MENOPAUSE & HRT

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Women are struggling to access

independent.co.uk/life-style/women/menopause-treatment-difficult-symptoms-hrt-b1875459.html

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WOMEN ARE STRUGGLING TO ACCESS MENOPAUSE TREATMENT, SURVEY FINDS

Women are 'waiting too long to get HRT, if it's prescribed at all', says researcher

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I know it's weird, but I rather en

independent.co.uk/independentpremium/voices/menopause-jenny-eclair-davina-mccall-b1848659.html

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I know it's weird, but I rather enjoyed my menopause

Being hormonally disturbed was a great excuse – now when I behave badly, I have to face the fact that it's because I'm a terrible person, writes **Jenny Eclair**

Monday 17 May 2021 21:30 | 3 comments

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NICE: 23: Menopause: Diagnosis & Management

Summary consensus statement

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.

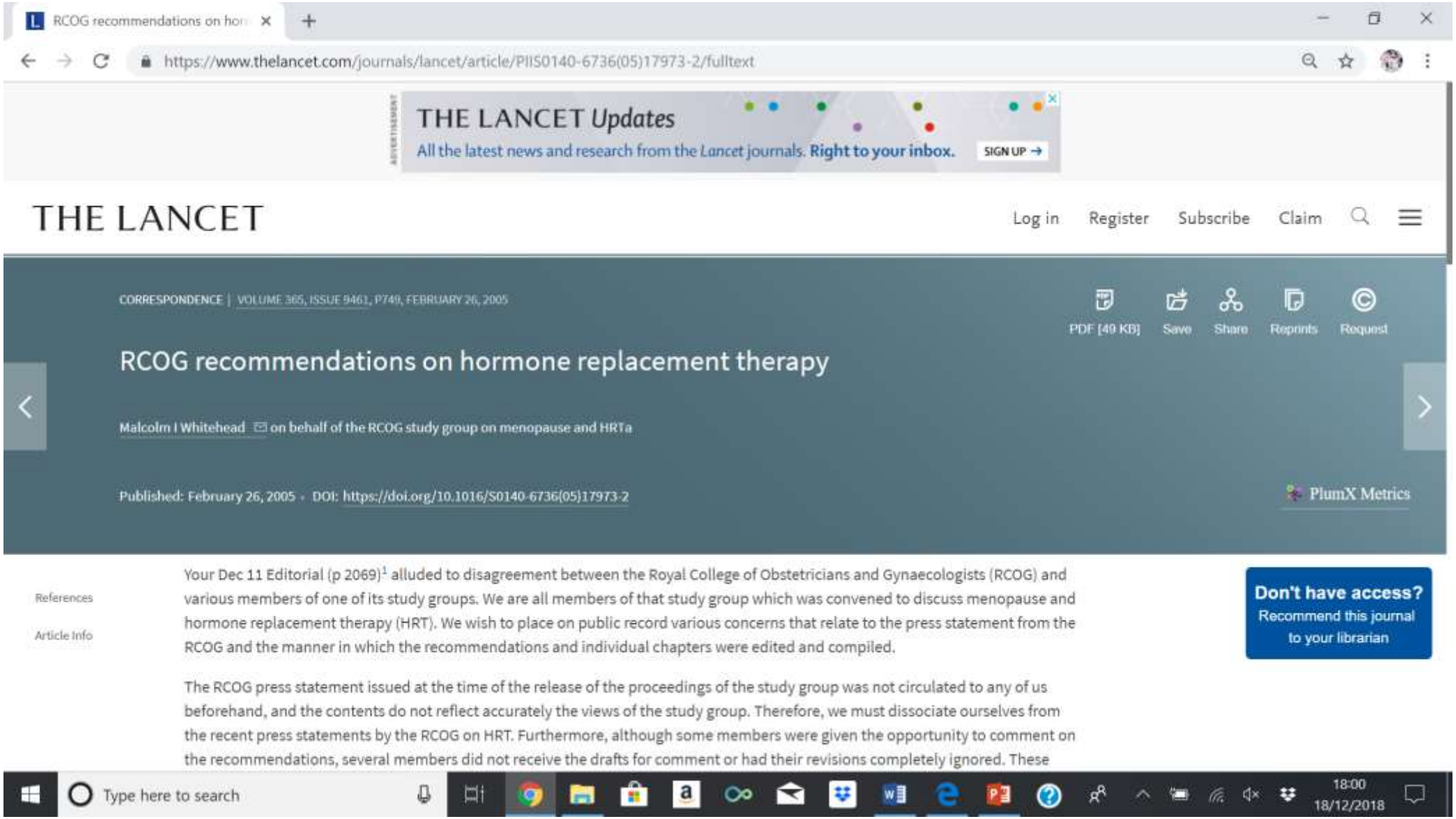
6 HRT prescribed before the age of 60 or within 10 years of the menopause has a favourable benefit /risk profile and is likely to be associated with a reduction in coronary heart disease and cardiovascular mortality.

