

## Prescribing advice for the management of menopause in primary care

This guidance contains suggested advice for the management and treatment of women experiencing symptoms of menopause. It applies to Camden primary care practitioners (GPs and practice nurses). It will also be relevant to community pharmacists in assisting with patient education and suitable treatments

Comments on this document should be sent to the Medicines Management Team, by email to [mmt.camdenccg@nhs.net](mailto:mmt.camdenccg@nhs.net)

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1	<b>SUMMARY</b>	This guidance contains suggested advice for the management and treatment of women experiencing symptoms of menopause. It applies to Camden CCG primary care practitioners (GPs and practice nurses)			
2	<b>RESPONSIBLE PERSON:</b>	Head of Medicines Management			
3	<b>ACCOUNTABLE DIRECTOR:</b>	Director of Quality and Clinical Effectiveness			
4	<b>APPLIES TO:</b>	NHS Camden Clinical Commissioning Group (CCG) primary care practitioners and prescribers			
5	<b>GROUPS/ INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS GUIDANCE:</b>	Camden Medicines Management Team Camden CCG GP (Clinical Lead for Gynaecology) Consultant Endocrinologist (Royal Free London NHS Foundation Trust) Consultant Gynaecologist (University College Hospitals NHS Foundation Trust)			
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**DOCUMENT CONTROL**

Date	Version	Action	Amendments
May 2015	1	Guidance first implemented  <i>Agreed by CMMC 25<sup>th</sup> February 2015</i>	N/A
February 2016	2	Guidance reviewed and updated in line with NICE guideline NG23  <i>Agreed by CMMC 24<sup>th</sup> February 2016</i>	Updated risk section, premature ovarian insufficiency diagnostic information updated.

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## SUMMARY OF PREFERRED PRESCRIBING PRODUCTS

*Hormone Replacement Therapy (HRT) formulations should be prescribed by brand name (best practice)*

*This guideline outlines Camden's Preferred Prescribing Recommendations of HRT. HRT dosage, regimen and duration should be individualised, with an annual evaluation of the risk vs. benefits<sup>1</sup>*

Type of HRT	Camden Preferred Prescribing Choice	Dose	Key Prescribing Messages
Sequential combined therapy	<b>Oral preparations (first line)</b> <ul style="list-style-type: none"> <li>• Elleste Duet<sup>®</sup> tablets (estradiol and norethisterone)</li> <li>• Femoston<sup>®</sup> tablets (estradiol and dydrogesterone)</li> <li>• Prempak-C<sup>®</sup> tablets (conjugated oestrogens and levonorgestrel)</li> </ul>	Refer to BNF	<ul style="list-style-type: none"> <li>• Option for patients with menopausal symptoms and last period <b>less</b> than 12 months ago.<sup>2,3</sup></li> <li>• Femoston<sup>®</sup> preferred for women intolerant of norethisterone</li> </ul>
	<b>Transdermal preparations (second line)</b> <ul style="list-style-type: none"> <li>• Evorel Sequi<sup>®</sup> patches (estradiol and norethisterone)</li> </ul>		
Continuous combined therapy	<b>Oral preparations (first line)</b> <ul style="list-style-type: none"> <li>• Kliovance<sup>®</sup> tablets (estradiol and norethisterone low strength) preferred for women who are starting HRT</li> <li>• Kliofem<sup>®</sup> tablets (estradiol and norethisterone high strength)</li> <li>• Femoston<sup>®</sup> Conti tablets (estradiol and dydrogesterone)</li> <li>• Premique<sup>®</sup> low dose and Premique<sup>®</sup> tablets (conjugated oestrogens and medroxyprogesterone)</li> </ul>	Refer to BNF	<ul style="list-style-type: none"> <li>• Option for patients with menopausal symptoms and last period <b>more</b> than 12 months ago.<sup>2,3</sup></li> <li>• Femoston<sup>®</sup> Conti preferred for women not tolerating norethisterone</li> </ul>
	<b>Transdermal preparations (second line)</b> <ul style="list-style-type: none"> <li>• Evorel<sup>®</sup> Conti patches (estradiol and norethisterone)</li> </ul>		
Oestrogen only	<b>Oral preparations (first line)</b> <ul style="list-style-type: none"> <li>• Climaval<sup>®</sup> tablets (estradiol)</li> <li>• Premarin<sup>®</sup> tablets (conjugated oestrogens)</li> </ul> <b>Transdermal preparation (second line)</b> <ul style="list-style-type: none"> <li>• Estradot<sup>®</sup> patches (estradiol)</li> <li>• Oestrogel<sup>®</sup> vaginal gel (estradiol)</li> </ul>	Refer to BNF	<ul style="list-style-type: none"> <li>• Option for women without a uterus<sup>2,3</sup></li> </ul>
Topical preparations for vaginal atrophy	<ul style="list-style-type: none"> <li>• Ovestin<sup>®</sup> vaginal cream (estriol 0.1%) (first line)</li> <li>• Vagiferm<sup>®</sup> vaginal tablets (estradiol 10 mcg) (second line)</li> </ul>	Refer to BNF	<ul style="list-style-type: none"> <li>• Vaginal atrophy (menopausal atrophic vaginitis)<sup>2,3</sup></li> </ul>
Tibolone	<ul style="list-style-type: none"> <li>• Tibolone tablets</li> </ul>	Refer to BNF	<ul style="list-style-type: none"> <li>• Alternative to combined HRT for postmenopausal women who wish to have amenorrhoea<sup>2,3</sup></li> <li>• Not suitable for use in the perimenopause or within 12 months of the last menstrual period<sup>2,3</sup></li> </ul>

