MENOPAUSE

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MRCOG & DRCOG SUBCOMMITTEE MEMBER & EXAMINER, RCOG
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FACULTY: BSGE, RCOG, LSTM-WHO, LONDON DEANERY

NICE: 23: Menopause: Diagnosis & Management
History
Hormone-replacement therapy: updated advice

Before prescribing hormone-replacement therapy, healthcare professionals should consider carefully the potential benefits and risks for every woman.

Contents:
- Menopausal symptoms
- Coronary heart disease (CHD)
- Stroke
- Venous thromboembolism (VTE)
- Endometrial cancer
- Breast cancer
- Colorectal cancer

Article date: September 2007

This guidance was reviewed in November 2019 and remains an accurate reflection of the current regulatory position.

Since the publication of Information about hormone-replacement therapy (HRT) in Current Problems in Pharmacology in October 2004, the evidence base has become available that affects prescribing advice.

Menopausal symptoms

HRT effectively relieves vasomotor symptoms. In most cases, 2-3 years therapy is sufficient, but some women may need longer-term treatment. The benefit is to balance the risks with adequate attempts in lessening the symptoms and the benefits of HRT.

Coronary heart disease (CHD)

Randomised controlled trials have found an increased risk of CHD in women who started hormone replacement therapy (HRT) more than 10 years after menopause. Very few randomised controlled trials have assessed younger, newly menopausal women, and some have suggested a lower risk. However, in these studies compared to older women, the risk is higher in young women, and the risk is attributed to the increase in HDL cholesterol levels in the young menopausal women. In general, HDL cholesterol levels are lower in younger women than in older women. Therefore, the risk of CHD in women who have stopped HRT is likely to be lower than in menopausal women. The net balance of risk of CHD in older women is lower than that of their menopause. Therefore, CHD risk is high in older women and the risk is higher in younger women. Therefore, the risk of CHD in younger women is lower than in older women.

Healthcare professionals should discuss carefully every woman's risk of CHD before prescribing HRT, especially if she is at increased risk of breast, uterine, or colorectal cancer.
Hormone replacement therapy

Summary points

1. All women should have access to advice so that they can make informed decisions about diet and lifestyle and treatment options to optimise their menopause transition and postmenopausal health.

2. HRT dosage, regimen and duration should be individualised, with annual evaluation of advantages and disadvantages.

3. Transdermal estradiol is unlikely to increase the risk of venous thrombosis or stroke above that of non-users and is associated with lower risk compared with oral estradiol.

4. Limited evidence suggests that micronised progesterone and dydrogesterone may be associated with lower risk of breast cancer and venous thrombosis compared to other progestogens.

5. Arbitrary limits should not be placed on the duration of use of HRT; if symptoms persist, the benefits usually outweigh the risks.

6. HRT prescribed before the age of 60 or within 10 years of the menopause has a favourable benefit/risk profile and is likely to be associated with a reduction in coronary heart disease and cardiovascular mortality.

7. If HRT is used in women over 60 years of age, low doses should be started.
Your Dec 11 Editorial (p 2069)\(^2\) alluded to disagreement between the Royal College of Obstetricians and Gynaecologists (RCOG) and various members of one of its study groups. We are all members of that study group which was convened to discuss menopause and hormone replacement therapy (HRT). We wish to place on public record various concerns that relate to the press statement from the RCOG and the manner in which the recommendations and individual chapters were edited and compiled.

The RCOG press statement issued at the time of the release of the proceedings of the study group was not circulated to any of us beforehand, and the contents do not reflect accurately the views of the study group. Therefore, we must dissociate ourselves from the recent press statements by the RCOG on HRT. Furthermore, although some members were given the opportunity to comment on the recommendations, several members did not receive the drafts for comment or had their revisions completely ignored. These
IMS Updated Recommendations on postmenopausal hormone therapy

Issued on behalf of the Board of the International Menopause Society by Amos Pines (President), David W. Sturdee (General Secretary), Martin H. Birkhäuser (Treasurer), Hermann P. G. Schneider, Marco Gambacciani and Nick Panay

INTRODUCTION

The past decade has seen marked fluctuations in opinions concerning the merits and risks of postmenopausal hormone therapy. In July 2002, menopause management faced a major turning point when the first data from the Women's Health Initiative (WHI) trial were released. The study was categorized as a primary prevention trial for coronary heart disease, although the fact that mean age at recruitment was 63 years was not given enough importance at that time. WHI investigators concluded that hormone therapy during postmenopausal period. In view of the above, the IMS Board decided that it is time to update the 2004 Statement and to enlarge its scope to menopause management and adult women's health in general. More than 30 experts from the various fields of menopause medicine reviewed the latest information in a Workshop held in Budapest in February 2007.