7 If HRT is used in women over 60 years of age, low doses should be started,

The full statement, scientific papers, charts, presentations etc are available in the Members Area. If you are not a member you can join online.

Reviewed: December 2016
Next review date: December 2018

Publications
- NICE Guideline
- Journal
- Handbook
- BMS Vision
- Consensus Statements
  - Bioidentical hormones
  - Hormone replacement therapy
  - The diagnosis of the menopause and management of oestrogen deficiency symptoms and arthralgia in women treated for breast cancer
  - Hormones and depression


RCOG recommendations on hor
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RCOG recommendations on hormone replacement therapy
Malcolm I Whitehead on behalf of the RCOG study group on menopause and HRTa
Published: February 26, 2005 DOI: https://doi.org/10.1016/S0140-6736(05)17973-2
PlumX Metrics
References
Article Info
Your Dec 11 Editorial (p 2069)[1] 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
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CLIMACTERIC 2007;10:181–194

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

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.

Menopause: diagnosis and management

NICE guideline [NG23] Published date: November 2015

Guidance

NICE interactive flowchart - Menopause Quality standard - Menopause

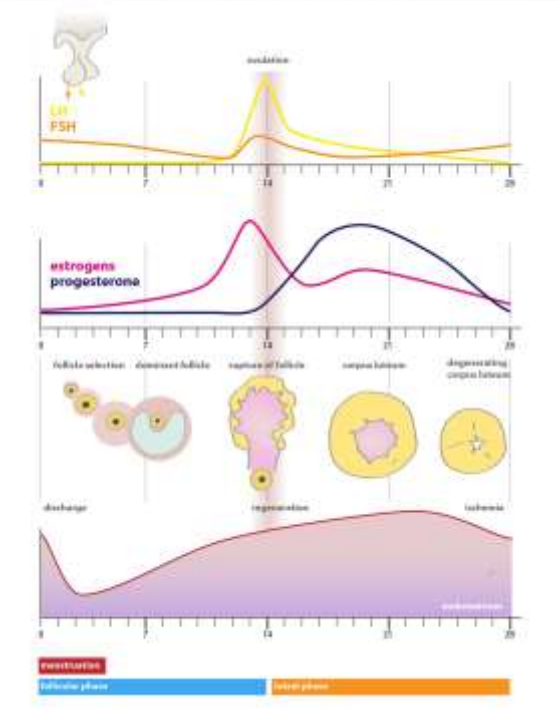
THE LOST GENERATION - HRT

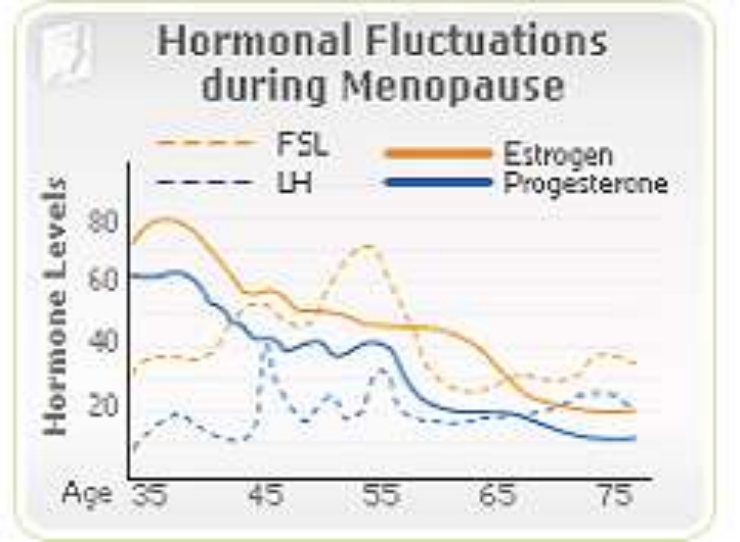
- 75% : NOT ENOUGH INFORMATION FOR INFORMED CHOICE
- 85%: NOT AWARE OF ALTERNATIVES
- 20% : ACCESSED SPECIALIST SERVICE
- <15%: RECEIVED TREATMENT
- POSTMENOPAUSE: HEALTH AFFECTED IN MULTIPLE WAYS (NOT JUST HORMONES)