*Please note this treatment summary should be read in conjunction with the full prescribing advice and information contained in this document – the summary is not intended to be read as a stand-alone message and should not be used as the sole basis for your clinical decisions.*

***Please also refer to the SPC / BNF for full prescribing information.***

## 1. Introduction

Menopause is the time when menstruation ceases permanently due to the loss of ovarian follicular activity. In the UK, the average age at the menopause is 51-years<sup>2</sup>. Menopausal symptoms such as hot flushes, night sweats, mood changes and sexual function can be alleviated by using Hormone Replacement Therapy (HRT) with small doses of an oestrogen together with a progestogen (in women with a uterus).<sup>1,2,3</sup> HRT may diminish postmenopausal osteoporosis, however other drugs are preferred in this instance (see NICE pathways for the management of osteoporosis).<sup>1,2</sup>

Women who have a premature menopause (younger than 45 years of age) can be encouraged to take HRT until 50-52 years of age.<sup>2</sup>

This guideline outlines Camden's preferred prescribing recommendations for HRT. HRT dosage, regimen and duration should be individualised, with an annual evaluation of the risk vs. benefits. For further information on general management and diagnosis of menopause, refer to NICE guidance on [Menopause: diagnosis and management \(NG23\)](#). NICE guidelines on menopause does not provide prescribing advice for specific HRT products.

## 2. Assessment / Diagnosis

Amenorrhoea, irregular bleeding, hot flushes and vaginal atrophy are signs of menopause, but can also be caused by other conditions.<sup>1,2</sup> Urinary incontinence, mood changes, cognitive disturbances, loss of libido, muscle and joint pain, skin changes and weight gain can also be associated with menopause. These symptoms may not be present in all types of menopause.

When a woman presents with menopausal symptoms, it is important to consider the following;

- Stage of the menopause and the severity of the symptoms.
- History of previous treatments, including non- prescribed treatments.
- Assess the risk of osteoporosis and cardiovascular risk factors.
- Before starting treatment with HRT, consider the benefits and risks of treatment.
- Try to gauge the woman's expectations of treatment.

A full history should be taken including personal, family and drug history. The height, weight, (BMI), and BP should be measured. Patients should be up to date with cervical cytology and mammography and to make necessary arrangements if screening is required.

## 3. Management Advice

### 3.1 General advice<sup>1,2</sup>

There is some evidence that women who are more active tend to suffer less from the symptoms of the menopause.

All women with menopausal symptoms should be given the following advice<sup>1</sup>:

- Taking regular exercise and losing weight (if applicable) may reduce the severity and frequency of flushes.
- Exercise and adequate sleep may improve subjective cognitive symptoms.
- Avoiding exercise late in the day and maintaining a regular bedtime can improve sleep.
- Wearing lighter clothing, sleeping in a cooler room, reducing stress, and avoiding possible triggers (such as spicy foods, caffeine, smoking, and alcohol) may be helpful.

All women should be advised about the risks and benefits of treatments for menopausal symptoms.<sup>1,2,3</sup> Refer to NICE guidance on [Menopause: diagnosis and management NG23](#) and the BNF for more information.