The following Recommendations express the views of the IMS on the principles of hormone therapy in the peri- and postmenopausal periods.
Postmenopausal hormone therapy: an Endocrine Society scientific statement.


Abstract

OBJECTIVE: Our objective was to provide a scholarly review of the published literature on menopausal hormonal therapy (MHT), make scientifically valid assessments of the available data, and grade the level of evidence available for each clinically important endpoint.

PARTICIPANTS IN DEVELOPMENT OF SCIENTIFIC STATEMENT: The 12-member Scientific Statement Task Force of The Endocrine Society selected the leader of the statement development group (R.J.S.) and suggested experts with expertise in specific areas. In conjunction with the Task Force, lead authors (n = 25) and peer reviewers (n = 14) for each specific topic were selected. All discussions regarding content and grading of evidence occurred via teleconference or electronic and written correspondence. No funding was provided to any expert or peer reviewer, and all participants volunteered their time to prepare this Scientific Statement.

EVIDENCE: Each expert conducted extensive literature searches of case control, cohort, and randomized controlled trials as well as meta-analyses, Cochrane reviews, and Position Statements from other professional societies in order to compile and evaluate available evidence. No unpublished data were used to draw conclusions from the evidence.

CONSENSUS PROCESS: A consensus was reached after several iterations. Each topic was considered separately, and a consensus was achieved as to content to be included and conclusions reached between the primary author and the peer reviewer specific to that topic. In a separate iteration, the quality of evidence was judged using the GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) system in common use by The Endocrine Society for preparing clinical guidelines. The final iteration involved responses to four levels of additional review: 1) general comments offered by each of the 25 authors; 2) comments of the individual Task Force members; 3)
The Osteoporosis Agenda
England
Menopause: diagnosis and management

NICE guideline [NG23]  Published date: November 2015

Guidance
## STUDIES BEFORE 2004

<table>
<thead>
<tr>
<th>STUDY</th>
<th>POPULATION</th>
<th>NUMBERS</th>
<th>F.UP (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2 alone</td>
<td>WEST</td>
<td>664</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>ESPRIT</td>
<td>1017</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>WHI</td>
<td>Healthy (?)</td>
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</tr>
<tr>
<td>E2 &amp; Progestin combined</td>
<td>HERS</td>
<td>2763</td>
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</tr>
<tr>
<td></td>
<td>EVIET</td>
<td>140</td>
<td>1.3</td>
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<tr>
<td></td>
<td>WHI</td>
<td>Healthy (?)</td>
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</tr>
<tr>
<td></td>
<td>PHASE</td>
<td>255</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>WAVE</td>
<td>423</td>
<td>2.8</td>
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NICE. 23. Menopause: Diagnosis & Management
WHI REVIEW: AGE WISE STATISTICS (/ 10,000): CVD

<table>
<thead>
<tr>
<th></th>
<th>50-59 yrs</th>
<th>60-69 yrs</th>
<th>70-79 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2 alone</td>
<td>-10</td>
<td>-5</td>
<td>+4</td>
</tr>
<tr>
<td>E2 &amp; Progestin</td>
<td>+5</td>
<td>+1</td>
<td>+23</td>
</tr>
</tbody>
</table>

Manson J et al 2003  
WHI Steering committee 2004  
(Main Study: No age wise statistics: CVD/CVA: No effect: 660 / placebo 628; RR: 1.05)
<table>
<thead>
<tr>
<th></th>
<th>50-59 yrs</th>
<th>60-69 yrs</th>
<th>70-79 yrs</th>
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</thead>
<tbody>
<tr>
<td>E2 alone</td>
<td>0</td>
<td>+19</td>
<td>+14</td>
</tr>
<tr>
<td>E2 + Progestin</td>
<td>+4</td>
<td>+9</td>
<td>+13</td>
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Wasserthall-Smoller et al 2003  
WHI Steering Committee 2004
### WHI: BREAST CANCER

