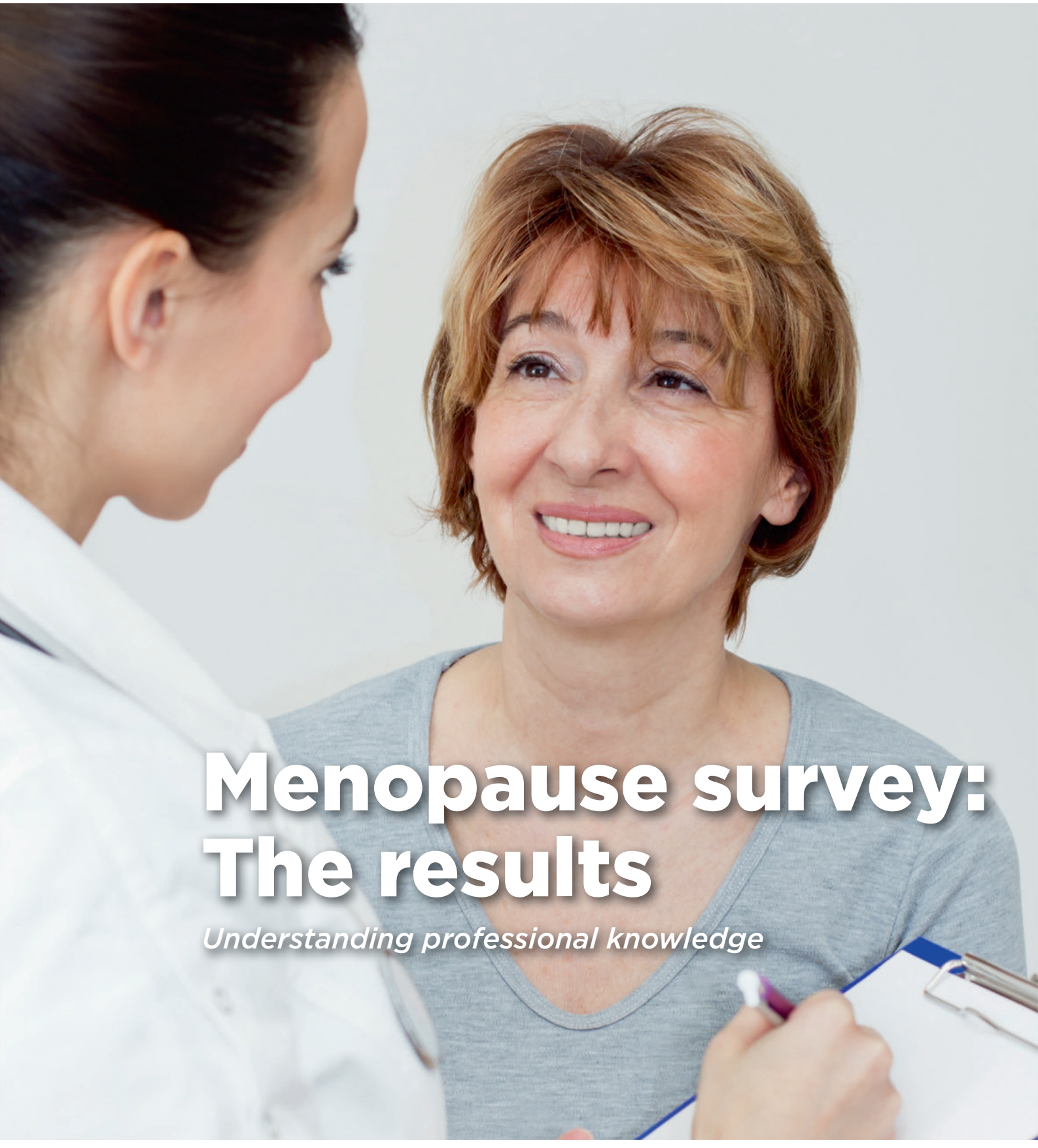
JANUARY/FEBRUARY 2017

BJFM British Journal of Family Medicine

SUPPORTING PROFESSIONAL PRACTICE • PEER REVIEWED • VOLUME 6 • ISSUE 1



Menopause survey: The results

Understanding professional knowledge

RESULTS FROM THE BJFM MENOPAUSE SURVEY

In September's issue of *BJFM* we ran, in partnership with our colleagues at Besins Healthcare (UK) Ltd., a survey to understand where health professionals may have gaps in knowledge when it comes to treating the menopause. The results are in, and the findings are available in this article

Louise Newson
Consultant Editor *Women's Health*

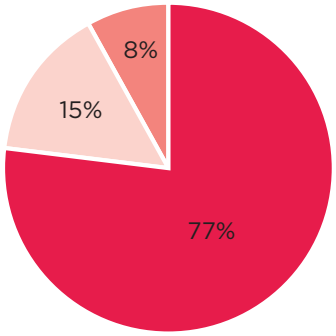
Rob Mair
Editor, *British Journal of Family Medicine*

When we launched our menopause survey, the single biggest aim was to understand the level of education and training among GPs regarding the menopause, and to determine the knowledge regarding the symptoms of the menopause and also the treatment options that would be considered in practice. Additionally, as a journal we wanted to use it as an opportunity to shape future editorial direction, using the results to fill in any knowledge gaps that might have been uncovered by the results. More than 200 people took the survey – 203 to be precise – exceeding our expectations, and this has given us a real handle on what health professionals are experiencing on the frontline, and the potential challenges that are faced.

To everyone who completed the survey, we'd like to thank you for your involvement and support.