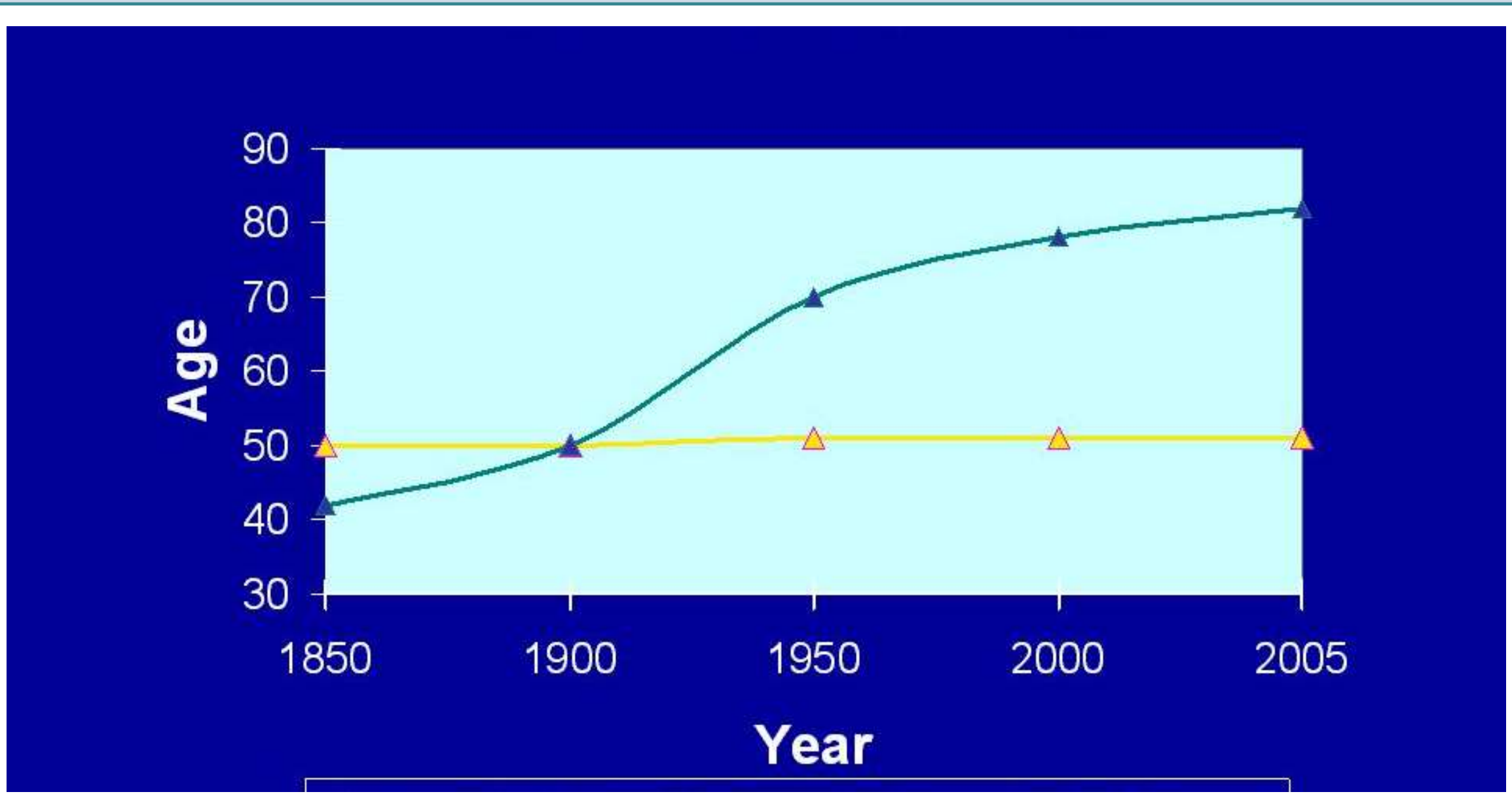
CONTENTS

WHAT IS MENOPAUSE?

