Barns Medical Practice Service Specification Outline: Menopause

# DEVELOPED February 2015 REVIEW February 2015

# Introduction

Menopause is the time when menstruation ceases permanently due to the loss of ovarian follicular activity. It occurs with the final menstrual period and therefore can only be diagnosed with certainty after 12 months of spontaneous amenorrhoea. This can occasionally be premature, for example if there is a family history of premature menopause, or premature ovarian failure. In the UK, the average age at the menopause is 52 years.

# Diagnosis

* About **80% of women in the UK will experience menopausal symptoms in their lifetime**, and 45% of them will find the symptoms distressing. Menopausal symptoms are usually self limiting, lasting for between 2 and 5 years. Symptoms commonly include:
	+ Hot flushes and night sweats.
	+ Sleep disturbance.
	+ Urinary and vaginal symptoms, including vaginal discomfort and dryness, dyspareunia, and recurrent urinary tract infections.

# Regular Review

* For some women, hormone replacement therapy (HRT) may be useful, but the risks and benefits of treatment must be considered for each woman.
	+ The risks of combined HRT include a small increase in the risk of breast cancer, coronary event (myocardial infarction [MI] or cardiac death), venous thrombo-embolism (VTE), stroke, gallbladder disease requiring hospital admission, death from lung cancer, ovarian cancer, and dementia (in women aged over 65 years).
	+ The risks of oestrogen-only HRT include a small increase in the risk of VTE, stroke, endometrial cancer, gallbladder disease requiring hospital admission, and ovarian cancer. Oestrogen-only HRT does *not* appear to significantly increase the risk of breast cancer.
	+ The benefits of HRT include improved vasomotor and urogenital symptoms, and a reduction in the risks of osteoporosis.
* Adverse effects of HRT include:
	+ Oestrogen-related adverse effects such as fluid retention, bloating, breast tenderness, nausea, headaches, leg cramps, and dyspepsia.
	+ Progestogen-related adverse effects such as fluid retention, breast tenderness, headaches or migraine, mood swings, depression, acne, lower abdominal pain, and headache.
	+ Bleeding.
* For women who are unable or unwilling to use HRT, treatment options include:
	+ For vasomotor symptoms — a trial of paroxetine, fluoxetine, citalopram, venlafaxine, clonidine or gabapentin?
	+ For vaginal dryness — a vaginal lubricant or moisturizer.
	+ For psychological symptoms — self-help groups, psychotherapy, counselling, or antidepressants, according to the individual.
* Complementary therapies, such as red clover or black cohosh, are not recommended.

#### Lifestyle advice for menopausal symptoms

* Encourage all women to make lifestyle modifications to reduce menopausal symptoms:
	+ **Hot flushes and night sweats:**
		- Taking regular exercise and losing weight (if applicable) may reduce the severity and frequency of flushes.
		- Wearing lighter clothing, sleeping in a cooler room, reducing stress, and avoiding possible triggers (such as spicy foods, caffeine, smoking, and alcohol) may also be helpful in reducing these symptoms.
	+ **Sleep disturbances:**
		- Avoiding exercise late in the day and maintaining a regular bedtime can improve sleep.
	+ **Mood and anxiety disturbances:**
		- Adequate sleep, regular physical activity, and relaxation exercises may help.
	+ **Cognitive symptoms:**
		- Exercise and good sleep hygiene may improve subjective cognitive symptoms.
* Hormone replacement therapy (HRT) is effective for:
	+ Treating vasomotor symptoms (for example hot flushes and night sweats).
	+ Treating urogenital symptoms (for example vaginal dryness, dyspareunia as a result of vaginal dryness, recurrent urinary tract infections, and urinary frequency and urgency).
	+ Managing sleep or mood disturbances caused by hot flushes and night sweats.
	+ Preventing osteoporosis.
		- However, due to the risks associated with long-term use, HRT is not normally used as first-line treatment for long-term prevention of osteoporosis in women over 50 years of age, except when other treatments are contraindicated, not tolerated, or ineffective.
* There is no strong evidence that HRT has a clinically meaningful impact on the incidence of colorectal cancer.
* HRT has no role in the prevention or treatment of cardiovascular disease.
* **Advise about:**
	+ Modifying their [lifestyle](http://cks.nice.org.uk/menopause#!scenariorecommendation:1) to reduce symptoms.
	+ The [risks](http://cks.nice.org.uk/menopause#!scenariorecommendation:3) and [benefits](http://cks.nice.org.uk/menopause#!scenariorecommendation:2) of hormone replacement therapy (HRT).
	+ The expected duration of treatment:
		- For vasomotor symptoms, most women require 2–3 years of treatment, but some women may need longer. This judgement should be made on a case-by-case basis with regular attempts to discontinue treatment. Symptoms may recur for a short time after stopping HRT.
		- Topical (vaginal) oestrogen may be required long term. Regular attempts (at least annually) to stop treatment are usually made. Symptoms may recur once treatment has stopped.
	+ Possible adverse effects of HRT such as breast tenderness or enlargement, nausea, headaches, or bleeding.

