
**Message from the Tonic Media Network Editorial Committee***

Welcome to another edition of Practice Connect - a newsletter designed for you, your practice and your patients with up-to-date news and information.

## Getting started with MyMedicare patient registration

MyMedicare is now open for voluntary registration to Australians with a valid Medicare card or a Department of Veterans' Affairs (DVA) Veteran card.

A practice must be registered in MyMedicare before a patient can start their own registration.

There are multiple ways a patient can register with their chosen practice in MyMedicare:

- Start the registration process in their Medicare Online Account or Express Plus Medicare Mobile app. Check that their practice is registered in MyMedicare before they start. Practice staff will then accept the registration in the MyMedicare system.
- Their practice may start the registration in MyMedicare or they can ask them to do this. This will trigger a registration in your Medicare Online Account or Express Plus Medicare Mobile app, which you can then complete.
- Fill out a registration form at your practice. By signing the form, you are giving consent to participate in MyMedicare. Practice staff will then complete the registration in the MyMedicare system.

The Department of Health has produced several resources for patients:

Introducing MyMedicare – Fact sheet

Registering in MyMedicare – Fact sheet

MyMedicare for patients – Frequently asked questions

Our friends at leading practice intelligence platform provider Cubiko recently held a webinar Getting started with patient registration: tips & tricks

This webinar covered:

- How to employ efficient workflows for patient registration

- The best way to keep up to date with the latest announcements and changes for MyMedicare
- What you can do to prepare your practice for the 1st of October and patient registration

Further information

To watch the webinar recording visit here

Cubiko have also produced several patient friendly MyMedicare posters

For more information about MyMedicare visit here

**Australian researchers call for new definition of menopause**

For many women – and some transgender men and non-binary individuals, menopause marks a significant life stage, usually occurring after midlife.

While the end of menstrual cycles is a common marker, experiences and symptoms vary widely.

While menopause doesn't in itself increase the risk of chronic illnesses, it can be a time to reassess your health looking forward in the long-term.

Australian researchers have reviewed the available evidence on menopause to make a number of recommendations, including shifting its definition and focus on areas of new research.

After reviewing more than 200 scientific papers on menopause, the researchers found that the common symptoms – from hot flashes to sleep troubles and mood changes – can start much earlier than changes to your periods and can also be influenced by ethnic background.

In some countries, like Bangladesh, joint pain is a more commonly reported symptom than hot flashes. Other studies suggest that African-American women face longer-lasting hot flashes compared to European women. Mood swings and sleep disturbances are common but can be influenced by external factors like stress. Factors like smoking, obesity, and socioeconomic status can also make symptoms more likely.

Research across several countries substantiates that the severity of these menopausal symptoms links to decreased performance at work. But job conditions, including stable employment, support from supervisors, and an accommodating work environment, can mitigate these challenges, according to the study authors. Menopausal women who face economic hardship or mental health issues are particularly vulnerable to difficulties at work during that stage of their lives.

The authors propose that menopause be defined as the final cessation of ovarian function as opposed to the end of menstruation. They argue that would include people without regular periods, such as those who used certain types of contraception like IUDs or have had hysterectomies.

Further information

Menopause: Biology, consequences, supportive care, and therapeutic options: Cell.com

Does the risk of dementia in women have anything to do with menopause?
Menopause: Are we over-medicalising this inevitable transition mydr.com.au

**What causes low testosterone?**

Low testosterone is linked to worse health outcomes among older men, especially in the areas of diabetes, dementia and mortality. But the scientific literature is still not clear on whether diminishing levels of testosterone are just due to ageing itself, or if the medical conditions we accumulate as we age contribute to lower testosterone levels. It's a complex picture because testosterone can vary significantly within and across age groups, so that some older men have testosterone levels similar to younger men.

A new study sought to unravel some of the complexity by examining large volumes of data linking testosterone levels to various health issues at an individual level.

The review analysed data from 11 cohort studies comprising more than 25,000 men. For each study, total testosterone, dihydrotestosterone (DHT) and oestradiol were measured using mass spectrometry. These data were supplemented by lifestyle, health and socio-demographic variables – things like physical activity, education status, BMI, age and alcohol consumption. The data were then put together to determine the relationships between various factors and whether they had an influence on testosterone independent of age.

The researchers found that for men aged 17 and above, average concentrations of testosterone did not change until the man reached 70 years of age, after which testosterone levels tended to drop. This drop even occurred in healthy older men (with no hypertension, diabetes, cancer or cardiovascular disease), although they experienced less of a reduction. High BMI had a major effect on testosterone levels as did diabetes and cancer. There were a host of smaller factors that also influenced testosterone concentrations – such as lower physical activity, high blood pressure, and – interestingly - being married.

Other studies have identified some of these associations before, but this is the first study to do it at scale and using consistent measurements of testosterone. The authors say it's an important piece of work for understanding how individual men might have varying levels of testosterone based on particular health factors, and how testosterone levels decline – with the potential for treatments if the levels are abnormally low - known as gonadal failure.