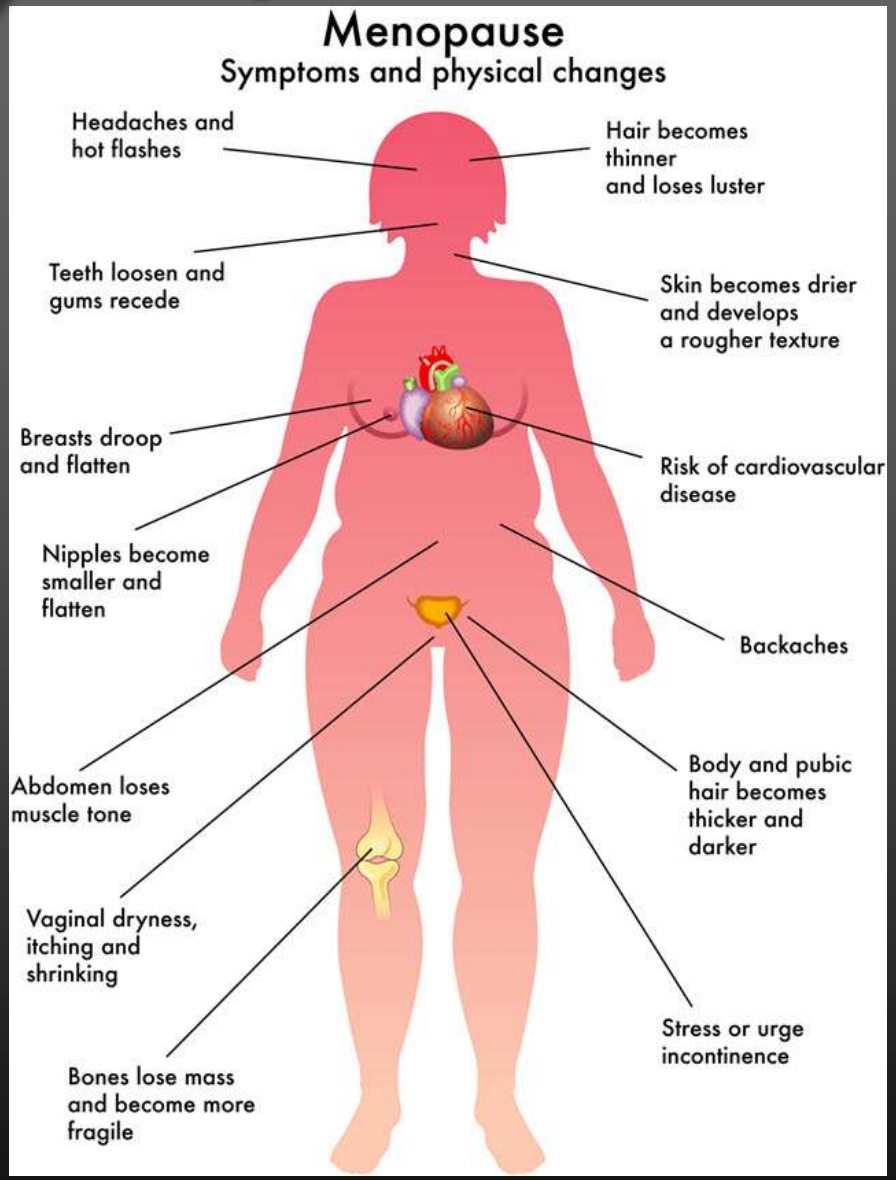
- NO PERIODS FOR 12 MONTHS
- EGGS (<1000)
- CLIMACTERIC
- 51 YEARS
- GENETIC & ENVIRONMENT
- FSH: FLUCTUATE (NOT HELPFUL)







NICE: 23: Menopause: Diagnosis & Management



SYMPTOM SCORE	Score before HRT	3 months after starting HRT	6 months
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
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, vasomotor, 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.

