**Menopause – Guidance on management and prescribing**

### DIAGNOSIS

The following can be diagnosed without laboratory tests in otherwise healthy women aged over 45 years with appropriate menopausal symptoms:

- **Peri-menopause** — if the woman has vasomotor symptoms and irregular periods.
- **Menopause in women who have:**
  - not had a period for at least 12 months and are not using hormonal contraception
  - OR
  - symptoms without a uterus

The mean age for the menopause is 52.

### Follicular Stimulating Hormone (FSH) test to diagnose menopause should only be done in women:

- Aged <40 years where menopause is suspected
- Aged 40-45 years with menopausal symptoms, including a change in their menstrual cycle
- Aged >45 years exhibiting atypical symptoms (include anything other than classic menopausal symptoms)

Level greater than 30 mIU/mL indicates post menopause, should be taken on day 2-5 of cycle.

In women taking hormonal contraception causing amenorrhoea (IUS, POP, nexplanon) take two levels 6 weeks apart to determine whether menopausal, in which case contraception can be stopped after 1 year if over 50y.

Some women may have normal levels of FSH during the menopausal transition, so this should not exclude peri-menopause as a cause of their symptoms.

### Information and advice

Ensure patients (family or carers) are given information to include:

- Explanation of the stages of the menopause
- Common symptoms and diagnosis
- Lifestyle changes and interventions to help general health and well being
- Benefits and risks of the treatments for menopausal symptoms (see page 4)
- Long term health implications of the menopause

### Managing symptoms 1st line

**Address modifiable lifestyle factors to reduce menopausal symptoms:**

- healthy balanced diet, to maintain an appropriate weight
- consume adequate calcium intake (700mg/day)
- undertaking regular weight bearing exercise
- Advise and support women in smoking cessation and reducing alcohol intake
- Ensure other long term conditions are managed appropriately and any treatment is optimised
- Avoiding triggers for hot flushes if experiencing them (spicy foods, alcohol etc.)
- Good sleep hygiene

### Hormone Replacement Therapy (HRT)

**Indications:**

- Short term relief of vasomotor symptoms e.g. hot flushes, night sweats
- Prevention of osteoporosis (long term)
- Premature ovarian failure
- Relief of other menopausal symptoms e.g. sleep disturbance, anxiety/depression, sexual function.

**Contraindications:**

- Pregnancy
- Undiagnosed abnormal vaginal bleeding
- Active thromboembolic disorder or acute MI
- Suspected or active breast or endometrial cancer
- Active liver disease with abnormal LFTs
- Porphyria
Menopause (menopause under 40 years old)

It is important to start treatment with either HRT or a combined oral contraceptive (COC). Treatment should continue until at least the age of natural menopause (unless contraindicated) to protect against increased risks of dementia, cognitive decline, cardiovascular disease, and osteoporosis seen in these women.

Counsel women that:
- HRT has negligible effects on blood pressure and beneficial effects on metabolic parameters, compared with COC.
- Both HRT and COC offer bone protection.
- HRT is not contraception.

Consider referring women with POI to a specialist for help and support in the physical and psychosocial aspects of their diagnosis.

Prescribing considerations

Oral therapy is usually first choice – most cost effective and acceptable for the majority of patients. Where HRT is to be used in women over 60 years of age, lower doses should be started, preferably with a transdermal route of administration. Consider patches where:
- poor control or side effects on oral HRT
- variable hypertension (control BP before starting)
- history of, or risk of thromboembolism (VTE), consider referring to haematologist for advice
- bowel disorder which may affect absorption of oral therapy
- history of migraine (benefit from steady hormonal levels)
- on interacting drugs (hepatic enzyme inducer) e.g. anticonvulsants
- lactose sensitivity
- history of gallstones.

