Menopause Management / HRT update

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London North West Healthcare NHS
NHS Trust

The NPH Mid Life Women's Service

Outpatient specialist service

- Thursday mornings
  - **Premature Ovarian Insufficiency** (POI) service / 1st Thurs each month
  - **Breast Cancer and Menopause (BCMS)** / Gynae cancers? Prostate Cancer? / 3rd Thurs each month
  - **High risk cases** / 2nd and 4th Thurs each month
  - Supported by
    - Medication Management Clinics
    - Specialist psychotherapist and counsellor / psychosexual counselling

Menopause / HRT update

- Mean age: 51 years
  - Climacteric phase 45-55 years of age
- Text book case – symptomatic upto 5 years
  - SWAN: 7-12 years
- HRT risk benefit evaluation
  - Annual assessments
  - Benefits
    - Vasomotor symptom control / Bone Health / Colorectal cancer
  - Risks
    - breast cancer / strokes / thrombosis risk?
- NICE Menopause Guidance NG23 (Nov 2015) https://www.nice.org.uk/guidance/ng23
  - Updated risk benefit profiles + for diabetes
  - ? dementia; muscle strength

NICE NG23

1.1 Individualised care

- 1.1.1 Adopt an individualised approach at all stages of diagnosis, investigation and management of menopause.

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1.2 Diagnosis of perimenopause and menopause

- 1.2.1 Diagnose the following without laboratory tests in otherwise healthy women aged over 45 years with menopausal symptoms:
  - perimenopause / 'vasomotor symptoms + irregular periods'
  - menopause / 'not had a period for at least 12 months + not using hormonal contraception'
  - menopause / 'symptoms in women without a uterus'.

- 1.2.2 Note - can be difficult to diagnose menopause in women who are taking hormonal treatments, eg. For treatment of heavy periods.

- 1.2.3 Do not use the following laboratory and imaging tests to diagnose perimenopause or menopause in women aged over 45 years:
  - anti-Müllerian hormone
  - inhibin A / inhibin B
  - oestradiol
  - antral follicle count
  - ovarian volume.

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- 1.2.4 Do not use a serum follicle-stimulating hormone (FSH) test to diagnose menopause in women
  - using combined oestrogen and progestogen contraception or high-dose progestogen.

- 1.2.5 Consider FSH test to diagnose menopause only:
  - in women 40 to 45 years with menopausal symptoms, including change in menstrual cycle
    - WHO: early menopause
  - in women aged under 40 years in whom menopause is suspected
    - WHO: young menopause

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1.3 Information and advice

- 1.3.1 Give information to menopausal women + family members / carers to include:
  - an explanation of the stages of menopause
  - common symptoms and diagnosis
  - lifestyle changes and interventions that could help general health and wellbeing
  - benefits and risks of treatments for menopausal symptoms
  - long-term health implications of menopause.

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- 1.3.2 Explain to women that they may see a change in their menstrual cycle + experience a **variety of symptoms** associated with menopause, including:

  - vasomotor symptoms (for example, hot flushes and sweats)
  - musculoskeletal symptoms (for example, joint and muscle pain)
  - effects on mood (for example, low mood)
  - urogenital symptoms (for example, vaginal dryness)
  - sexual difficulties (for example, low sexual desire).