NICE: 23: Menopause: Diagnosis & Management

SYMPTOMS

- HOT FLUSHES & NIGHT SWEATS: 70%
- UROGENITAL, SEXUAL
- EMOTIONAL, SLEEP, CONCENTRATION, MEMORY
- MOST: 5 YEARS
- 15% > 10 YEARS

SYMPTOMS: PSYCHO-SEXUAL

SEXUAL

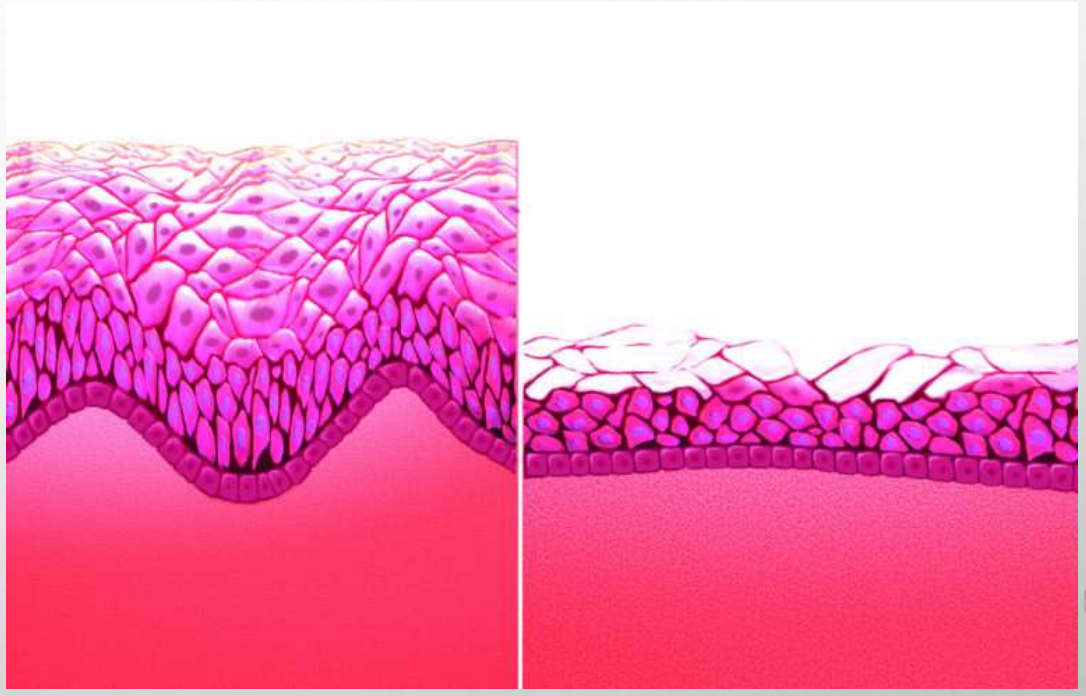
- VAGINAL DRYNESS: 1:2
- LOW DESIRE/ ORGASM
- SLEEP, TIREDNESS
- MALE/ SOCIAL FACTORS