<table>
<thead>
<tr>
<th>Estimated Hazards Ratio (95% C.I.)</th>
<th>Breast cancer event rate (/ 1000 women over 5 years)</th>
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<tbody>
<tr>
<td></td>
<td>HRT</td>
<td>Placebo</td>
</tr>
<tr>
<td>All Breast cancers 1:24 (1.02-1.50)</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Invasive cancers 1:24 (1.01-1.54)</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>In situ cancers 1:18 (0.77-1.27)</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

NICE: 23: Menopause: Diagnosis & Management
## WHI: AGE WISE STATISTICS: BREAST CANCER

<table>
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<tr>
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<th>50-59 yrs</th>
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<tbody>
<tr>
<td>E2 alone</td>
<td>-9</td>
<td>-10</td>
<td>-2</td>
</tr>
<tr>
<td>E2 + Progestin</td>
<td>+5</td>
<td>+10</td>
<td>+13</td>
</tr>
</tbody>
</table>

NICE: 23: Menopause: Diagnosis & Management
HRT and CARDIOVASCULAR PREVENTION 2

Results:

- Women receiving HRT early after the menopause have a significantly reduced risk of:
  - Mortality (HR 0.57, 95% CI 0.50 to 1.08; P=0.084)
  - Heart Failure + MI + Death (HR 0.48, 95% CI 0.26 to 0.87; P=0.015)
- No apparent increased risk of:
  - Any cancer (HR 0.92, 95% CI 0.58 to 1.45; P=0.71)
  - Breast cancer (HR 0.58, 95% CI 0.27 to 1.27; P=0.17)
  - Stroke (HR 0.77 95% CI 0.55 to 1.07)
- DVT (HR 2.01 95% CI 0.18 to 22.16)

Safety of long-term use
"Window of opportunity"

(Schiebeck LL, Reijnmark L, Tofteng CL et al. BMJ 2012; 345:e5409)
Effects of oral versus transdermal menopausal hormone treatments on self-reported sleep domains and their association with vasomotor symptoms in recently menopausal women enrolled in the Kronos Early Estrogen Prevention Study (KEEPS)

Dahiana Cistron, MS,1 Brian D. Lehr, MS,1 Kent R. Bailey, PhD,2 Nanovic Sexton, MD,3 Bolin Lloyd, MD,4 Justin E. Maness, MD, DMH,1 Gynecare, Neal-Perry, MD, PhD,5 Lubna Pol, MBBS, MS, FRCOG,1 Hugh S. Taylor, MD,6 Whitney Whisman, PhD,1

Fredrick Nishith, MD,7 S. Mitchell Harman, MD, PhD,8 and Virginia M. Miller, PhD1

Abstract

Objective: This study determined whether two different formulations of hormone therapy (oral conjugated estrogen: 0.625 mg q.d., n = 240; transdermal 17β-estradiol 0.05 mg q.d., n = 201) plus cyclic progesterone (Premarin 200 mcg or placebo [PBO] n = 241) affect sleep domains in participants of the Kronos Early Estrogen Prevention Study.

Methods: Participants completed the Pittsburgh Sleep Quality Index at baseline and during the intervention at 3, 6, 12, and 18 months. Global sleep quality and individual sleep domain scores were compared between treatments using analysis of covariance, and conducted with vasomotor symptoms (VMS) scores using Spearman correlation coefficients.

Results: Global Pittsburgh Sleep Quality Index scores (mean 6.5 ± 2.4 vs. 6.4 ± 2.4) were similar across groups at baseline and were not modified by improved sleep quality by both BT (average change +1.37 [CITF] and -1.32 [PBO]) when compared with PBO (P = 0.61; P = 0.61 [CITF] vs. PBO) and P = 0.002/1.25 vs. PBO). Domain scores for sleep satisfaction and latency improved with both BT. The domain scores for sleep disturbances improved more with CITF than CPTB. Global sleep scores significantly correlated with VMS severity (r = 0.70, P < 0.001 for both CITF and PBO). Change in scores for all domains except sleep latency and sleep efficiency correlated with change in severity of VMS.

Conclusions: Poor sleep quality is common in recently menopausal women. Sleep quality improved with both BT formulations. The relationship of VMS with domains of sleep suggests that assessing severity of symptoms and domains of sleep may help direct therapy to improve sleep for postmenopausal women.