Women should be offered patient information leaflets (available from <http://patient.info/>, NHS choices etc.)

## 4. Hormone Replacement Therapy (HRT)

### 4.1 Prescribing HRT

***HRT should be prescribed at the lowest effective dose and for the shortest time possible***<sup>1,2</sup>

The following information should be considered before prescribing HRT<sup>1,2</sup>:

- The decision whether to start/stop HRT should be based on individual's risk vs benefits ratio.
- The HRT dosage, regimen and duration should be individualised, with an annual evaluation of the treatment.
- HRT prescribed before the age of 60 usually has a favourable benefit / risk profile.
- Women with premature ovarian insufficiency should be encouraged to use HRT at least until the average age of the menopause.
- **HRT should be prescribed by brand name.**
- Allow 3 months on treatment before making any changes as side effects frequently subside with use.

### 4.2 HRT risk

HRT may increase the risk of venous thromboembolism, cardiovascular disease, breast cancer, endometrial cancer and ovarian cancer. HRT risk should be assessed on an individual case basis. For more information refer to NICE guidelines on menopause (NG23), NICE CKS and the current BNF.

### 4.3 Alternatives to HRT

Alternative options may be considered if a woman does not want to consider HRT or is unsuitable for treatment with HRT,<sup>1,2,4</sup> although evidence for alternative pharmacological, non-pharmacological and complimentary treatments is limited. Trials for these treatments on the whole are small and of short duration and are therefore of limited value in determining efficacy and safety.

- Non-pharmacological treatments e.g. Lubricants for vaginal dryness: Lubricants usually consist of a combination of protectants and thickening agents in a water-soluble base. They are usually used to relieve vaginal dryness during intercourse. They therefore do not provide a long-term solution<sup>4</sup>.
- Pharmacological treatments (unlicensed): Including SSRI's, clonidine, beta-blockers; the evidence for the use of these in menopause is limited<sup>4</sup>. For this reason, they are not recommended for routine use in Camden for this indication.
- Complimentary treatments (including herbal remedies): Some patients perceive complementary therapies to be safer and more natural alternatives to traditional hormone therapies<sup>4</sup>. However, the efficacy and safety of a number of these preparations have not been properly evaluated<sup>1,2</sup>. For this reason, they are not recommended in Camden.
- The efficacy and safety of unregulated compounded bioidentical hormones are unknown.<sup>1,2</sup> These preparations are not recommended in Camden.

For patient information on alternatives to HRT see the following link on The Royal College of Obstetricians & Gynaecologists website: <https://www.rcog.org.uk/en/patients/patient-leaflets/alternatives-to-hrt-for-symptoms-of-the-menopause/>

### 4.4 Contraindications and Cautions

Check individual Summary of Product Characteristics (SPC) for full list of contraindications and cautions.

This information is a broad guideline only. Treatment of an individual patient should always be modified according to need & circumstances, and may involve a multidisciplinary approach

## 4.5 HRT Products

The choice of HRT products should be based on the following:

- Type of menopause
- Choices of different hormones - Medroxyprogesterone and dydrogesterone are sometimes better tolerated than norethisterone or levonorgestrel because they are less androgenic<sup>1</sup>
- Choice of formulation - Certain formulations may be more acceptable to an individual and hence aid adherence to treatment.
  - **Oral or transdermal preparations** may be used to treat urogenital symptoms or vasomotor symptoms (for example flushes or sweats) with or without urogenital symptoms
  - **Transdermal preparations** may be appropriate if:
    - The woman is taking a hepatic enzyme-inducing drug (for example an anticonvulsant drug).
    - The woman has a severe liver disorder
    - The woman has a bowel disorder which may affect absorption of oral treatment.
    - The woman has a history of migraine (when steadier hormone levels may be beneficial). The woman has lactose sensitivity (most HRT tablets contain lactose).
  - **Low-dose vaginal oestrogen** (tablet, cream, pessary, or vaginal ring) may be used for urogenital symptoms alone

## 4.6 HRT products included in Camden Prescribing Recommendations (CPR)

The choice of HRT products included in the CPR takes into account the evidence for efficacy, safety and cost.

### 1. Sequential Combined Therapy<sup>1,2</sup>

Indications:

- Menopausal symptoms and last period **less** than 12 months ago.