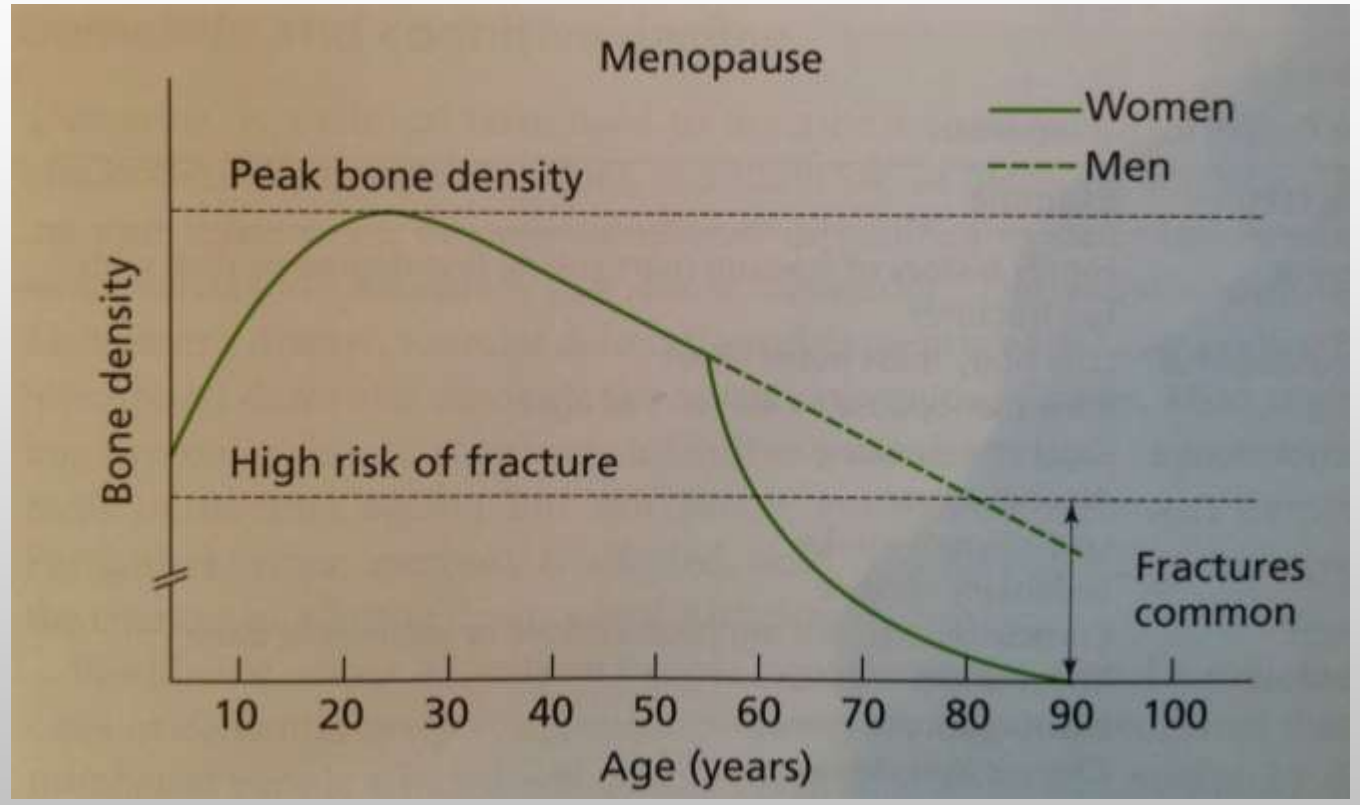
PSYCHOLOGICAL

- MOST WITH PAST HISTORY
- LETHARGY & TIREDNESS: AUGMENTS
- SLEEPLESSNESS: WORSENS
- RELATIONSHIP/ SOCIAL

SYMPTOMS: URO-GENITAL

- Oestrogen sensitive
- Includes glycogen & microbiome