The NPH Mid-life Womens Health - SAC

	QUESTIONS	ANSWERS 0	1	2	3	Office Use Only
General Problems:	Daytime Sweats & Flushes				X	
	Night-time Sweats & Flushes			X		
	Unable to sleep				X	
	Headaches		X			
	Tiredness				X	
	Loss of energy			■	X	
	General aches & pains Variable		X →			
	General itchiness		X			
Emotional Problems:	Formication (feeling of something crawling over you)	X				
	Tearfulness			X →		
	Depression			X →		
	Feeling of unworthiness			X		
	Irritability			X	→	
	Anger		X			
	Bitterness		X			
	Panic Attacks	X				
	+/− Palpitations		X			
	Aggression	X				
Bladder Problems:	Daytime Frequency	X				
	Urgency	X				
	Urge Incontinence (leakage if you do not get there in time)	X				
	Stress Incontinence (Leakage if cough, sneeze or laugh)	X				
	Night-time Frequency		X			
	Bed Wetting	X				
Sexual Problems:	Vaginal dryness/soreness		X →			
	Vaginal Itching		X →			
	Soreness / pain with intercourse * ?					
	Bleeding with intercourse * ?					
	Loss of Libido (sex drive) * ?			X		
	Difficulty achieving orgasm * ?					
Personality Problems:	Loss of Memory			X		
	Loss of concentration			X		
	Inability to cope		X			
	Feelings of personality dixintigration			X		
Period Problems:	Periods increasingly erratic ?					
	Periods much lighter ?					
	Periods much heavier ?					
	Irregular Bleeding between periods ?					
	New bleed over 1 year after periods have stopped ?					

* Not in a relationship
** No periods for well over a year.

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- 1.3.3 Give information to menopausal women + family members / carers about the following types of treatment for menopausal symptoms:
  - hormonal, for example hormone replacement therapy (HRT)
  - non-hormonal, for example clonidine [alpha 2 adrenergic agonist]
  - non-pharmaceutical, for example cognitive behavioural therapy (CBT).

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- 1.3.5 Information about contraception / think re perimenopausal and postmenopausal phase.
  - See guidance Faculty of Sexual & Reproductive Healthcare on contraception for women aged over 40 years.

- 1.3.6 Women likely to go through menopause due to medical or surgical treatment (including women with cancer, at high risk of hormone-sensitive cancer or having gynaecological surgery) – offer support and:
  - information about menopause and fertility before they have their treatment
  - referral to a healthcare professional with expertise in menopause.

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Vasomotor symptoms

- 1.4.2 Offer HRT for vasomotor symptoms
  - after discussing short-term (up to 5 years) and longer-term benefits and risks.

Offer 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 Some evidence that isoflavones or black cohosh may relieve vasomotor symptoms. BUT:
  - multiple preparations available / safety uncertain
  - different preparations may vary
  - interactions with other medicines reported.

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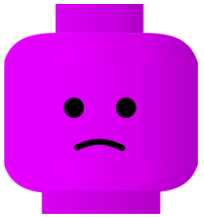

Psychological symptoms

1.4.5 Consider HRT for low mood with menopause.

1.4.6 Consider CBT for low mood / anxiety with menopause.

1.4.7 No clear evidence for SSRIs / SNRIs to ease low mood in menopausal women not diagnosed with depression (see NICE guideline on depression in adults).

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Altered sexual function

1.4.8 Consider testosterone[1] supplementation for menopausal women with low sexual desire - if HRT alone is not effective.

1. Off license use

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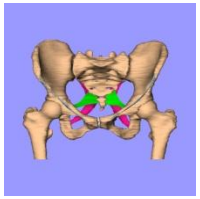

Urogenital atrophy

1.4.9 Vaginal oestrogen for urogenital atrophy (including with systemic HRT); continue for as long as needed for symptom relief.

1.4.10 Consider vaginal oestrogen when systemic HRT is contraindicated, with advice from menopause specialist

1.4.11 If vaginal oestrogen does not relieve symptoms of urogenital atrophy, can consider increasing the dose?

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.

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Complementary therapies and unregulated preparations

1.4.15 Efficacy and safety of unregulated compounded bioidentical hormones unknown.

1.4.16 Complementary therapies - quality, purity and constituents may be unknown.

1.4.17 Advise women with h/o or at high risk of breast cancer:

Some evidence that St John's Wort may offer benefit for vasomotor symptoms, but uncertainty?:

- appropriate doses
- persistence of effect
- variation in the nature and potency of preparations
- potential serious interactions with other drugs (including Tamoxifen, anticoagulants and anticonvulsants).