Key Words: Conjugated estrogen: Transdermal—Hot flashes—Night sweats—Pittsburgh Sleep Quality Index—Vasomotor symptoms.
Does hormone replacement therapy (HRT) cause breast cancer? An application of causal principles to three studies

Part 5. Trends in breast cancer incidence in relation to the use of HRT

Samuel Shapiro, Richard D T Farmer, John C Stevenson, Henry G Burger, Alfred O Mueck, Anne Gompel

ABSTRACT

Background: Based principally on findings in three studies, the Collaborative Reanalysis (CR), the Women’s Health Initiative (WHI), and the Million Women Study (MWS), it is now claimed that hormone replacement therapy (HRT) with estrogen plus progesterin (E+P) is an established and major cause of breast cancer. The CR and MWS investigators have claimed that unopposed estrogen therapy (ET) also increases the risk, although to a lesser degree than does E+P. However, in the WHI study, there was unblinded and statistically robust evidence to suggest that ET (conjugated estrogens) does not increase the risk; borderline evidence, still in need of independent confirmation, suggested that ET may even decrease it.

Methods: Using generally accepted causal criteria, in this article Part 5, the authors evaluate reported trends in the incidence of breast cancer.

Results: The evidence to suggest a correlated decline in the incidence of breast cancer following a decline in the use of HRT has not adequately satisfied the criteria of time order, detection bias, confounding, statistical stability and strength of association, internal consistency, and external consistency. Biological plausibility is difficult to assess.

Conclusions: Based on the observed trends in the incidence of breast cancer following the decline in HRT use, the ecological evidence is too limited either to support or refute the possibility that HRT causes breast cancer.

BACKGROUND

Based principally on evidence from three studies, the Collaborative Reanalyses (CR), the Women’s Health Initiative (WHI), and the Million Women Study (MWS), it is now claimed that hormone replacement therapy (HRT) with estrogen plus progesterin (E+P) is an established and major cause of breast cancer. The CR and MWS investigators have claimed that unopposed estrogen therapy (ET) also increases the risk, although to a lesser degree than does E+P. However, in the WHI study, there was unblinded and statistically robust evidence to suggest that ET (conjugated estrogens) does not increase the risk; borderline evidence, still in need of independent confirmation, suggested that ET may even decrease it.

In Parts 1-4 of this series of articles we applied generally accepted epidemiological principles of causality to the evidence in the three studies. We concluded that HRT may or may not cause breast cancer, but the studies did not establish that it does.

The WHI findings for E+P were published in July 2002, following which there was an immediate decline in the use of HRT, and two initial studies reported a corresponding decline, in 2003, in the incidence of breast cancer in nine US National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) registries, and in the Kaiser Permanente Northern California health plan. The SEER study was first published as a conference abstract and then in full. The Kaiser Permanente findings were published in a letter to the editor.
HRT for women with premature ovarian insufficiency: a comprehensive review

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BACKGROUND: Premature ovarian insufficiency (POI), often and misleadingly referred to as ‘premature menopause’, is defined as a loss of ovarian activity before the age of 40 years and is characterised by irregular or absent periods and reduced fertility. Symptoms include those associated with the natural menopause (night sweats and vaginal dryness), and with the long-term adverse effects of estrogen deficiency (osteoporosis and cardiovascular disease); the latter is believed to explain the shorter life expectancy associated with POI.

OBJECTIVE AND RATIONALE: The objective of the current review was to collect all relevant studies supporting recommendations on the indications, treatment options, and risks of hormone replacement therapy (HRT) (estrogen, progesterone, and androgens) for women with POI.

SEARCH METHODS: The current review was written based on the best available evidence on the topic collected for the recently published ESHRE guidelines on the management of women with POI. PUBMED/MEDLINE and the Cochrane Library were searched in a stepwise approach. Relevant references were cross-referenced in evidence tables, with assessment of the quality.

OUTCOMES: HRT is strongly recommended for women with POI, mainly for vasomotor and genito-urinary symptom relief. In addition, HRT has been shown to have a role in bone protection and probably also in primary prevention of cardiovascular disease. There is little evidence on the optimal type, regimen, and dose of HRT, patient preference for route and method of administration, or effect of oral estrogen therapy on women with POI is physiological replacement of estrogen (and progesterone) is essential for their health, and the controversy that surrounds the use of HRT in postmenopausal women does not apply.

