisfied with the shared decision making process to aid in health care decisions. (Baseline: 40%; Post-intervention: 70%)	Women will complete a brief experiences survey following the provider visit.	<u>Ambulatory Care Experiences Survey (ACES)</u> Overall, women in control and intervention groups rated clinicians very high on communication, interpersonal treatment, patient trust, whole-person orientation, and health promotion (range 85-98 out of 100) *See Figure 1 in Issue Brief.* <u>Satisfaction: SDM</u> Control group: 143/154 (92.9%) reported complete satisfaction with shared decision making process; all others were somewhat satisfied. Intervention group: 189/214 (88.3%) reported complete satisfaction with shared decision making process; all others were somewhat satisfied (p-value=0.15 between groups) *See practice outcomes report: Chart 2.*
		Providers will complete a modified ambulatory care experiences survey baseline, 6 months, and 12 months.	*See practice outcomes report: Table A.*

Secondary Outcomes	Hypothesis	Method for Assessment	Results
1. Evaluate implementation success of validated health risk appraisal tools for menopause	Validated health risk assessment tools embedded in tablet technology will be integrated into a majority of EHRs for physician viewing at the point of care. (Baseline: 0%; Post-intervention: 80%)	Determine number (%) of practices that are able to view health risk appraisal tools at the point of care (after patient completes them) in EHR.	100% of practices were able to view health assessment report in the following ways: printing the health assessment or downloading it from a secured server and directly on the tablet. Most patients enjoyed using the tablets and found the surveys easy to use. *See Table 1 in Issue Brief*
2. Determine rate of all prescriptions used to treat menopausal symptoms over a specific time period	Documented prescription use for HT and non-hormonal therapies (e.g., SSRI, SNRI, gabapentin) for menopausal symptoms will increase for women age 45-59 years. (Baseline: 28%; Post-intervention: 34%)	Pre- and post-intervention assessment via query of EHR for prescriptions of HT or non-hormonal therapy in women age 45-59 years.	Rate of prescription use increased across eligible practices (n=7); Baseline: 6.1/100 women; End of study: 9.2/100 women The number of medications prescribed for menopause; Baseline: 59.2/clinician. End of study: 94.3/clinician (35.1 mean increase; 95% CI (-5.5, 66.9); p-value=0.085. *See practice level outcomes report; Chart 1.*
		Women will be asked about therapy changes after visit with provider.	Control group: 11/177 (6.25%) had medication changes Intervention group: 27/231 (11.25%) had medication changes; p-value=0.06
3. Determine the rate of HT discontinuation in women age 60-65 years	Documented prescription use for hormone therapy for menopausal symptoms will decrease for women age 60-65 years. (Baseline: 8.6%; Post-intervention: 4%)	Pre- and post-intervention assessment via query of EHR for prescriptions of HT in women age 60-65 years. Women will also be asked about therapy changes after visit with provider.	No discontinuation of HT occurred for women age 60-65 years. The SDM process between provider and women may have deemed this treatment appropriate. Of 93 women in this cohort, only 3 women (3.2%) were taking an estrogen containing medication.
4. Determine rate of patients age 45-59 years that discuss menopause or symptoms with provider	Discussions about menopause or menopausal symptoms will increase for women age 45-59 years after taking the MRS. (Baseline: 38%; Post-intervention: 50%)	Women will be asked about discussions with their provider about menopause or menopausal symptoms after the visit.	Women age 45-59 years in control and intervention groups had frequent discussions about menopause, but it was not statistically different between groups. Control group: 79/106 (74.5%) had discussions. Intervention group: 112/142 (78.9%) had discussions (p-value = 0.42) Women age 45-65 years in control and