#### types of HRT are available

* **Oestrogen-only** preparations - only in women without a uterus or with endometrial protection from Mirena
	+ Oral tablet (daily).
	+ Transdermal patch (once weekly or twice weekly) or gel (daily).
	+ Vaginal ring (Estring®), creams, and pessaries.
	+ **Combined oestrogen–progestogen** preparations for women with uterus
	+ Oral tablet (daily).
	+ Transdermal patch (once weekly or twice weekly):
		- In transdermal combined hormone replacement therapy (cyclical or continuous) the progestogen is either combined into the patch or given separately as a tablet.

**Choice of vaginal oestrogen:**

* + Low-dose natural oestrogens, such as estriol (cream or pessary) or estradiol (tablet or ring) preparations, are suitable for vaginal use. Endometrial effects should not be incurred. A progestogen is not needed with such low-dose preparations.
	+ Synthetic or conjugated oestrogens should be avoided as they are well absorbed from the vagina and may potentially result in endometrial stimulation.

**TIBOLONE** is an alternative no-bleed regimen for postmenopausal women.

* **Tibolone** is a synthetic steroidal compound with oestrogenic, progestogenic, and androgenic activity. It may be used as an alternative to combined HRT for **postmenopausal** women who wish to have amenorrhoea.
	+ Tibolone is not suitable for use in the perimenopause or within 12 months of the last menstrual period.

#### benefits and risks of tibolone

* **Advise the woman that tibolone is beneficial in that it**:
	+ Is effective for treating vasomotor symptoms (such as hot flushes and night sweats).
	+ Reduces postmenopausal osteoporosis (although other drugs are preferred).
	+ May improve sexual functioning.
* **Discuss the risks of tibolone:**
	+ Tibolone is associated with a small increased risk of stroke and endometrial cancer.
	+ Limited data suggest that it may be associated with:
		- A small increased risk of breast cancer.
		- An increased risk of breast cancer recurrence in women with a history of breast cancer.
	+ In younger women, the risk profile of tibolone is broadly similar to that for conventional combined hormone replacement therapy).
	+ For women over 60 years of age, the risks associated with tibolone start to outweigh the benefits because of the increased risk of stroke

#### Regimen and route of delivery

* **Offer oestrogen-only hormone replacement therapy (HRT) to women who *do not* have a uterus** (usually taken continuously).
* **Offer combined (oestrogen and progestogen) HRT to women *with* an intact uterus**:
	+ Combined hormone replacement therapy can be prescribed as:
		- Monthly cyclical regimens — oestrogen is taken daily and progestogen is given at the end of the cycle for 10–14 days.
		- Three-monthly cyclical regimens — oestrogen is taken every day and progestogen is given for 14 days every 13 weeks.
		- Continuous combined regimens — oestrogen and progestogen are taken every day.
	+ For perimenopausal women, monthly or 3-monthly cyclical regimens may be used:
		- A 3-monthly regimen may be more suitable for women with infrequent periods or who are intolerant to progestogens.
		- A monthly regimen produces monthly bleeding whilst a 3-monthly regimen produces a bleed every three months.
	+ For postmenopausal women, monthly or 3-monthly cyclical regimens, or continuous combined regimens may be used. Continuous combined regimens may be preferred because they do not produce withdrawal bleeding:
		- Continuous combined HRT may produce irregular bleeding or spotting for the first 4–6 months of treatment. Bleeding should be investigated if it persists beyond 6 months, becomes heavier rather than less, or occurs after amenorrhoea.
* **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 prefers this route.
		- Symptom control is poor with oral treatment.
		- Oral treatment causes adverse effects (such as nausea).
		- The woman has a history or risk of venous thromboembolism (in this situation, consider hormone replacement therapy [HRT] only after full discussion and appropriate investigation. See [Thromboembolic disease or known thrombophilia](http://cks.nice.org.uk/menopause#!scenariorecommendation:50)).
		- The woman is taking a hepatic enzyme–inducing drug (for example an anticonvulsant drug).
		- 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.
* **The levonorgestrel-releasing intrauterine system (IUS) (Mirena®)** is an alternative route of delivery of progestogen to protect the endometrium. Since levonorgestrel is delivered locally to the uterus, a much lower daily dose is used, which also results in low systemic levels of levonorgestrel.
	+ Offer the levonorgestrel-releasing IUS when:
		- The woman is experiencing persistent progestogenic adverse effects from systemic HRT, despite changes in type and route of progestogen.
		- Contraception is required along with HRT in the perimenopause.
		- Withdrawal bleeds on sequential HRT are heavy, after investigation if indicated.
	+ The licence for use of the levonorgestrel-releasing **IUS for the progestogen part of HRT is currently 4 years, as opposed to 5 years when used solely for contraception.**
	+ **Prescribe the lowest effective dose of hormone replacement therapy (HRT) for the shortest time possible.**

