Initiating hormone replacement therapy (HRT) / menopausal hormone therapy (MHT)

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Before you prescribe

• Ensure there are no contraindications to HRT/MHT
  – Breast cancer (hormonally sensitive)
  – Thrombophilia/past venous thrombo-embolic event (VTE)
  – Undiagnosed vaginal bleeding
  – Active liver disease
  – Uncontrolled hypertension
  – CVD risk or disease

• Ensure screening is up to date
• Start with a mid-range dose (can be titrated up or down at first review) and use for the shortest duration for symptom control
**Oestrogen only vs. oestrogen + progestogen**

- **oestrogen only** if the woman has had a hysterectomy or has a levonorgestrel IUD in situ

- Women who have undergone an endometrial ablation will still require a progestogen if prescribed systemic oestrogen

**Systemic HRT/MHT vs. vaginal oestrogen**

**Vaginal oestrogen**
- appropriate if the woman has vaginal atrophy symptoms only
- urogenital syndrome of the menopause

**Systemic MHT** for symptoms such as:
- flushes/night sweats
- insomnia
- joint aches and pains etc.
- (will also be beneficial for genito-urinary symptoms)
Continuous combined vs. sequential HRT/MHT

This is a decision based on the likelihood of bleeding

Continuous combined
• if more than 12 months post menopause
• (if use it earlier there is a risk of erratic bleeding which can be inconvenient or confusing)

Sequential
• if perimenopausal or within 12 months of menopause
• or if ongoing bleeding despite being >12 months after menopause (NB. any new bleeding that occurs in a postmenopausal woman who has been bleed-free for some time needs to be investigated)

Perimenopausal vs. postmenopausal

Perimenopausal
• will potentially need contraception
• will need a sequential regimen of MHT or will have bleeding issues
• Levonorgestrel IUD is a good option for both of these and will provide the progestogen for up to 5 years

Postmenopausal
• can use continuous combined therapy
# Types of HRT

- PBS vs. non PBS - will be a financial consideration for some women
- oral vs. transdermal vs. vaginal oestrogen
- combined products (oestrogen and progestogen) vs. combination of separate oestrogen and progestogen products vs. oestrogen only (if hysterectomy or Levonorgestrel IUD in situ)
  - MHT is not contraceptive
  - resources - AMS guide to equivalent doses / Jean Hailes info sheet on MHT for patients

## Oral or transdermal?

### Oral
- Convenient, daily dosing
- Reliably absorbed
- May have nausea
- Undergoes first-pass metabolism – larger effective dose
- May have more tendency for weight gain / fluid retention / breast tenderness or enlargement
- Increase in VTE risk (not tibolone)

### Transdermal
- Convenient, twice weekly dosing (if patch; daily if gel)
- Lower effective dose as avoids first-pass metabolism (dose is delivered straight into the bloodstream)
- Less tendency for weight gain / breast tenderness or enlargement
- No increase in VTE risk
Tibolone?

- Appropriate if >1 year postmenopause
- Synthetic HRT/MHT
- Oestrogenic / progestogenic / androgenic properties
- Does not increase breast density
- Less VTE risk vs. oral oestrogen + progestogen combination
- Consider if low libido a predominant symptom
What type to choose?

Based on the woman's history and other factors

- if concerned about weight gain or breast tenderness - transdermal approach

- special scenarios:
  - scalp hair loss – oestradiol and drospirenone combination may be a good option
  - low libido - Tibolone may be a good option

- Start at the middle dose for the product and then can titrate up or down depending on response

- If the woman has had an adverse experience on HRT/MHT previously, use the lowest dose
Potential side effects

- bleeding or breast tenderness is common in the first 3 months - reassure patient that it should settle
- if bleeding does not settle after 3 months and the woman is early postmenopausal, consider change to sequential regimen
- initial VTE risk increase on oral combined oestrogen and progestogen (2-3 fold overall increase in risk)

Breast cancer risk

- Between 1 in 8 and 1 in 9 Australian women will develop breast cancer over their lifetime
- HRT/MHT is associated with a similar risk of breast cancer as consuming 2 alcoholic drinks per day; the major risk factors for breast cancer are a family history of breast cancer and having dense breasts
- From the largest HRT/MHT study to date (WHI):
  - Combined oestrogen and progestogen HRT/MHT increases breast cancer risk after 4-5 years use
  - Oestrogen only HRT/MHT is associated with a decrease in risk
- Different progestogens have different effects on breast cancer risk, with dydrogesterone and micronised progesterone having a lesser risk compared with medroxy-progesterone acetate
- Discuss breast cancer risk and VTE risk specifically and document in their history
Review

- Ideally review at 3 months
- discuss negatives and positives and problem solve - e.g. bleeding / breast tenderness
- dose adjustment if required
- if change of product necessary then will need another review in 3 months otherwise 6 months (as most scripts will last this long)
- make sure screening is up to date (cervical screening / mammogram)

Ceasing HRT/MHT

- annual review of reasons for HRT/MHT
- trial a dose reduction to see if symptoms recur
- weaning rather than ‘cold-turkey’ cessation usually gets better results (although research studies suggest the same outcome)
Non-hormonal treatment options for vasomotor symptoms

Prescribed medications shown in RCTs to have evidence for efficacy and safety in the treatment of VMS

Note: ‘off label use’:

- SSRI/SNRI anti-depressant medications: effective in some women with added benefits on mood
  - See menopause.org.au for doses (link)
  - Caution in women on tamoxifen (paroxetine / sertaline / fluoxetine will inactivate tamoxifen and should not be used; venlafaxine, desvenlafaxine, citalopram and escitalopram appear to be safe options)
- Gabapentin: also useful for sleep; expensive and needs dosing 2-3 x daily
- Pregabalin (neuropathic pain)
- Clonidine – mixed trial results, effect modest (side effects dose related); this is the only PBS product available for VMS as a primary indication

Resources

jeanhales.org.au
- Patient information & fact sheets
- GP menopause management tool (pictured)
- Green climacteric (symptom) scale
- Health professional webinar library

menopause.org.au (Australasian Menopause Society)
- A Practitioner’s Toolkit for the Management of the Menopause
- Guide to HRT equivalent doses
- AMS symptom score sheet
- Patient information sheets
Jane

• 51 yr lady, last period 6 months ago, symptoms: flushes / drenching night sweats, irritability, vaginal dryness, joint aches and pains, sleep disturbance.
• Overweight, no other medical problems.

Maria

• 53 yr lady, amenorrhoea 2 yrs.
• Symptoms: insomnia, anxiety - impacting on general ability to function, urinary urgency, generally hot "like I'll combust".
• Hyperlipidemia, smoker, hypertension (stable - on meds)
Sophie

• 55yr lady, amenorrhea 4 yrs.
• Symptoms: low libido, vaginal dryness.

Helen

• 52yr lady, amenorrhea 12 months. No symptoms.
• DXA - osteopaenia. Strong family history cardiovascular disease and osteoporosis with fracture. Maternal aunt had breast cancer in 40s.