- Recurrent uti
- Incontinence
- prolapse





CHRONIC HEALTH: OSTEOPOROSIS

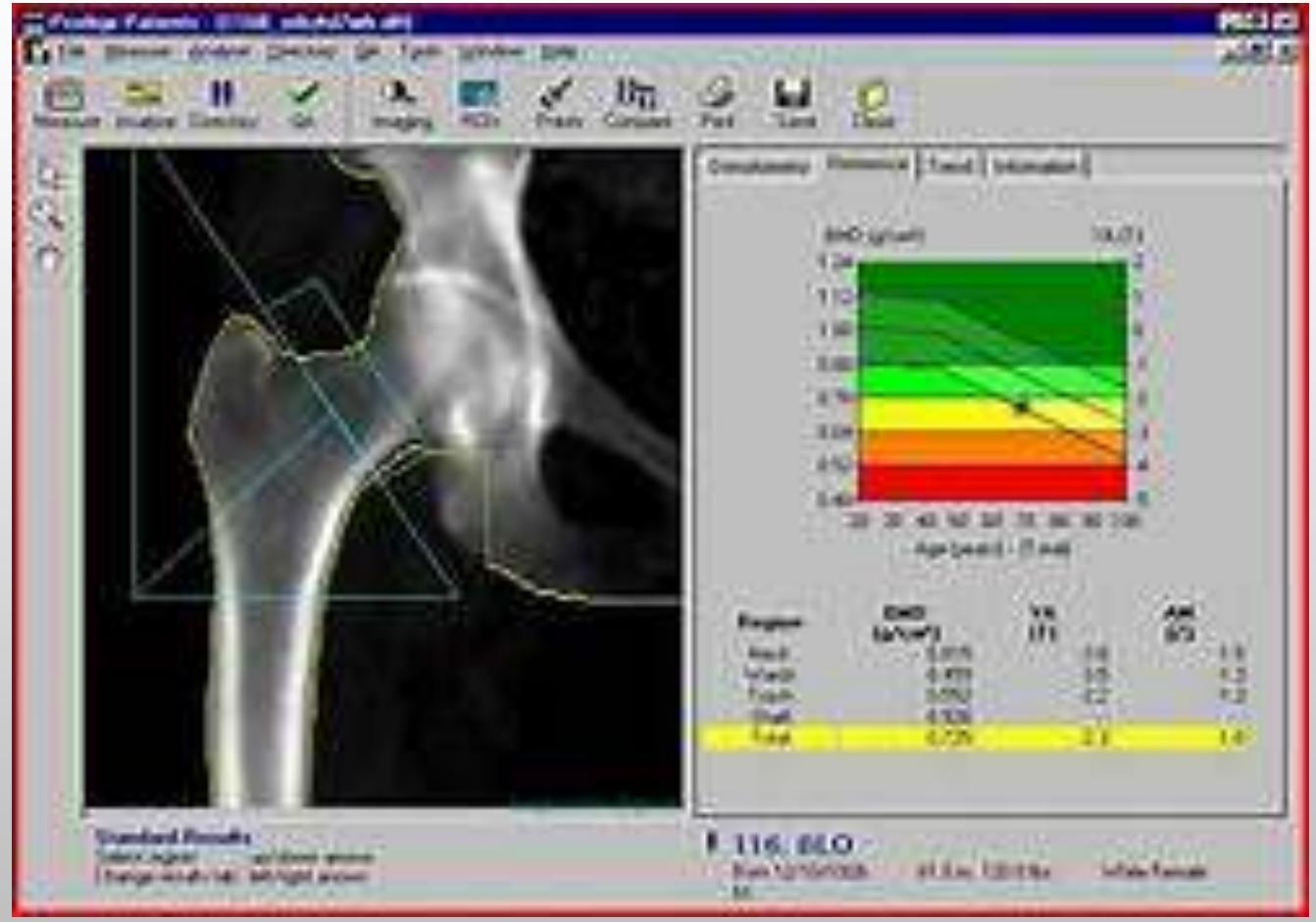
- GENETIC
- LOW BMI
- EARLY MENOPAUSE
- SMOKING, LOW CA, ALCOHOL
- SEDENTARY
- CHRONIC DISEASE/ STEROIDS