#### contraindications to HRT

* **Contraindications to hormone replacement therapy are:**
	+ Current, past, or suspected breast cancer.
	+ Known or suspected oestrogen-sensitive cancer.
	+ Undiagnosed genital bleeding.
	+ Untreated endometrial hyperplasia.
	+ Previous idiopathic or current venous thromboembolism (deep vein thrombosis or pulmonary embolism).
	+ Active or recent arterial thromboembolic disease (for example angina or myocardial infarction).
	+ Untreated hypertension.
	+ Active liver disease.
	+ Porphyria cutanea tarda (absolute contraindication).
* Be aware that 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 the calf of one leg.
	+ Severe stomach pain.
	+ Serious neurological effects, including unusual severe, prolonged headache, especially:
		- If it is the first time, or getting progressively worse, or
		- There is sudden partial or complete loss of vision, or
		- Sudden disturbance of hearing or other perceptual disorders, or
		- Dysphasia, or
		- Bad fainting attack or collapse, or
		- First unexplained epileptic seizure, or
		- 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.

#### Management of peri-menopausal and menopausal women with intact uterus with HRT

* Advise about the [risks](http://cks.nice.org.uk/menopause#!scenariorecommendation:3) and [benefits](http://cks.nice.org.uk/menopause#!scenariorecommendation:2) of hormone replacement therapy (HRT) and record in the notes.
* **For urogenital symptoms alone** (for example vaginal dryness and dyspareunia):
	+ Offer treatment with low-dose vaginal oestrogen (cream, pessary, tablet, or ring) or systemic, cyclical, combined HRT (oral or transdermal):
		- Low-dose vaginal oestrogen may be preferred if the woman does not wish to take, or cannot tolerate, systemic HRT.
		- For women with infrequent periods or women who cannot tolerate progestogens, a systemic 3-monthly regimen may be preferred.
		- The lowest effective amount of topical oestrogens should be used in order to minimize systemic absorption. Treatment should be interrupted at least annually to re-assess the need for continued treatment. If breakthrough bleeding or spotting appears at any time on therapy, the reason should be investigated; investigation may include an endometrial biopsy to exclude endometrial malignancy. Long-term treatment is often required as symptoms can recur on cessation of therapy.
* **For vasomotor symptoms** (for example hot flushes and night sweats), with or without urogenital symptoms:
	+ Offer systemic cyclical combined HRT (oral or transdermal) if perimenopausal and consider continuous combined if post menopausal
		- Prescribe HRT at the lowest effective dose for the shortest duration possible.
		- For women with infrequent periods or women who cannot tolerate progestogens, a 3-monthly regimen may be preferred.
		- Maximal benefit of systemic HRT is usually seen within 3 months, and treatment is generally continued for up to 5 years.
	+ Oestrogen-only HRT is *not* recommended for women with an intact uterus..
* Advise the woman that she may still get pregnant if contraception is not used:
	+ A suitable method of contraception should be used for 1 year after the last menstrual period if the woman is more than 50 years of age, or for 2 years after the last menstrual period if the woman is less than 50 years of age

#### Management of peri-menopausal and menopausal women without uterus with HRT

* **Use oestrogen-only HRT and**  advise that:
	+ There is a *small* absolute increased risk of VTE, stroke, and endometrial cancer. There is also a small absolute increased risk of gallbladder disease requiring hospital admission.
	+ There is some evidence suggesting that oestrogen-only HRT may be associated with an increased risk of ovarian cancer.
	+ Oestrogen-only HRT does *not* appear to significantly increase the risk of breast cancer.

