



PRIMARY CARE
WOMEN'S HEALTH FORUM

Easy HRT prescribing guide

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The menopause is a normal life event for women - it is not an illness or a medical condition. As the life expectancy of women has increased over the past century, this means that on average, women spend nearly one-third of their lives being postmenopausal.

Many women suffer in silence and do not realise how effective hormone replacement therapy (HRT) can be at dramatically improving not only their symptoms but also their quality of life.

Managing symptoms

It is estimated that around 75% of menopausal women experience symptoms and around 25% of women experience severe symptoms that are having a negative effect on their lives, often affecting their family and work lives.

The vasomotor symptoms of the menopause are the ones that are most obvious when thinking about the menopause, but these are not the symptoms that affect women the most. It is the symptoms of low mood, anxiety, reduced self-esteem, poor memory and concentration, reduced libido and vaginal dryness that affect them the most.

Managing women with symptoms of the menopause is a very rewarding aspect of clinical practice. There are now excellent guidelines available, both national and international, for healthcare professionals on the management of the menopause¹⁻³.

However, these guidelines have not been read by many healthcare professionals which means that many women are being denied evidence-based treatment. All the guidelines support the notion that for the majority of women starting HRT when they are under 60 years old, the benefits of taking HRT usually outweigh any risks.

Risks and benefits of HRT

There are numerous potential benefits to be gained by women taking HRT. Symptoms of the menopause such as hot flushes, mood swings, night sweats, and reduced libido improve. In addition, taking HRT has also been shown to reduce future risk of cardiovascular disease, osteoporosis, type 2 diabetes, osteoarthritis and dementia⁴⁻⁶. Most benefit is afforded when women start HRT within 10 years of their menopause.

The type of HRT also affects a woman's risks and benefits. HRT containing micronised progesterone appears to be associated with a lower risk of breast cancer, cardiovascular disease, and thromboembolic events compared with androgenic progestogens⁷⁻⁸.

In addition, the mode of delivery of oestrogen is also important because, in contrast with oral oestrogen, transdermal oestrogen at standard doses is not associated with an increased risk of venous thromboembolism (VTE).

Most women and healthcare professionals are concerned about the possible risks of breast cancer in women taking HRT. However, the risk is far lower than many realise. Women who take oestrogen only HRT (women who have had a hysterectomy) do not have a greater risk of breast cancer. Women who take oestrogen and a progestogen who are over 51-years-old may have a small increased risk of breast cancer. However, this increased risk is a similar magnitude to the risk of breast cancer for women who are overweight or drinking a glass or two of wine each night. Telling them this often really helps to put this risk into perspective.

Studies have shown that women who take micronised progesterone have an even lower risk of breast cancer than other women who take other progestogens.

How to prescribe HRT

Firstly – keep it simple!

There is robust evidence demonstrating that transdermal oestrogen in association with micronised progesterone could represent the optimal HRT regimen, particularly in women at risk of cardiovascular events⁹. This combination should ideally be initiated by healthcare professionals at a primary care level.

Considerations when prescribing combination products:

- There is less flexibility if you want to alter the oestrogen dose
- They all contain older progestogens.

Considerations when prescribing oral oestrogen first line:

- There is VTE risk with oral oestrogen
- Oral oestrogen increases sex hormone binding globulin (SHBG) so reduces free androgen index (lowers libido even more)
- There is less reliable absorption
- There are more contraindications (for example obesity, diabetes, gallbladder disease, migraine and so on).

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The most important hormone in HRT is oestrogen – best as 17 beta oestradiol

The optimal dose for each woman should be given to improve symptoms and also to optimise bone and heart health. Women can continue taking HRT for as long as the benefits outweigh any risks. They should have an annual review.

It is NOT about lower dose and shortest length of time anymore!

Patches – pros:

- Usually stick well and easy to use
- Can swim, shower, bath, swim with them on
- Constant level given so can be better in women with migraines
- Can use more than one which is useful for women with early menopause / primary ovarian insufficiency (POI).

Patches – cons:

- Some women do not like to have something stuck to their skin
- Can lead to local irritation
- Some women find they do not stick on well or they crinkle (therefore reduced absorption)
- Some women find they have high absorption in hot climates
- Plaster mark on bottom – can be removed with baby oil and dry flannel!

Gel – pros:

- Easy to alter dose so women have more control
- Usually absorb really easily
- Can be used with patches to ‘top up’
- Women with cyclical symptoms (including PMS) can use more on the days with worse symptoms.

Gel – cons:

- Young women needing higher doses need to use large quantities
- Harder to remember as needed once or twice a day
- Sachets can be hard to open.