When to refer:
- Persistent side effects despite following logical therapy changes
- Inadequate control despite logical changes in HRT
- Complex medical history
- History of hormone dependent cancer
- Premature ovarian insufficiency (see separate box)
- Bleeding problems:
  - during sequential therapy – change in pattern of bleeding including increased duration, frequency and/or heaviness, and irregular bleeding
  - during continuous combined therapy or tibolone – if still bleeding after 6 months of therapy or if bleeding occurs after a spell of amenorrhoea
  - Selective estrogen receptor modulators (SERMs) – any bleeding whilst on therapy should be treated as a post-menopausal bleed

Premature ovarian insufficiency (POI)

In POI (menopause under 40 years old) it is important to start treatment with either with HRT or a combined oral contraceptive (COC). Treatment should continue until at least the age of natural menopause (unless contraindicated) to protect against increased risks of dementia, cognitive decline, cardiovascular disease, and osteoporosis seen in these women.

Counsel women that:
- HRT has a negligible effect on blood pressure and beneficial effects on metabolic parameters, when compared with COC
- Both HRT and COC offer bone protection.
  - HRT is not contraception

Consider referring women with POI to a specialist for help and support in the physical and psychosocial aspects of their diagnosis.
### Type of HRT

<table>
<thead>
<tr>
<th>Sequential combined HRT</th>
<th>Continuous combined HRT</th>
<th>Unopposed oestrogen HRT</th>
<th>Progestogen (See box below for features)</th>
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<tbody>
<tr>
<td><strong>Criteria for use</strong></td>
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<tr>
<td>Intact uterus</td>
<td></td>
<td></td>
<td>➢ Post hysterectomy</td>
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<tr>
<td>Perimenopausal – under 1 yr or amenorrhoea</td>
<td>➢ Intact uterus - amenorrhoeic &gt;1yr</td>
<td>➢ &gt;54 yrs old</td>
<td>➢ As adjunct to topical oestrogen if not had a hysterectomy</td>
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<tr>
<td>➢ &gt;3 yrs on sequential HRT</td>
<td>➢ &gt;54 yrs old</td>
<td>➢ &gt;3 yrs on sequential HRT</td>
<td>➢ Medroxyprogesterone acetate (Provera) 10mg Days 14-28 or 5mg daily</td>
</tr>
<tr>
<td>➢ Post hysterectomy</td>
<td>➢ &gt;3 yrs on sequential HRT</td>
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<td>➢ Progesterone 100mg daily or 200mg days 14-28</td>
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### ORAL TREATMENT OPTIONS

1st line
- Elleste Duet tablets (1mg or 2mg estradiol & 1mg norethisterone)
- Elleste Duet Conti (2mg estradiol & 1mg norethisterone)
- Elleste Solo (1mg or 2mg estradiol)

2nd line
- Femoston 1/10 or 2/10 tablets (1mg or 2mg estradiol & 10mg dydrogesterone)
- Femoston Conti (0.5/2.5 = 0.5mg estradiol & 2.5mg dydrogesterone or 1/5 = 1mg estradiol & 5mg dydrogesterone)

3rd line
- Tibolone 2.5mg tablets
- Evorel patch 25, 50, 75, 100mcg estradiol
- Evorel patch Change patch TWICE a week

### TRANSDERMAL TREATMENT OPTIONS

1st line
- Evorel Sequi patches 50micrograms estradiol & 170micrograms norethisterone
- Change patch TWICE a week
- Evorel conti patch 50micrograms estradiol & 170micrograms norethisterone
- Change patch TWICE a week

2nd line
- FemSeven Sequi patches 50micrograms estradiol & 10micrograms levonorgestrel
- Change patch ONCE a week
- FemSeven conti patches 50micrograms estradiol & 7micrograms levonorgestrel
- Change patch ONCE a week

### Monitoring

- Started on HRT or HRT changed— review at 3 months
- Established on HRT—review annually unless there are clinical indications for earlier review.
- At each review assess efficacy and side effects to assess ongoing risk/benefit balance.