#### Follow up

* Review the woman 3 months after starting hormone replacement therapy (HRT) and once she is settled on treatment, follow up annually.
* **At the initial 3-month review:**
	+ Assess the effectiveness of treatment and if necessary, adjust treatment to achieve better symptom control. Enquire about any adverse effects and manage appropriately. Enquire about bleeding patterns.
	+ Check body weight and blood pressure.
		- Stop HRT *immediately* if blood pressure is above systolic 160 mmHg or diastolic 95 mmHg.
* **Once each year,** repeat the above checks and also:
	+ Consider switching from cyclical HRT to continuous combined HRT, if appropriate e(see below). Interrupt treatment with intravaginal oestrogen and consider stopping systemic HRT, to re-assess the need for continued use.
	+ Discuss the advantages and disadvantages of continuing HRT. In particular, discuss the increased risk of breast cancer with long-term HRT. Perform a breast examination if indicated by personal or family history. Encourage breast awareness and participation in the national breast screening programme as appropriate for their age.
	+ Perform a pelvic examination if clinically indicated (for example if there is unscheduled bleeding, especially if heavy, prolonged, or recurrent). Encourage participation in the national cervical screening programme.

#### Referring women who have started HRT or tibolone

* Refer women who are taking cyclical hormone replacement therapy (HRT) if:
	+ There is a change in pattern of withdrawal bleeds or breakthrough bleeding.
* **for women taking continuous combined hormone replacement therapy (HRT),** refer if:
	+ Breakthrough bleeding persists for more than 4–6 months after starting therapy.
	+ A bleed occurs after amenorrhoea.
* Refer to a team specializing in the management of gynaecological cancer (depending on local arrangements), any persistent or unexplained bleeding after cessation of HRT for 6 weeks.
* **For women taking tibolone,** refer for gynaecological investigation to exclude endometrial malignancy if they bleed beyond 6 months of starting treatment, or after stopping treatment with tibolone.
	+ Refer if there is multiple treatment failure, for example three or more regimens have been tri

**Switching from cyclical to continuous combined hrt**

* Cyclical HRT preparations may be used in postmenopausal women; however, continuous combined preparations are generally preferred because they do not induce bleeding. Furthermore, continuous combined HRT may have a reduced risk of endometrial cancer compared with cyclical HRT
* Consider switching from cyclical hormone replacement therapy (HRT) to continuous combined HRT when the woman is considered to be postmenopausal. However, it may be difficult to decide when the woman is postmenopausal.
* **Women are generally considered to be postmenopausal if:**
	+ They are more than 54 years of age (it is estimated that 80% of women will be postmenopausal by this age).
	+ They have had previous amenorrhoea or increased levels of follicle-stimulating hormone (FSH). Women who experienced 6 months of amenorrhoea or had increased FSH levels in their mid-40s are likely to be postmenopausal after taking several years of cyclical HRT

#### When should I consider stopping hormone replacement therapy?

* 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](http://cks.nice.org.uk/menopause#!scenariorecommendation:3) 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 treatment has stopped.
	+ Stop treatment at least annually to re-assess the need for continued treatment.
	+ Detection of a risk factor which contraindicates treatment.

#### How should HRT be stopped?

* Some women do not notice any symptoms even with abrupt cessation of hormone replacement therapy (HRT), while others may experience a recurrence of hot flushes and sweats.
* Some experts suggest that HRT should be gradually reduced rather than stopped abruptly. Suggested strategies are:
	+ **For oestrogen-only tablets:** reduce from a 2 mg to a 1 mg tablet for 1–2 months, then use 1 mg on alternate days for a further 1–2 months.
	+ **For 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.
	+ **For 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.
	+ **For 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.
	+ **For 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.
* 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.

#### Management of premature menopause

For the purposes of this guideline, premature menopause is menopause which occurs in women younger than 45 years of age.