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Women with a uterus need a progestogen too

A few tips:

- Give cyclical HRT for first year or so if they are having periods
- Continuous progestogens are better for endometrial protection
- Any age woman can take continuous HRT but it may cause erratic bleeding if given too early.

The evidence supports the use of micronised progesterone as the most favourable progestogen:

Pros:

- Fewer side effects so better tolerated
- Can improve cardiovascular risk / lipids
- Neutral effect on BP / may reduce BP
- No VTE risk
- No breast cancer risk for first 5 years of taking it (in women over 51 years old)
- Studies have shown some positive effect on bone strength
- Can be used vaginally (off license) in women who cannot tolerate oral progesterone.

Cons:

- Can have more breakthrough bleeding for first 3-6/12 (consider giving as a 14-day regimen every 28 days)
- Can cause some sedation – take at night time
- Needs to be taken on empty stomach (eating food increases absorption)
- Not a contraceptive.

Coil (IUS)

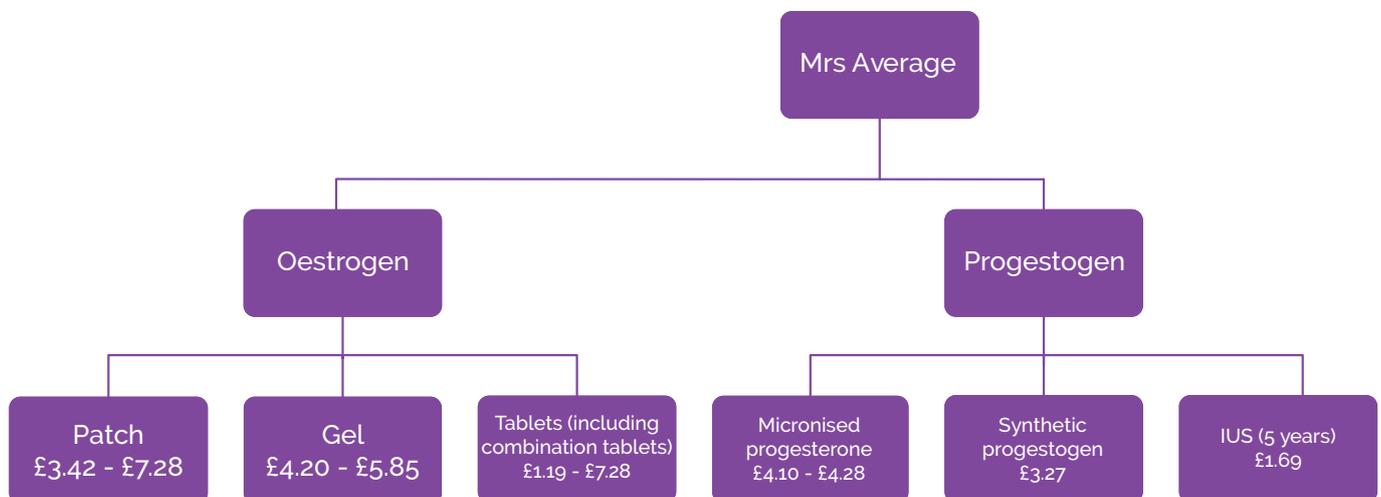
Pros:

- Contraception
- Less risk of bleeding
- Can be safely used for 5 years as endometrial protection as recommended by FSRH¹⁰ (actually licensed for 4 years).

Cons:

- Systemic side effects in some women (especially first 3-6/12)
- Spotting and irregular bleeding can occur in first 3-6/12
- Not every woman's choice
- Sometimes difficult to access because of local commissioning arrangements.

Using oestrogen as a patch or gel and micronised progesterone is cheap for the NHS (price per month):



Clearly HRT is only one part of the management of perimenopausal and menopausal women. Lifestyle recommendations regarding diet, exercise, smoking cessation, and safe levels of alcohol consumption should be encouraged.

Vaginal oestrogens

Although vaginal oestrogen is not actually HRT it is important to know the following:

- Vaginal oestrogen is safe to give with HRT (about 20% of women need both)
- Vaginal oestrogen can be given as a pessary, cream or vaginal ring
- Vaginal oestrogen should be prescribed in the long term (ie on repeat prescriptions)
- The dose of vaginal oestrogen is very low (using 10mcg oestrogen pessaries regularly for one year is an equivalent dose to just one 1mg oestradiol HRT tablet)
- Women who have had breast cancer (except those taking aromatase inhibitors) can still safely use oestrogen vaginally
- Many women using vaginal oestrogen should also be recommended to use vaginal moisturisers and lubricants too.

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