Primary Care Hormone Replacement Guidelines

[APC ClinDoc 010]

For the latest information on interactions and adverse effects, always consult the latest version of the Summary of Product Characteristics (SPC), which can be found at: http://www.medicines.org.uk/

Approval and Authorisation

<table>
<thead>
<tr>
<th>Approved by</th>
<th>Job Title</th>
<th>Date</th>
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<tr>
<td>Geoff Braham on behalf of NHS Berkshire West APC</td>
<td>APC Chair, NHS Berkshire West APC</td>
<td>1st May 2019</td>
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Change History

<table>
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<tr>
<th>Version</th>
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<tr>
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<td>Updating existing expired guidelines (v1.0). Based on British Menopause Society guidance</td>
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*This prescribing guideline remains open to review considering any new evidence*

*This guideline should only be viewed online and will no longer be valid if printed off or saved locally*
Hormone Replacement Treatment Guideline

Transdermal

Oestrogen only
(No uterus/Mirena coil) 1 prescription charge

Oestradiol patch
Evorel 25 - 100mcg 2 x wk
Oestradiol gel
Sandra 0.5 - 1.5mg/g daily
Oestrogel 0.06%

Sequential combined
(Uterus present, monthly bleed) 2 prescription charges

Oestradiol/norethisterone patch
Evorel Sequi 50-170mcg 2 x wk
Oestradiol/levonorgestrel patch
FemSeven Sequi 10-50mcg once wk

Continuous combined
(Uterus present, no bleed for 1 year if > 50 years or 2 years if < 50 years) 1 prescription charge

Oestradiol/norethisterone patch
Evorel Conti 50mcg/170mcg 2 x wk
Oestradiol/levonorgestrel patch
FemSeven Conti 50mcg/10mg wkly
If progesterone SEs/low libido

Oral

Conjugated equine oestrogen tablets
Premarin 300mg, 0.625mg, 1.25mg daily

Oestradiol tablets
Elleste solo 1-2mg daily

See the British Menopause Society website https://thebms.org.uk/publications/tools-for-clinicians/ for further advice on the following: For healthcare professionals: NICE: Menopause Diagnosis and Management from Guideline to Practice – Guideline Summary HRT Guide For women: Understanding the Risk of Breast Cancer Pt info leaflets: http://www.menopauserelates.co.uk/oestrogen.php

Vaginal

Untergenal atrophy is present in approximately 60% of patients. Ask patients if they have symptoms such as vaginal dryness, itching, dyspareunia or tenderness. NICE advice is to offer vaginal oestrogen (including those on systemic HRT). Vaginal oestrogen may also be used where HRT is contraindicated.

Vagifem® 10mg oestradiol tablets or Ovestin (0.1% oestril cream)
Use every night for 14 nights then alternate nights for 14 nights then twice weekly thereafter. Or Estring (7.5mg/24hr delivery system: 3 month device OR

Vaginal moisturisers and lubricants may be used alone or in combination with vaginal oestrogen.

Testosterone
At present, there is no licensed product for women as testosterone patches and implants have been withdrawn for commercial reasons. In studies testosterone supplementation may help improve libido in women who have undergone bilateral oophorectomy. NICE recommend testosterone supplementation for menopausal women with low sexual desire when HRT alone is not effective.
Patients who may require testosterone supplementation should be referred to secondary care for specialist advice.

Utrogestan is an option for continuous progesterone

Modifiable lifestyle factors - ensure that these are addressed
• Women should be advised to eat a healthy balanced diet, to maintain a healthy BMI, to ensure they eat sufficient dietary calcium (700mg/day) and undertake regular weight-bearing exercise.
• Ensure that a discussion occurs with the patient in order to address stopping smoking, reducing alcohol intake.
• Ensure optimum treatment of conditions such as diabetes and blood pressure as applicable in order to reduce the impact of such diseases on menopausal symptoms.

Preferred first line

Duration of treatment
Current recommendations are that there should be no arbitrary limits for use of HRT. Women can take HRT for as long as they feel that it is beneficial to them. Many women continue to have menopausal symptoms in their 60s, 70s, even some in their 80s and so for them treatment continues to be required. The duration of symptoms cannot be predicted and so neither can the duration that HRT will be needed. See page 3 for information on risks
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About the menopause
The menopause is a normal life event for women; it is neither an illness nor medical condition\(^1\). Cessation of oestrogen leads to a long series of hormone deficiency related signs and symptoms in the vagina, skeleton, skin, brain, vasomotor, genitourinary and cardiovascular system. Many women suffer in silence in particular with urogenital symptoms such as dyspareunia (pain on intercourse), reduced libido, vaginal dryness and itching\(^2\). Other troublesome symptoms include low mood, anxiety, poor memory and concentration, reduced self-esteem, hot flushes and night sweats. These symptoms can devastate and reduce a woman’s quality of life\(^2\). Hormone replacement is the most effective way to manage symptoms\(^3\). Concerns around safety have led to a decline in prescribing by around 66% over the last 10 years\(^3\). Patient and clinician education is required to increase the awareness and promote the safe and balanced use of hormone replacement in menopause.