LIMITATIONS, REASONS FOR CAUTION: N/A.

WIDER IMPLICATIONS: New areas of study on HRT for women with POI should focus on life expectancy, quality of life and neurological function. Furthermore, randomized controlled trials comparing transdermal estradiol with oral estrogens with regard to efficacy, patient satisfaction, and side effects are urgently needed.

STUDY FUNDING/COMPETING INTERESTS: The authors received no funding for the review. The costs for the development of the ESHRE guidelines were covered by ESHRE. The authors have no conflicts of interest to disclose.

Key words: HRT / primary ovarian insufficiency / premature ovarian failure / androgens / estrogen / progesterone

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PATIENT AS INDIVIDUAL

- INDIVIDUALISED CARE (MHRA)
  - DIAGNOSIS
  - INVESTIGATION
  - MANAGEMENT
- G.P. : BEST PLACED

- ? LOWEST EFFECTIVE DOSE FOR SHORTEST PERIOD OF TIME (MHRA)

NICE: 23: Menopause: Diagnosis & Management
DIAGNOSIS

• >45:
  - PERIMENOPAUSE: VASOMOTOR, PERIODS
  - MENOPAUSE: 12/12 N PERIODS (& X HORMONES)
  - NO UTERUS: SYMPTOMS

• <45: FSH: IF SYMPTOMS, PERIODS
  - FSH: X: IF ON HORMONES OR > 45

• TESTS NOT DONE TO DIAGNOSE:
  - AMH
  - INHIBIN A & B
  - E2
  - ANTRAL FOLLICLE COUNT
  - OVARIAN VOLUME

NICE: 23: Menopause: Diagnosis & Management
### Menopause

#### Symptoms and physical changes

- Headaches and hot flushes
- Hair becomes thinner and loses luster
- Teeth loosen and gums recede
- Skin becomes drier and develops a rougher texture
- Breasts droop and flatten
- Nipples become smaller and flatten
- Risk of cardiovascular disease
- Backaches
- Abdomen loses muscle tone
- Body and pubic hair becomes thicker and darker
- Vaginal dryness, itching and shrinking
- Bones lose mass and become more fragile
- Stress or urge incontinence

#### SYMPTOM SCORE

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score before HRT</th>
<th>8 months after starting HRT</th>
<th>6 months after starting HRT</th>
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<tbody>
<tr>
<td>Hot flushes</td>
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<td></td>
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<tr>
<td>Light headed feelings</td>
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<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Irritability</td>
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</tr>
<tr>
<td>Depression</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Unloved feelings</td>
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<td></td>
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<tr>
<td>Anxiety</td>
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<td>Mood changes</td>
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<td>Sleeplessness</td>
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<td>New facial hair</td>
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<tr>
<td>Dry skin</td>
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<tr>
<td>Crawling feelings under the skin</td>
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</tr>
<tr>
<td>Less sexual feelings</td>
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<tr>
<td>Dry vagina</td>
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<td></td>
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<tr>
<td>Uncomfortable intercourse</td>
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<td></td>
</tr>
<tr>
<td>Urinary frequency</td>
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</tbody>
</table>

#### TOTAL

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS:

SCORE: None = 0; Mild = 1; Moderate = 2; Severe = 3

NB: The symptoms are grouped into 4 categories, somatomotor, psychological, locomotor and urogenital. If one group does not respond to HRT, look for other causes and specific treatments for that group.

Not all of the symptoms listed are necessarily oestrogen deficiency symptoms.

