Lancashire &
South Cumbria
Medicines
Management
Group

Primary Care Management of Menopause

Version 1.0

Introduction



VERSION CONTROL		
Version	Date	Amendments made
1.0	June 2023	New guideline. AG.

Contents

- 1. Algorithm 1 Primary Care Management of Menopause
- 2. Initial assessment
- 2. Advice to provide to all patients diagnosed with menopause
- 3. Long term risks and benefits of HRT
- 4. HRT treatment routines

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Primary Care Management of Menopause Yes Initial assessment and diagnosis see page 2 Uncertainty in diagnosis? Refer No **Current breast cancer** diagnosis or at high risk of breast cancer? Yes Reassure patients with No Type 2 DM that HRT is not generally Type 2 diabetes? associated with an adverse effect Yes on blood glucose No control. Provide all patients with information and advice - see page 2 Consider the following pharmacological treatment options for short term menopausal symptoms For all treatment options: Review at THREE months (unless indicated otherwise) to assess efficacy and tolerability Review annually thereafter unless there are clinical indications for an earlier review (such as treatment ineffectiveness, side effects or adverse events) **Urogenital** Vasomotor Altered sexual **Psychological** atrophy symptoms function symptoms low mood due Vaginal oestrogen menopause **ONLY** Offer to patients with urogenital atrophy (including those on systemic HRT) and Is HRT continue treatment No contraindicated for as long as HRT 1st Line - see page 2 and 3. Offer: or declined by needed to relieve oestrogen AND progesterone HRT for patients WITH symptoms. the patient? a uterus and oestrogen ONLY HRT for patients WITHOUT a uterus If systemic HRT is **Review after THREE months** contraindicated seek Yes advice from a specialist before commencing Explain that Consider clonidine ONLY if: 2nd Line Altered Sexual symptoms often return **Function ONLY** Where HRT is contraindicated or when treatment is declined, a trial of Clonidine 25 mcg stopped and that they **Testosterone** tablets may be considered for should report unscheduled vaginal (transdermal) menopausal VMS. bleeding to their GP. can be considered for **Review after FOUR weeks** supplementation in Advise patients with postmenopausal patients If no improvement in symptoms is vaginal dryness that with low sexual desire if observed or the patient is experiencing moisturisers and HRT alone is not effective. significant adverse events, treatment lubricants can be should be discontinued. **Shared care following** used alone or in addition to vaginal specialist initiation oestrogen. <u>ONLY</u>

Still symptomatic or troublesome side effects?

Refer to the specialist service

Primary Care Management of Menopause: Additional information

1. Initial assessment

Potential symptoms of menopause

Change in menstrual cycle

Insomnia

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).

Diagnose without laboratory tests in otherwise healthy women aged over 45 years with menopausal symptoms:

- perimenopause based on vasomotor symptoms and irregular periods
- menopause in women who have not had a period for at least 12months and are not using hormonal contraception
- menopause based on symptoms in women without a uterus.

Take into account that it can be difficult to diagnose menopause in women who are taking hormonal treatments, for example for the treatment of heavy periods.

Consider using a follicle-stimulating hormone test* to diagnose menopause only in women aged 40 to 45 years with menopausal symptoms, including a change in their menstrual cycle, or in women aged under 40 years in whom menopause is suspected.

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

2. Advice to provide to all patients diagnosed with menopause

- Stages of the menopause
- Common symptoms and diagnosis (above)
- · Lifestyle changes and interventions that could help general health and wellbeing
- Treatment options Hormonal, non-hormonal, non-pharmaceutical
- Benefits and risks of treatments for menopausal symptoms see below. Discuss short-term (up to 5 years) and longer-term benefits and risks of HRT.
- Explain to women who wish to try complementary therapies that the quality, purity and constituents of products may be unknown
- Contraception to women who are in the perimenopausal and postmenopausal phase (up to aged 55years)
- · Long-term health implications of menopause

Advise women with a uterus that unscheduled vaginal bleeding is a common side effect of HRT within the first 3 months of treatment but should be reported at the 3-month review appointment, or promptly if it occurs after the first 3 months.

Stopping HRT

Offer women who are stopping HRT a choice of gradually reducing or immediately stopping treatment. Gradually reducing HRT may limit recurrence of symptoms in the short term but makes no difference to symptoms in the long term.

Primary Care Management of Menopause: Additional information

3. Long term risks and benefits of HRT

Venous thromboembolism (VTE) - VTE risk is increased by oral HRT compared with baseline population risk. The risk associated with transdermal HRT given at standard therapeutic doses is no greater than baseline population risk.

Consider transdermal rather than oral HRT for menopausal women who are at increased risk of VTE, including those with a BMI over 30 kg/m². Consider referring menopausal women at high risk of VTE (for example, those with a strong family history of VTE or a hereditary thrombophilia) to a haematologist for assessment before considering HRT.

Cardiovascular disease – HRT does not increase cardiovascular disease risk when started in women aged under 60 years. Oral (but not transdermal) oestrogen is associated with a small increase in the risk of stroke, however the baseline population risk of stroke in women aged under 60 years is very low. Consider transdermal preparations to those aged over 60 to reduce cardiovascular risk.

Breast cancer - HRT with oestrogen alone is associated with little or no change in the risk of breast cancer. HRT with oestrogen and progestogen can be associated with an increase in the risk of breast cancer. Any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT.

See MHRA alert for further detail: <u>'Hormone replacement therapy (HRT): further information on the known increased risk of breast cancer with HRT and its persistence after stopping'</u>

Osteoporosis – The risk of fragility fracture is decreased while taking HRT.

Muscle mass – There is limited evidence suggesting that HRT may improve muscle mass and strength.

Dementia – The likelihood of HRT affecting their risk of dementia is unknown.

4. HRT treatment routines

The 2 types of routines are cyclical (or sequential) HRT and continuous combined HRT.

Cyclical HRT

Cyclical HRT, also known as sequential HRT, is often recommended for women taking combined HRT who have menopausal symptoms but still have their periods. There are 2 types of cyclical HRT:

- monthly HRT oestrogen every day, and progestogen alongside it for the last 14 days of the menstrual cycle. Monthly HRT is usually recommended for women having regular periods.
- **3-monthly HRT** oestrogen every day, and progestogen alongside it for around 14 days every 3 months. 3-monthly HRT is usually recommended for women having irregular periods.

Continuous combined HRT

Continuous combined HRT is usually recommended for women who are postmenopausal. A woman is usually said to be postmenopausal if she has not had a period for 1 year.

Continuous combined HRT involves taking oestrogen and progestogen every day without a break. Oestrogen-only HRT is also usually taken every day without a break.

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