HRT – the risk benefit ratio?

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1.5 Long-term benefits and risks of hormone replacement therapy

Venous thromboembolism

1.5.1

- VTE risk increased by oral HRT - compared with baseline population risk
- VTE risk associated with HRT is greater for oral than transdermal preparations
- VTE risk with transdermal HRT [standard therapeutic doses] no greater than baseline population risk.

1.5.2 Transdermal rather than oral HRT for menopausal women who are at increased risk of VTE, including those with a BMI over 30 kg/m^2.

1.5.3 Refer? menopausal women at high risk of VTE (eg, with strong family history of VTE or a hereditary thrombophilia) to haematologist for assessment before considering HRT.

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Cardiovascular disease

1.5.4 HRT:

- does not increase CVD risk when started in women aged under 60 years
- does not affect the risk of dying from CVD.

1.5.5 Presence of cardiovascular risk factors is not a contraindication to HRT
- as long as risks are optimally managed.

1.5.6 Refer tables 1 and 2:

- baseline risk of coronary heart disease and stroke for women of menopausal age varies from one to another according to presence of CVD risk factors
- HRT with oestrogen alone is associated with no, or reduced, risk of coronary heart disease
- HRT with oestrogen and progestogen is associated with little or no increase in the risk of coronary heart disease.

1.5.7 Oral (but not transdermal) oestrogen is associated with a small increase in the risk of stroke.

Also explain that baseline population risk of stroke in women under 60 years is very low (table 2).

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Type 2 diabetes

1.5.8 HRT (either orally / transdermally) not associated with an increased risk of developing DMT2

1.5.9 HRT not generally associated with an adverse effect on blood glucose control.

1.5.10 Consider HRT for menopausal symptoms in women with type 2 diabetes

- after taking co-morbidities into account and seek specialist advice if needed.

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Breast cancer

1.5.11 (Table 3):

Baseline breast cancer risk for women around menopausal age varies from one woman to another according to the presence of underlying risk factors

- Oestrogen alone associated with little or no change in risk of breast cancer
- Oestrogen + Progestogen can be associated with an increase in the risk of breast cancer

- any increase in risk of breast cancer is related to treatment duration and reduces after stopping HRT.

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Osteoporosis

1.5.12 Bone health advice + discuss at review appointments (NICE guideline Osteoporosis: assessing risk of fragility fractures).

1.5.13 (Table 4)
Baseline population risk of fragility fracture around menopausal age in the UK is low and varies from one woman to another.

1.5.14
Risk of fragility fracture is decreased while taking HRT and that this benefit:

- maintained during treatment; decreases once treatment stops
- may continue for longer in women who take HRT for longer.

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Dementia

1.5.15 Likelihood of HRT affecting risk of dementia is unknown.

Loss of muscle mass and strength

1.5.16

- limited evidence - HRT may improve muscle mass and strength
- muscle mass + strength maintained through, and is important for, activities of daily living.

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Managing premature ovarian insufficiency (POI)

1.6.6 HRT or a combined hormonal contraceptive to women with POI, unless contraindicated (eg. with hormone-sensitive cancer).

1.6.7 Explain to women with POI:

- Important to start hormonal treatment either HRT / COC and continuing treatment until at least the age of natural menopause (unless contraindicated)
- baseline population risk of diseases eg. breast cancer, CVD increases with age and is very low in women aged under 40

- HRT may have a beneficial effect on blood pressure when compared with a COC
- Both HRT and COCs offer bone protection
- HRT is not a contraceptive.

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1.6.8 For women with POI and contraindications to hormonal treatments

- Offer advice, including bone and cardiovascular health, and symptom management.

1.6.9 Refer POI patients

- to healthcare professionals with relevant experience for help to manage all aspects of physical and psychosocial health

Menopause / HRT update

- Health professional linkline
  - 020 8869 2937

- Teaching and training unit
  - Rationale HRT prescribing

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