Diagnosis of menopause
An individualised approach to diagnosis should be adopted for each woman. Full medical history, including personal, family and drug history should be taken. Contraception should be discussed and blood pressure, height, weight and BMI calculated.

Diagnosis should be based on the woman’s symptoms and age. Women older than 45 years with menopausal symptoms can be diagnosed without laboratory tests if the woman has vasomotor symptoms and irregular periods or there have been no periods for a year (or based on symptoms in women without a uterus).

Consider measuring FSH levels if the woman is between 40-45 years with symptoms including a change in cycle or the woman is younger than 40 and premature menopause is suspected\(^4\).

Managing short-term (up to 5 years) menopausal symptoms using HRT\(^4\)
- Treatment of urogenital symptoms such as vulvovaginal atrophy (dyspareunia, vaginal dryness etc) and urinary tract infections (UTI))
- Reduction in vasomotor symptoms including night sweats and hot flushes
- Prevention of osteoporosis
- Relief of other symptoms such as sleep disturbance, anxiety, depression

Choice of hormone replacement treatment
The choice of treatment should follow a supportive consultation and should be tailored to the patient’s symptoms. Like contraception in younger women, a menopausal woman should be offered a choice of route which includes oral or transdermal ± topical vaginal preparations (vaginal preparations may also be used alone especially if symptoms are largely urogenital)

The oral route should be avoided in women experiencing poor symptom control after taking oral HRT for a suitable time period or in women experiencing side-effects. The transdermal route may be a more appropriate route for these women. The oral route should also be avoided in women at risk of VTE or with a history of VTE. This will also include women who are overweight with a BMI > 30\(^4\). Oral HRT containing oestrogen is associated with a higher risk of stroke when compared with transdermal therefore it is advised to avoid the oral route in women at risk of stroke. Women
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taking enzyme inducing agents should also avoid the oral route due to first pass metabolism in the liver which the transdermal route bypasses. Other contraindications such as intolerance to lactose or other tablet excipients make the oral route less suitable. The oral route should be avoided in women with a history of migraines, diabetes and gall stone disease.\(^1\)

The most important hormone is oestrogen and best prescribed as 17 beta oestradiol. Women with a uterus will also need a progestogen too. Studies show that women who take micronised progesterone have an even lower risk of breast cancer than those who take progestogens. There is robust evidence demonstrating that transdermal oestrogen with micronized progestogen (Utrogestan) represents optimal HRT especially in women at risk of cardiovascular disease.\(^3\)

Duration of hormone replacement treatment

The lowest effective dose should be used and a review of symptoms should be carried out after 3 months of treatment. Improvements in vasomotor symptoms may be seen after one month and usually by a maximum of 3 months. Improvements in urogenital symptoms are usually seen by 3 months but may take 6 months. A variable response may be observed with psychological symptoms.\(^4\)

Annual review

Once symptoms are under control, reviews should be conducted annually.\(^4\)

Lifestyle interventions

Women should be encouraged to maintain a healthy weight and engage in 2.5 hours of exercise each week (where possible).\(^4\)

Risks associated with hormone replacement as outlined in NICE Guideline (NG23)\(^4\)

Patients may find the following helpful: [https://www.menopausematters.co.uk/pdf/Understanding%20Risk%20of%20Breast%20Cancer.pdf](https://www.menopausematters.co.uk/pdf/Understanding%20Risk%20of%20Breast%20Cancer.pdf)

**Breast cancer**

Oestrogen-only HRT is associated with little or no increased risk of breast cancer. Oestrogen and progestogen HRT can be associated with an increased risk of breast cancer. Generally the risk is considered low. Any increase in risk is related to duration of HRT and reduces after stopping.

**Ovarian cancer**

HRT use may be associated with a small increased risk of ovarian cancer with both oestrogen only and combined HRT but the risk falls after cessation of HRT.

**Cardiovascular disease (CVD)**

Oral (not transdermal) oestrogen is associated with a small increased risk of stroke. In women <60 years the risk is very low. HRT does not increase CVD if started under 60 years or risk of dying of CVD. The presence of CVD risk factors is not a contraindication to HRT if they are optimally managed. The risk of coronary heart disease and stroke for women around menopause varies according to her risk factors. Oestrogen-alone HRT does not increase risk of coronary heart disease. HRT with oestrogen and progestogen is associated with little or no increased risk of coronary heart disease.

**Diabetes**

HRT is not associated with an increased risk of developing type 2 diabetes. HRT is not generally associated with adverse effect on blood glucose in women with type 2 diabetes. Consider HRT symptoms in women with type 2 diabetes after considering comorbidities and/or seeking specialist advice.

**Venous thromboembolism (VTE)**

The risk of VTE is increased by oral HRT, particularly in the first year of use. The risk associated with transdermal HRT with standard doses is no greater than baseline population risk. Consider transdermal HRT if woman has VTE risk factors including BMI>30. If high risk of VTE (including family history) consider referring to specialist service.

References

1. Newton L, Easy HRT prescribing, Primary Care Women's Health forum accessible via [https://www.menopausematters.co.uk/pdf/Understanding%20Risk%20of%20Breast%20Cancer.pdf](https://www.menopausematters.co.uk/pdf/Understanding%20Risk%20of%20Breast%20Cancer.pdf)