			intervention groups had frequent discussions about menopause, but it was not statistically different between groups. Control group: 105/145 (72.4%) had discussions. Intervention group: 143/187 (76.5%) had discussions (p-value = 0.40) *See Table 2 in Issue Brief* *See practice outcomes report: Chart 3*
5. Determine rate of counseling regarding breast cancer risk prevention in women 45-65 years	Counseling regarding breast cancer risk will increase for women age 45-65 years after taking breast cancer risk assessment. (Baseline: 20%; Post-intervention: 50%)	Women will be asked about discussions with provider about breast cancer risk after the visit.	Women age 45-65 years in control and intervention groups had frequent discussions about breast cancer, but it was not statistically different between groups. Control group: 109/167 (65.3.4%) had discussions. Intervention group: 146/187 (63.5%) had discussions (p-value = 0.71) *See Table 2 in Issue Brief* *See practice outcomes report: Chart 3*
6. Determine the rate of counseling regarding lifestyle changes (e.g., diet, exercise, alcohol) in women age 45-65 years	Counseling about lifestyle modification will increase for women age 45-65 years after taking the MRS and breast cancer risk assessment. (Baseline: 25%; Post-intervention: 40%)	Women will be asked about discussions with provider about lifestyle modifications after the visit.	Women age 45-65 years in control and intervention groups had very frequent discussions about lifestyle, but it was not statistically different between groups Control group: 151/179 (84.4%) had discussions. Intervention group: 225/255 (88.2%) had discussions (p-value = 0.25) *See Table 2 in Issue Brief* *See practice outcomes report: Chart 3*
7. Provider knowledge	Improvement in knowledge from pre- to post-test	Pre-Posttest – Webinar	Overall results for providers: Mean % Correct: pre-test=66%; post-test=74% (Mean difference = 0.07; 95% CI -0.008-0.16; p=0.07) *Individual pre-post test results will be sent via email to practices with more than one provider.* *Solo Providers: See practice outcomes report: Table B*

Appendix B: Participant Demographics

Descriptor	Response Category	Total N=408 n (%)	Control N=177 (43.4%)	Intervention N=231 (56.6%)	p-value	Overall p-value
Age	45-49 years	84 (20.6%)	33 (18.6%)	51 (22.1%)	0.4	0.7
	50-54 years	116 (28.4%)	53 (30.0%)	63 (27.3%)	0.55	
	55-59 years	114 (27.9%)	53 (29.9%)	61 (26.4%)	0.43	
	60-65 years	94 (23.0%)	38 (21.5%)	56 (24.2%)	0.51	
Race	AI/AK	1 (0.2%)	0 (0.0%)	1 (0.4%)		
	Asian	5 (1.2%)	3 (1.7%)	2 (0.9%)		
	Black/AA	65 (15.9%)	35 (19.8%)	30 (12.9%)	0.06	0.03
	Unknown	7 (1.7%)	5 (2.8%)	2 (0.8%)		
	White	332 (81.0%)	134 (75.7%)	198 (85.0%)	0.01	
Ethnicity	Hispanic	24 (5.9%)	12 (6.8%)	12 (5.2%)	0.5	
	Non-Hispanic	384 (94.1%)	165 (93.2%)	219 (94.8%)		
Menopausal status	Perimenopausal	60 (14.7%)	27 (15.3%)	33 (14.3%)		0.97
	Menopausal	98 (24.1%)	44 (25.0%)	54 (23.4%)		
	Postmenopausal	123 (30.2%)	50 (28.4%)	73 (31.6%)	0.73	
	Surgical Menopause	50 (12.3%)	22 (12.5%)	28 (12.1%)		
	Unknown	76 (18.7%)	33 (18.8%)	43 (18.6%)		
Breast cancer history	Yes	23 (5.7%)	10 (5.6%)	13 (5.6%)	0.97	
	No	384 (94.3%)	167 (94.4%)	218 (94.4%)		
Concurrent conditions	Anxiety	112 (27.5%)	37 (11.2%)	75 (32.0%)	0.02	
	Back Pain	93 (22.8%)	40 (21.4%)	58 (23.8%)	0.56	
	Depression	104 (25.5%)	39 (22.0%)	65 (28.1%)	0.57	
	High Cholesterol	132 (32.4%)	61 (33.3%)	24 (31.6%)	<0.0001	
	Hypertension	149 (36.5%)	75 (41.2%)	76 (32.9%)	0.05	
	Obesity	94 (23.0%)	37 (20.3%)	59 (25.1%)	0.27	
	Allergic Rhinitis	58 (14.2%)	24 (13.6%)	34 (14.7%)	0.7	
	Asthma	50 (12.3%)	21 (11.9%)	29 (12.6%)	0.6	
	Diabetes	48 (11.8%)	22 (13.6%)	14 (10.4%)	0.03	
	Hypothyroidism	54 (13.1%)	15 (8.5%)	39 (16.5%)	0.01	
	None	69 (16.9%)	30 (16.4%)	40 (17.3%)	0.92	
	Reflux Esophagitis	71 (17.4%)	37 (20.3%)	35 (15.2%)	0.13	
Medications for menopause	Black cohosh	8 (1.9%)	3 (1.6%)	5 (2.1%)		
	Combined estrogen and progesterone (in one dosage form)	8 (1.9%)	4 (2.2%)	4 (1.6%)		
	Compounded bioidentical hormone therapy	6 (1.4%)	0 (0.0%)	6 (2.5%)		
	Estrogen	25 (5.8%)	9 (4.9%)	16 (6.6%)		
	Gabapentin	7 (1.6%)	4 (2.2%)	3 (1.2%)	0.03	
	None	297 (69.4%)	143 (77.7%)	154 (63.1%)		
	Other	18 (4.2%)	7 (3.8%)	11 (4.5%)		
	Progesterone	16 (3.7%)	5 (2.7%)	11 (4.5%)		
	SNRI (e.g.,venlafaxine)	11 (2.6%)	2 (1.1%)	9 (3.7%)		
	SSRI (e.g., sertraline, fluoxetine, paroxetine)	32 (7.5%)	7 (3.8%)	25 (10.3%)		