* Refer women who are younger than 40 years of age to a gynaecologist.
* Offer [lifestyle](http://cks.nice.org.uk/menopause#!scenariorecommendation:31) advice.
* Offer systemic oestrogen replacement therapy; systemic hormone replacement therapy (HRT) or the combined oral contraceptive pill (COC) may be used.
	+ **HRT:** the HRT regimen used will depend on whether or not the woman has undergone a hysterectomy, still has some ovarian activity, and still has periods.
		- For women who are still having periods, offer combined, systemic (oral or transdermal), cyclical HRT. For women with infrequent periods or women who cannot tolerate progestogens, a systemic 3-monthly regimen may be preferred.
		- For women who have had a hysterectomy, offer oral or transdermal unopposed oestrogen replacement therapy.
	+ **COC:** the decision to prescribe the COC will depend on the woman's age and the presence of associated risk factors (for example smoking).
* Advise the woman that she may still become pregnant if contraception is not used.
	+ See the [Scenario: Approaching the menopause](http://cks.nice.org.uk/contraception-assessment#!scenario:4) in the CKS topic on [Contraception - assessment](http://cks.nice.org.uk/contraception-assessment) for a detailed discussion on the choice and duration of contraception in perimenopausal women.
* Testosterone implants and patches (licensed) may be considered for treating decreased libido (especially in oophorectomized women); however, seek specialist advice before prescribing these.

#### poor symptom control with hormone replacement therapy

* **Review the woman:**
	+ 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.
	+ Review the woman's expectations. HRT can help reduce symptoms due to oestrogen deficiency, but it is not an answer to all problems.
	+ Consider an alternative diagnosis.
* **Treatment options include:**
	+ Increasing the oestrogen dose.
	+ Adding vaginal oestrogen, if urogenital symptoms are not controlled.
	+ 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).
	+ Switching delivery system, if patch adhesion is poor.

#### bleeding on monthly cyclical regimens

* Monthly cyclical regimens should produce regular predictable bleeding starting towards or soon after the end of the progestogen phase.
* **It is mandatory to investigate unexplained bleeding before changing treatment, to exclude pelvic pathology.** Before changing treatment:
	+ Visualize the cervix, check smears are up to date, and refer for transvaginal ultrasound to exclude pelvic abnormalities.
	+ Check for compliance with treatment, drug interactions (for example with anticonvulsants), or gastrointestinal upset (which can interfere with absorption).
* **Altering the progestogen part of the regimen may improve bleeding problems:**
	+ For heavy or prolonged bleeding: increase the duration or dose of the progestogen, or change the type of progestogen. Idiopathic menorrhagia may be helped by using the levonorgestrel-releasing intrauterine system (Mirena®) combined with an oestrogen delivered orally or transdermally.
	+ For bleeding early in the progestogen phase: increase dose or change the type of progestogen.
	+ For irregular bleeding: change the treatment regimen or increase the dose of progestogen.
* The absence of bleeding whilst taking a cyclical regimen reflects an atrophic endometrium and occurs in 5% of women.
	+ Exclude pregnancy in perimenopausal women or women with ovarian failure.
	+ Check compliance if the progestogen component is taken separately.

#### bleeding on continuous combined or during long cycle hormone replacement therapy regimens

* Irregular breakthrough bleeding or spotting is common in the first 4–6 months of continuous combined hormone replacement therapy.
* Bleeding beyond 6 months or after a spell of amenorrhoea requires further investigation or referral.

#### weight gain

* Reassure the woman that weight gain is very common around the time of the menopause and that hormone replacement therapy does not cause significant further weight gain.
* In addition, there is some evidence that the tendency towards central abdominal obesity is ameliorated by oestrogen therapy. Studies generally indicate a reduction in overall fat mass, improved insulin sensitivity, and a lower rate of development of type 2 diabetes with hormone replacement therapy (oestrogen only and combined)

# Resources for Staff and or Patients

Practice specific information as per service specification

Internet information

 Patient information leaflet - <http://www.patient.co.uk/health/menopause-and-hrt-leaflet>

Patient information leaflet - <http://www.patient.co.uk/health/menopause-alternatives-to-hrt>

Patient information leaflet - <http://www.nhs.uk/Conditions/Menopause/Pages/Treatment.aspx>

GP notebook- <http://www.gpnotebook.co.uk/simplepage.cfm?ID=1288699910>

#  Staff involved and training required

* Trained clinicians guided by appropriate protocols and committed to regular update sessions via continual professional development and appraisal systems.

# Advertising of service to patients

* Practice Website: [Barns Medical Practice](http://medicayr.com/)