CHRONIC HEALTH: CARDIOVASCULAR

- Leading cause of death (> women)
- Increases after menopause
- Genetic, bmi, alcohol, bp, lipids
- Oestrogen protects
- Premature menopause

INVESTIGATIONS

- **NONE ROUTINE**
- FSH:?
- THYROID PROFILE, LIPIDS
- LIFESTYLE: BP, DM
- RISKS: BONE MINERAL DENSITY
- DVT (IF INDICATED)
- BREAST CANCER SCREENING



TREATMENT: HORMONES (E2)

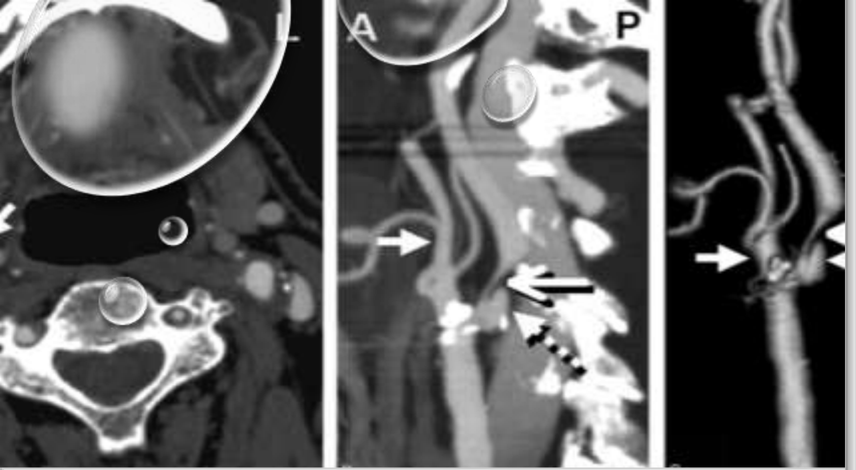
Vasomotor (hot flushes): most effective

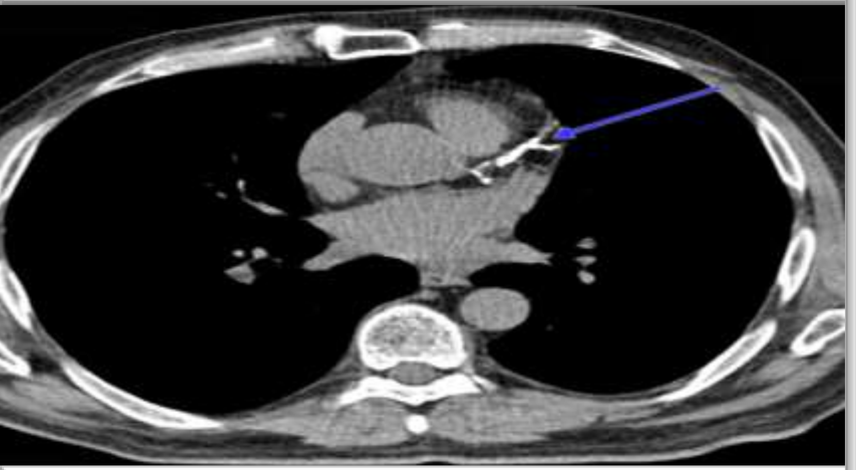
Urogenital (urinary & sexual): most effective

Prevents osteoporosis & bone loss

Protective effect on cardiovascular system (if started early)

May improve mood (observational studies only)



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OESTROGEN & HEART

- PROTECTIVE IF STARTED EARLY (< 60 YEARS)
- HARMFUL (IF STARTED LATE)
- OTHER LIFESTYLE FACTORS: SMOKING, ALCOHOL, BMI, BP, DM, LIPIDS
- ORAL HRT: INCREASES RISK OF DVT/ STROKE
- TRANSDERMAL: DOES NOT INCREASE RISK
- HRT DOES NOT AFFECT DIABETES

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REVIEW

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 characterized 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, progestogens 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 guideline on the management of women with POI. PUBMED/MEDLINE and the Cochrane library were searched in a stepwise approach. Relevant references were summarized 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 of each component of HRT must be considered when prescribing, as should contraceptive needs. In women with POI, physiological replacement of estrogen (and progesterone) is essential for their health, and the controversies that surround the use of HRT in postmenopausal women do 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 guideline 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

OESTROGEN & BONES

- INCREASES BONE DENSITY (STARTED <60 YRS)
- DOSE RELATED
- DECREASES WITH STOPPING RX
- BIPHOSPHONATES: SIDE EFFECTS

OESTROGEN & COGNITION/ MEMORY

- OBSERVATIONAL STUDIES: MAY BENEFIT IN ALZHEIMER'S & OTHER DEMENTIA
- WHI: NO BENEFIT
- CONTROVERSIES

OESTROGEN & BREAST CANCER

Minimal risk (2/1000 in 5 years)

Oestrogen: ? No increased risk

Progesterone: increases

Dose & duration dependant

Decreases with stopping Rx

Lifestyle risks: more important:

bmi, alcohol, late menopause (?)

TREATMENT: HRT

- Individualised
- Lowest possible dose for shortest possible time (BMS/ NICE)
- 1mg oral / 25-50 mcg transdermal: Oestrogen
- Mirena or Utrogestan: Progesterone (more s.e due to progesterone)
- No arbitrary limit
- Generally safe if started early & for upto 5 years
- If needed: usually benefits outweigh the risks
- Breast cancer risk: low & reversible (unless high risk)
- DVT/ stroke risk: Not with transdermal

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

NON HORMONAL

- SSRI (Anti depressants) : Hot flushes helps (interaction with Tamoxifen)
- Clonidine (Anti BP): hot flushes
- Gabapentin (unlicensed): hot flushes
- Lubricants/ moisturisers : topical

COMPLIMENTARY/ ALTERNATIVE RX

- NONE AS EFFECTIVE AS OESTROGEN
- HERBAL: NOT NECESSARILY SAFE OR EFFECTIVE (DOSE/ COMBINATION/ LIMITED DATA)
- ST JOHN'S WORT: DRUG INTERACTION
- RED CLOVER & PHYTO-OESTROGENS (ISOFLAVONES): CONFLICTING: STILL CONTAINS E2
- CBT: HELPS: PSYCHO-SEXUAL
- LIFESTYLE: EXERCISE, RELAXATION, YOGA, MEDITATION, DIET
- STOPPING: SMOKING

BIOIDENTICAL (?NATURAL) HORMONES

- COMPOUNDED: CONTROVERSIES
- REGULATED: SOME ADVANTAGES
- NO EVIDENCE OF BENEFITS/ SAFETY/ DOSAGE
- UTROGESTAN & DYDROGESTONE
- BENEFITS: DVT, BREAST CA. (?), MOOD, CVS & LIPIDS, SIDE EFFECTS

THANK YOU

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