Further information

Factors associated with circulating sex hormones in men: ACP Journals

**Direct-to-consumer egg-timer tests make misleading marketing claims**

The egg-timer test, known clinically as anti-mullerian hormone (AMH) testing, is marketed to the public as a way of testing fertility for women but that in fact is exactly what it does not do. AMH is linked to the number of egg sacs in a woman's ovaries – a proxy for how many eggs a woman has remaining. Originally used for IVF to see what egg supply a woman might have for ovarian stimulation, AMH tests are increasingly being marketed as measuring general fertility. Research suggests AMH levels tests are a poor predictor of current or future fertility that's because for as long as a woman has eggs, she is likely to be just as fertile as any other woman during each cycle. If her AMH is low, the main implication is that she and her partner should get on and try to have a baby.

A new study from researchers at the University of Sydney has taken a microscope to the marketing claims of such tests.

After pruning out irrelevant websites, the researchers were left with 27 sites that sold AMH tests. The countries where these sites originated were most commonly the United States (9 sites), India (6), the United Kingdom (4) and Australia (3). Test costs varied greatly with the cheapest test advertised at $16 and the most expensive at $214.

Concerningly, the researchers found that many of these websites made misleading claims about egg timer tests to their audience. 75% of sites said the test could help women understand their fertility and chances of conception, which the study's authors say is at odds with current evidence. Many sites also said the test could predict the timing of menopause or detect premenopausal women, claims that are also not supported by current evidence.

The authors argue these tests could incorrectly reassure women, leading them to delay having a baby, while others may be anxious or stressed about their fertility based on a test that may not give them accurate information. They argue increased regulation of this market in countries like Australia, as well as education campaigns for people looking to conceive, could reduce some of the potential harms of these misleading marketing materials.

Further information

Websites selling direct-to-consumer anti-mullerian hormone tests: JAMA Network

What is Anti Mullerian Hormone (AMH) Test and Ovarian Reserve? : myDr.com.au

**Marriage and money – how cognitive decline affects the household finances**

The interactions between ageing, cognition and financial health have been of growing interest to economists and public health researchers. We're living longer, and that means greater numbers of people will experience cognitive decline. Older adults have major financial decisions to make including retirement, superannuation and investments, at times when they may have some level of cognitive impairment, and must live with the consequences of those choices for longer than ever before. That becomes more complex when you factor in the effects on your partner.

Researchers from the Queensland University of Technology designed a study to investigate how the declining cognition of one partner might affect the financial situation of the other.

Researchers recruited married couples aged 60 or over. Participants were tested for their overall cognitive score, their own and their partner's level of cognitive decline over the past decade, and their financial competency and decision-making (by being presented with hypothetical scenarios where they had to make short calculations to decide the most favourable option).

There were 63 husband-wife couples included in the study with an age range of 60-88 years. Husbands were typically older than their wives and had lower cognition overall.

Researchers found that when women thought their husband had declined cognitively, they were more likely to carry out financial tasks and choices – indicating that they were successfully compensating for their partner's behaviour. But the same relationship wasn't seen when the sexes were switched. The authors say this compensating behaviour could be important to the financial health of married couples in older age.

Typically there's a divide and conquer approach to finances – with men making decisions about things like investments and women making decisions about more day-to-day financial concerns. But the researchers warn this old-school pattern, could have harmful consequences where one partner has significant cognitive decline and the other is unable to adapt and compensate for the lost knowledge and ability to service that area of a couple's finances.

Further information

Cognition and financial decision-making in older adult spouses: Karger.com

**Additional COVID-19 vaccine now recommended for vulnerable Australians.**

COVID-19 is now one of Australia's leading causes of death according to data from the Bureau of Statistics. This is an important reminder for eligible Australians to get a booster shot.

All adults can get a booster if it's been 6 months or longer since their last COVID-19 booster or confirmed infection (whichever is most recent). Boosters give extra protection against severe illness from COVID as well as Long COVID.

The Australian Technical Advisory Group on Immunisation (ATAGI) recently recommended a booster jab for the most vulnerable Australians.

All adults aged 75 years and older should receive an extra 2023 COVID-19 vaccine dose if six months have passed since their last dose.

This particularly includes people at higher risk of severe illness, such as:

- adults aged 65-74 years
- everyone 18 years and over with medical comorbidities, disability or complex health needs.

Children and young people aged 5 to 17 years can consider getting a booster dose if:

- they have a health condition that put them at risk of severe illness, and
- if it's been 6 months since their last dose or COVID-19 infection.

Booster doses are not recommended currently for children and adolescents under 18 years of age who do not have any risk factors for severe COVID-19.

According to the Department of Health, all vaccines approved for use in Australia continue to give strong protection against serious illness from COVID-19. Omicron-specific bivalent vaccines are preferred for boosters.

Updated COVID vaccines approved in the United States

The Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) approved updated vaccines by Pfizer-BioNTech and Moderna in mid-September.

The new shots are designed to protect against XBB.1.5, a subvariant of Omicron, and should also protect against more recent virus strains, including EG.5 and BA.2.86.

At the time of writing, there is no indication if or when these new vaccines will be approved for use in Australia.

Further information

COVID-19 Vaccines: Department of Health

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