Appendix C: Individual Symptoms for Women Taking the Menopause Rating Scale

Somatic Symptoms			Psychological Symptoms			Urogenital Symptoms		
Specific Symptom	**Response Category**	**Frequency (%)**	**Specific Symptom**	**Response Category**	**Frequency (%)**	**Specific Symptom**	**Response Category**	**Frequency (%)**
Hot Flushes N=253	None	75 (29.6%)	**Anxiety N=252**	None	83 (32.9%)	**Dryness of vagina N=251**	None	103 (41.0%)
	Mild	96 (37.9%)		Mild	83 (32.9%)		Mild	58 (23.1%)
	Moderate	53 (21.0%)		Moderate	62 (24.6%)		Moderate	51 (20.3%)
	Severe	22 (8.7%)		Severe	19 (7.5%)		Severe	26 (10.4%)
	Very severe	7 (2.8%)		Very severe	5 (2.0%)		Very severe	13 (5.2%)
Joint and muscular discomfort N=250	None	57 (22.8%)	**Depressive mood N=253**	None	74 (29.3%)	**Bladder problems N=251**	None	95 (37.9%)
	Mild	87 (34.8%)		Mild	69 (27.3%)		Mild	79 (31.5%)
	Moderate	64 (25.6%)		Moderate	80 (31.6%)		Moderate	50 (19.9%)
	Severe	37 (14.8%)		Severe	26 (10.3%)		Severe	20 (8.0%)
	Very severe	5 (2.0%)		Very severe	4 (1.6%)		Very severe	7 (2.8%)
Sleep problems N=253	None	58 (22.9%)	**Irritability N=252**	None	65 (25.8%)	**Sexual problems N=251**	None	82 (32.7%)
	Mild	63 (24.9%)		Mild	93 (36.9%)		Mild	56 (22.3%)
	Moderate	83 (32.8%)		Moderate	66 (26.2%)		Moderate	66 (26.3%)
	Severe	39 (15.4%)		Severe	24 (9.5%)		Severe	32 (12.8%)
	Very severe	10 (4.0%)		Very severe	4 (1.6%)		Very severe	15 (6.0%)
Heart discomfort N=253	None	148 (58.5%)	**Physical and mental exhaustion N=252**	None	47 (18.7%)			
	Mild	71 (28.1%)		Mild	89 (35.3%)			
	Moderate	29 (11.5%)		Moderate	75 (29.8%)			
	Severe	4 (1.6%)		Severe	33 (13.1%)			
	Very severe	1 (0.4%)		Very severe	8 (3.2%)			