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INFORMATION

• EXPLANATION
• SYMPTOMS, DIAGNOSIS
• LIFESTYLE CHANGES
• TREATMENT: BENEFITS, RISKS, MYTHS
• LONG TERM HEALTH IMPACT
• CONTRACEPTION
• FERTILITY (POF, SURGERY, RADIO/CHEMO)

• SYMPTOMS
  - CYCLES
  - VASOMOTOR
  - MUSCULOSKELETAL
  - PSYCHOLOGICAL
  - UROGENITAL
  - SEXUAL

NICE: 23: Menopause: Diagnosis & Management
TREATMENT

VASOMOTOR
- E2+PROGESTIN : IF UTERUS
- E2: IF NO UTERUS
- SSRI,SNRI, CLONIDINE: 2ND LINE
- ISOFLAVONE, BLACK COHOSH, ST.JOHN’S WORT
  - SAFETY?, VARY, DRUG INTERACTION
- UPTO 5 YEARS

UROGENITAL
- TOPICAL E2: AS LONG ( INCL ON HRT)
  - O.K. FOR MOST WITH HRT C.I.
  - INCREASE DOSE IF NO RESPONSE
  - SYSTEMIC S.E. RARE
  - BLEEDING REPORT
  - + LUBRICANTS IF NEEDED

PSYCHO-SEXUAL
- PSYCH:
  - HRT FOR LOW MOOD
  - CBT
  - SSRI, SNRI: X BETTER UNLESS DEPRESSION
  - SEXUAL:
    - TESTOSTERONE (+HRT) : FOR LIBIDO

NICE: 23: Menopause: Diagnosis & Management
REVIEW

- AT 3/12: EFFICACY, S.E.
- ANNUAL THEN
- REFER IF X EFFECT OR S.E.
- REFER: IF C.I., RISKS, UNCERTAIN

- BLEEDING: 1ST 3 MONTHS: COMMON
- BLEEDING AFTER 3/12: INVESTIGATE
- STOPPING HRT: GRADUAL: BETTER IN SHORT TERM SYMPTOM CONTROL

NICE: 23: Menopause: Diagnosis & Management
### LONG TERM RISKS: VTE, BREAST CANCER

#### VTE:
- ORAL HRT INCREASES RISK OF VTE
- TRANSDERMAL: NO MORE RISK OF VTE
  - FOR ALL AT HIGH RISK (INCL. BMI > 30)
  - REFER TO HEMATOLOGIST
- NATURAL PROGESTIN: BETTER
- ANDROGENIC SYNTHETIC: WORST

#### BREAST CANCER:
- E2 ALONE: LITTLE OR NO RISK OF BREAST CA
- E2+PROGESTIN: INCREASES RISK
  - RELATED TO RX DURATION
  - STOPS WITH STOPPING TREATMENT
- ALTERNATIVES: OSPEMIFENE, CEE-BZA, TOPICAL E2, NON HORMONAL: ??

NICE: 23: Menopause: Diagnosis & Management
BREAST CANCER

• REFER TO SPECIALIST

• ONLY IN SEVERE VASOMOTOR SYMPTOMS:
  SSRI (BUT NOT ON TAMOXIFEN)

• NOT SOY, BLACK COHOSH, VIT.E

• LIFESTYLE CHANGES

• COUNSELLING

NICE: 101: Early & Locally Advanced Breast Cancer: Diagnosis & Management: 2018
LONG TERM RISKS: CVD, CVA, DM

**CVD:**
- No risk of CVD if started <60
- Does not affect risk of dying from CVD
- No C.I. if CVD
- E2 alone reduces risk of CVD
- E2 + progestin: little or no risk of CVD
- Oral (x transdermal): small increase of stroke

**DM:**
- No risk of type 2 DM
- Does not alter blood sugar control

NICE: 23: Menopause: Diagnosis & Management
LONG TERM RISKS: DEMENTIA, MUSCLE MASS

• EFFECT ON DEMENTIA UNKNOWN
• LIMITED EVIDENCE THAT IT INCREASES MUSCLE MASS - ACTIVITY

• OVARIAN CA: E2 OR E2+PROGESTIN: SLIGHTLY ↑ RISK
OSTEOPOROSIS

• FRAGILITY FRACTURE
  - LOW IN U.K. (AT MENOPAUSAL AGE)
  - ↓ AS LONG AS ON RX
PREMATURE OVARIAN FAILURE

• HISTORY, REDUCED PERIOD
• FSH >20 : 2 SAMPLES 4-6 WEEKS APART
• HRT OR COC (UNLESS C.I./ CANCER)
• CONTINUE TILL NATURAL MENOPAUSE AGE
• BOTH OFFER BONE PROTECTION
• RISK OF BREAST CA & CVD LOW IN <40
• HRT BETTER FOR B.P. CONTROL THAN COC
• HRT NOT CONTRACEPTION

NICE: 23: Menopause: Diagnosis & Management