Preferred choices at Camden:

- **Tablets:** Elleste Duet<sup>®</sup> (estradiol 1 mg, 2 mg and norethisterone 1 mg), **Femoston<sup>®</sup>** (estradiol 1 mg, 2 mg and dydrogesterone 10 mg), **Prempak-C<sup>®</sup>** (conjugated oestrogens 625 mcg, 1.25 mg and levonorgestrel 150 mcg)
- **Patches** (reserved for patients who can't tolerate or can't have oral treatment – see under HRT products): **Evorel Sequi<sup>®</sup>** (estradiol 50 mcg and norethisterone 170 mcg)

### 2. Continuous Combined Therapy<sup>1,2</sup>

Indications:

- Menopausal symptoms and last period **more** than 12 months ago.

Preferred choices at Camden:

- **Tablets:** **Kliefem<sup>®</sup>** (Estradiol 2 mg and norethisterone 1 mg), **Kliovance<sup>®</sup>** (estradiol 1 mg and norethisterone 500 mcg), **Femoston<sup>®</sup> Conti** (estradiol 500 mcg, 1 mg and dydrogesterone 2.5mg, 5 mg), **Premique<sup>®</sup> Low Dose** modified release (Conjugated oestrogens 300 mcg and medroxyprogesterone 1.5 mg), **Premique<sup>®</sup>** (conjugated oestrogens 625 mcg and medroxyprogesterone 5 mg)
- **Patches:** (reserved for patients who can't tolerate or can't have oral treatment – see under HRT products) **Evorel<sup>®</sup> Conti** (estradiol 50 mcg and norethisterone 170 mcg)

### 3. Oestrogen only<sup>1,2</sup>

Indications:

- Menopausal symptoms in women without a uterus.

Preferred choices at Camden:

- **Tablets: Premarin®** (conjugated oestrogens 1mg, 2 mg).
- **Patches:** (reserved for patients who can't tolerate or can't have oral treatment – see under HRT products) **Estradot®** (estradiol 25 mcg, 37.5 mcg, 50 mcg, 75 mcg, 100 mcg).
- **Gel: Oestrogel®** (estradiol 0.06%).

#### 4. Topical HRT for vaginal atrophy

Indication:

- Improvement of vaginal epithelium in menopausal atrophic vaginitis.

Preferred choices at Camden for intravaginal use:

- **Intravaginal Cream: Ovestin®** (estriol 0.1%).
- **Vaginal Tablets: Vagifem®** (estradiol 10 mcg).

#### 5. Tibolone (synthetic steroid with oestrogenic, progestogenic, and androgenic activity)

Indication:

- Short term treatment of symptoms of oestrogen deficiency (including women treated with gonadotrophin releasing hormone analogue<sup>1,2</sup>). It can improve mood and libido, useful for women with low libido<sup>5</sup>
- Not suitable for perimenopause or within 12 months of the last menstrual period<sup>1,2</sup>

**Note: The use of custom-compounded bio-identical hormone therapy is not recommended<sup>1</sup>**

#### 4.7 Counselling points

- When starting HRT, it is important to warn the woman about the expected bleeding pattern with the chosen regime. Irregular bleeding may be common in the first 3-6 months of treatment. Women should be routinely asked about unscheduled bleeding at the 3<sup>rd</sup> month review appointment and counselled to report this promptly if this occurs after the first 3 months of treatment.<sup>2</sup>
- Reinforce the importance of taking the preparations correctly – especially with combined HRT, it is important not to miss the progesterone.
- Warn perimenopausal women that HRT is not a contraceptive.
- Weight gain is very common around the time of the menopause. There is no clear evidence that HRT causes weight gain.<sup>1,2</sup>

#### 4.8 Side effects <sup>2</sup>

Side effects can be categorised into estrogenic and progestogenic.

- There are 2 groups of progestogens: testosterone-derived and progesterone-derived.
- Women who have troublesome side effects from a progestogen in the testosterone-derived group e.g. breast tenderness, mood swings, acne etc., may find these side effects improve if they try a progestogen from the progesterone-derived group and vice versa.