### Stopping HRT

- Consider weaning dose down after 5 years of HRT (5 years after reaching average menopausal age in POI). Withdraw HRT slowly to reduce risk of recurrent symptoms.
- If symptoms do recur then recommence treatment.

### Vaginal oestrogen urogenital atrophy

- Ovestin cream (0.1% estradiol vaginal cream) OR Vagifem (10microgram vaginal tablet)
- Start early before irreversible changes have occurred. Can be taken whilst on systemic HRT.
- If symptoms not relieved consider dose increase, after seeking advice from specialist.
- Explain that symptoms may come back when treatment is stopped, adverse effects are rare.
- Moisturisers and lubricants (OTC purchase) can be used alone or in addition to vaginal oestrogen for vaginal dryness.

If preparation exists at lower dose reduce dose for 4 weeks then stop if already on lowest dose or no lower strength exists then stop.
**Benefits of HRT**

- Reduction in vasomotor symptoms
- Improved sleep, joint pain & QOL
- Potential improvement in psychological symptoms e.g. depression & anxiety
- Relief vaginal dryness
- Improved sexual function
- Improved bone mineral density, reduced fracture risk

**Cardiovascular disease**
- HRT does not increase coronary heart disease (CHD) risk when started in women aged under 60 yrs old, and does not affect the risk of dying from cardiovascular disease.
- Cardiovascular co-morbidities are not a contra-indication to HRT as long as they are optimally managed.
- Monotherapy oestrogen HRT is associated with no, or reduced, risk of CHD.
- Combined HRT is associated with minimal or no increase in the risk of CHD.
- Oral oestrogen is associated with small increase in risk of stroke. As the baseline risk of stroke in women under 60 yrs is very low the increased risk is insignificant.

**Venous thromboembolism (VTE)**
- Risk is increased (RR =2) by oral HRT compared to baseline population risk. (low risk)
- Risk associated with transdermal HRT given at standard therapeutic doses (under 50mcg/24hr) is no greater than baseline population risk.
- Consider transdermal rather than oral HRT in women with an increased risk of VTE, e.g. BMI over 30.
- Consider referring women with high risk of VTE to haematologist for assessment before considering HRT.

**Type 2 diabetes**
- There is no increased risk of developing type 2 diabetes with any type of HRT.
- HRT is not associated with an adverse effect on blood glucose control in diabetics.

**Osteoporosis**
Give women advice on bone health and discuss any risk factors for osteoporosis.
Risk of fragility fractures is decreased whilst taking HRT but increases once treatment is stopped, although may persist for a while in women who take HRT for longer.

**Loss of muscle mass and strength**
There is limited evidence suggesting that HRT may improve muscle mass and strength, which would otherwise decrease after the menopause. Muscle mass and strength is also maintained through daily activities and weight bearing exercise.

**Breast cancer**
Oestrogen only HRT is associated with little or no increase in the risk of breast cancer.
Combined HRT can be associated with an increase in the risk of breast cancer, however this increase is small and is related to HRT duration and reduces after stopping.
The baseline risk of getting breast cancer is 15 cases per 1000 women over 5 years.
The Women Health Institute study suggests that if 1000 women used HRT for 5 years there would be 4 extra cases of breast cancer with combined HRT and 4 fewer cases with oestrogen only HRT.

**Ovarian cancer**
A 2015 meta-analysis of 52 epidemiological studies has shown an increased risk of ovarian cancer with all types of HRT. Whilst this study provides evidence of an association between HRT use and some tumour subtypes, there is insufficient evidence to claim HRT causes ovarian cancer. When counselling patients it is important to discuss these findings in terms of absolute risk.
After 5 years of HRT there is only 0.1% increase in ovarian cancer and less than 0.6% additional deaths.
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|                 | [https://www.nice.org.uk/guidance/ng23](https://www.nice.org.uk/guidance/ng23)  
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|                 | [http://cks.nice.org.uk/menopause](http://cks.nice.org.uk/menopause) 
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<th><strong>Previous version</strong></th>
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