#### Oestrogen-related adverse effects<sup>2</sup>

- Oestrogen-related adverse effects (such as fluid retention, bloating, breast tenderness or enlargement, nausea, headaches, leg cramps, and dyspepsia) may occur continuously or randomly throughout the cycle.
- Encourage the woman to persist with the treatment for 3 months (as adverse effects may resolve)



- Leg cramps can improve with lifestyle changes, including exercise and regular stretching of the calf muscles.
- Nausea/gastric upset may be helped by adjusting the timing of the oestrogen dose or taking with food.
- Breast tenderness may be alleviated by a low-fat, high-carbohydrate diet.
- For persistent adverse effects, consider:
  - Reducing the dose of oestrogen *or*
  - Changing the oestrogen type (that is, swapping between the two main forms of oestrogen (estradiol and conjugated oestrogens) *or*
  - Changing the route of delivery (for example tablets may cause nausea, but patches and gels generally do not).

#### Progestogen-related adverse effects<sup>2</sup>

- Progestogen-related adverse effects tend to occur in a cyclical pattern during the progestogen phase of cyclical (HRT). They include fluid retention, breast tenderness, headaches or migraine, mood swings, depression, acne, lower abdominal pain, and backache.
- Encourage the woman to persist with treatment for about 3 months to await possible resolution of adverse effects. For persistent or troublesome symptoms, consider the following options:
  - Changing the progestogen type, for example from the more androgenic ones (such as norethisterone and norgestrel) to the less androgenic ones (such as medroxyprogesterone or dydrogesterone).
  - Changing the route of progestogen delivery, for example from oral to transdermal, vaginal, or intrauterine progestogen. This may be most beneficial for women who experience nausea with oral HRT.
  - Changing to a product with a lower dose of progestogen (doses are preparation dependent).
- Changing to continuous combined therapy to tibolone often reduces progestogenic adverse effects with established use, but these options are only suitable for postmenopausal women.

For detailed information on side effects, refer to the Summary Product Characteristic for the product prescribed <http://www.medicines.org.uk/emc/>.

#### **4.9 Follow up/annual review<sup>1,2</sup>**

- After starting HRT, it is advisable to review after 3 months to assess effect of therapy and enquire about side effects and bleeding pattern.
  - An annual review is recommended to check the effectiveness of therapy, presence of side effects and review the preparation given. Ask about bleeding patterns. Ensure the patient is up to date with smears and mammograms, encourage breast awareness and advise how to arrange mammogram if due. Assess osteoporosis risk and if appropriate consider need for investigation. Check blood pressure.
- Consider the pros and cons of continuing HRT (especially related to breast cancer) and discuss current advice.

#### **4.10 Poor symptom control<sup>1,2</sup>**

- Check that the hormone replacement therapy (HRT) has been used as recommended for at least 3 months to ensure full effect.
- If applicable, check that patches are adherent and consider switching delivery system, if patch adhesion is poor.
- Review the woman's expectations. HRT can help to reduce symptoms due to oestrogen deficiency, but it's not an answer to all problems.
- Consider an alternative diagnosis.

- Check for drug interactions if the woman is taking other medication.
- Consider increasing the oestrogen dose.
- Consider adding vaginal oestrogen, if urogenital symptoms are not controlled.
- Consider switching from oral to a non-oral route of administration (for example if absorption is poor owing to a bowel disorder, or if a drug interaction is present).

#### 4.11 Stopping HRT<sup>1,2</sup>

If systemic HRT is being used for symptom control, consider a trial withdrawal (if a woman is symptom-free) after 1-2 years.

- Advise the woman that symptoms may recur for a short time once HRT is stopped.
- Counsel the woman about the possible risks of HRT if she wishes to continue treatment, particularly if treatment is being used for longer than 5 years.
- Topical (vaginal) oestrogen may be required long term as symptoms can recur once the treatment has stopped. Review regularly.
- Review the treatment at least annually to re-assess the need for continued treatment.
- HRT may need to be stopped immediately (depending on clinical judgement, and pending investigation and treatment), if any of the following occur:
  - Sudden severe chest pain (even if not radiating to left arm).
  - Sudden breathlessness (or cough with blood-stained sputum).
  - Unexplained swelling or severe pain in calf of one leg.
  - Severe stomach pain.
  - Serious neurological effects, including unusual severe, prolonged headache, weakness, motor disturbances, or very marked numbness suddenly affecting one side or one part of body.
  - Hepatitis, jaundice, or liver enlargement.
  - Blood pressure above systolic 160 mmHg or diastolic 95 mmHg.
  - Prolonged immobility after surgery or leg injury.
  - Detection of a risk factor which contraindicates treatment.

Ideally HRT should be stopped gradually<sup>1</sup>:

- **Cyclical combined HRT tablets:** reduce to a cyclical HRT pack containing 1 mg estradiol for 1–2 months. Cut the tablet in half for the next 1–2 months; this will ensure that the woman still receives oestrogen combined with a progestogen.
- **Cyclical combined HRT patches:** reduce the dose as for oestrogen-only patches, but ensure that the woman still uses the oestrogen-only patches for 2 weeks of the cycle followed by the combined patches for a further 2 weeks, to ensure endometrial protection.
- **Continuous combined HRT tablets or patches:** reduce the dose gradually every 1–2 months to the lowest strength tablet or patch. Then, take half a tablet or patch daily for a further 1–2 months.
- **Oestrogen-only tablets:** reduce from a 2 mg to a 1 mg tablet for 1–2 months, and then use 1 mg on alternate days for a further 1–2 months.
- **Oestrogen-only patches:** reduce the dose gradually to 25 micrograms daily (for example step the dose down a patch strength each month). Half a matrix-type patch (12.5 micrograms daily) can be used for a further 1–2 months.

If symptoms are severe after HRT is stopped, or persist for several months after stopping, the woman may wish to restart HRT after reassessment and counselling. Often a lower dose of HRT can be used (for example estradiol 1 mg) if HRT is restarted. For advice on stopping specific HRT products, see individual SPCs at: <https://www.medicines.org.uk/emc/>

#### 4.12 Premature and early menopause<sup>1,2</sup>

- Refer women who are younger than 40 years.
- Diagnose premature ovarian insufficiency in women aged under 40 years based on<sup>3</sup>:
  - Menopausal symptoms, including no or infrequent periods (taking into account whether the woman has a uterus).
  - Elevated FSH levels on 2 blood samples taken 4–6 weeks apart.
- There is an increased risk of osteoporosis due to early loss of oestrogens in premature menopause.
- Reassess the need for HRT after the age of the natural menopause.

#### 4.13 HRT and contraception

HRT does not provide contraception. A suitable method of contraception should be used for one year after the last menstrual period if the woman is more than 50 years of age, or for two years after the last menstrual period if the woman is younger than 50 years of age<sup>2</sup>. Women who require contraception should be advised the following:

- A progestogen-only pill can be used with combined sequential HRT to provide effective contraception and adequate endometrial protection (a progestogen-only pill used with oestrogen-only HRT will not provide an adequate level of endometrial protection; combined continuous HRT regimens are not appropriate in this age group due to bleeding)<sup>9</sup>.
- Women using oestrogen replacement therapy may use the levonorgestrel–releasing Intra Uterine Contraceptive device (Mirena<sup>®</sup>) as the progestogenic component for HRT (as well as for contraception)<sup>6</sup>.

#### 5. Reassessment or referral<sup>1,2</sup>

- Review all women on sequential combined HRT who have a change in pattern of withdrawal bleeds for example increased duration, frequency or heaviness or irregular bleeding.
- Review women on continuous combined therapy or tibolone who have persistent breakthrough bleeding.
- Refer via the 2 week rule any:
  - Persistent intermenstrual bleeding in women over 45 (lasting more than 6 weeks after stopping HRT) with a normal vaginal examination.
  - Unexpected or prolonged bleeding persisting for more than 6 weeks after stopping HRT.
- Refer if there is multiple treatment failure (3 or more regimes) or persistent side effects.
- Consider referring women with complex medical problems, menopausal issues or premature menopause.

Consider referring women with menopausal symptoms and contraindications to HRT or there is uncertainty about the most suitable treatment option<sup>1</sup>.

## References

1. National Institute for Health and Clinical Excellence (NICE). Menopause: diagnosis and management. Clinical guidelines NG23. Published 12 November 2015.  
<http://www.nice.org.uk/guidance/ng23>
2. NICE Clinical Knowledge Summaries (CKS): Menopause. Revised October 2015.  
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3. BNF 70. September 2015-March 2016 [www.bnf.org.uk](http://www.bnf.org.uk)
4. Alternatives to HRT for the management of symptoms of the menopause. Scientific Impact Paper 6. September 2010 <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/sip6/>
5. Genazzani et al. Beneficial effect of tibolone on mood, cognition, well-being, and sexuality in menopausal women. *Neuropsychiatric Disease and Treatment* 2006;2(3) 299–307
6. NICE Clinical Knowledge Summaries (CKS): Contraception - assessment. Revised June 2012 <http://cks.nice.org.uk/contraception-assessment>