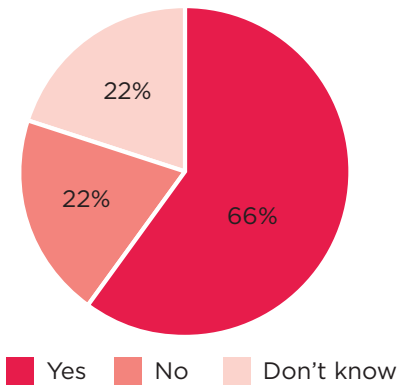
The following article provides an overview and analysis of the survey.

Q1. ARE YOU A GP?



As GPs are the journal's primary target audience, we're delighted to see that more than 75% of respondents were GPs. Nurses made up for a healthy secondary audience – and as they often play an important role in management of the menopause – not to mention other long-term conditions where knowledge of the menopause might be valuable – we welcomed their involvement. Other accounts for anyone not covered by these two job titles included gynaecologists, educators and commissioners.

Q3. ARE YOU CONFIDENT IN MANAGING THE MENOPAUSE?

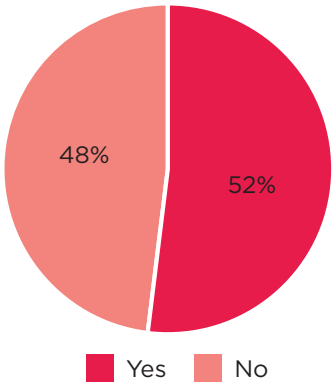


Despite a high number of GPs taking part in the survey, only 66% of respondents felt confident in treating the menopause. If nothing else, it shows the value in this piece of work. GPs face an increasingly complicated workload, managing patients with chronic conditions and multiple co-morbidities. The menopause offers up an interesting challenge for GPs in managing a myriad of symptoms, and defining best treatment options – often complicated by long-term conditions and co-morbidities.

Q4. HAVE YOU HAD ANY TRAINING IN MENOPAUSE MANAGEMENT?

Marginally more people said they had received some form of menopause training, and this was explored in more detail in Question 4, which asked: 'What type of training?
Responses here included:

- Lectures and private reading
- Self-directed learning
- Teaching from senior colleagues
- Attendance at FSRH updates
- Attendance at various conferences, including those run by the BMS
- BMS specialist skills
- Attending the FSRH/BMS two-day study and practicals with a trainer

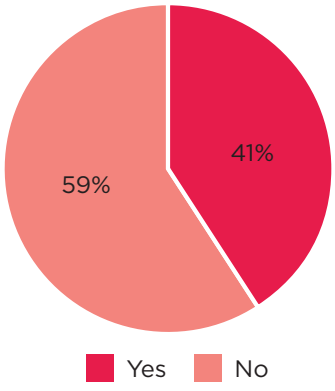


Every GP will see menopausal women during their career. It is imperative that all GPs have some menopause training, whether this is as an undergraduate or postgraduate. It is therefore potentially concerning that nearly half of the respondents had not actually received any training in the menopause. The menopause should be seen as an opportunity as appropriate medical intervention and advice at this point of life potentially offers women years of benefits from preventive health care.

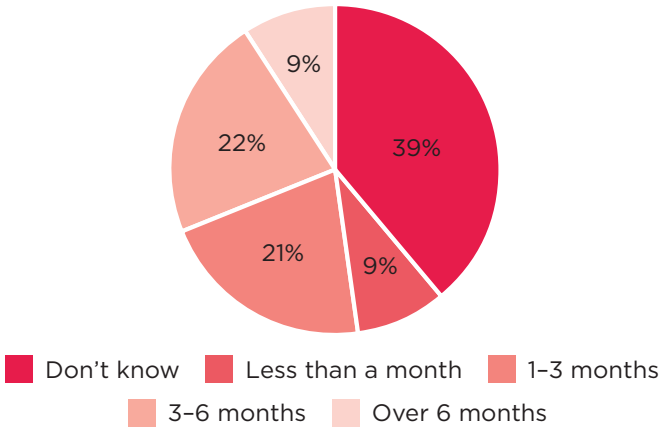
There is currently a range of training opportunities for GPs, but many of these are limited in availability and the type of training available varies considerably between regions. There needs to be more GP-based training, ideally led by GPs who are experienced in primary care as well as the menopause. There should also be menopause education introduced formally in medical schools and as part of general practice training. All this training should be based on the current available menopause guidelines, especially NICE and IMS guidelines.

As you can see, training varied hugely, from courses and attending meetings, to that offered by the British Menopause Society with their Menopause Specialist Accreditation pathway. This would indicate that, overall, there is a lack of knowledge regarding any single, clear, education pathway, and could go some way to accounting for differences in treatments.

Q5. DO YOU HAVE AN NHS MENOPAUSE CLINIC IN YOUR AREA?



Q6. HOW LONG IS THE WAITING LIST?

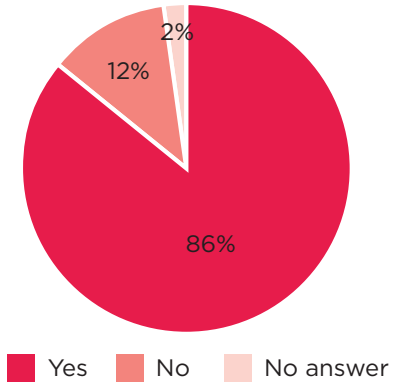


These two charts show understanding around local NHS menopause clinics. These are still not available in every region or, if they are, health professionals may not be aware of them. The second chart looks at the length of the waiting lists in these regions and excludes all of those who answered no to question 5. It shows, simply, the postcode lottery of access, with a small number waiting over 6 months to see a specialist. While a large proportion of respondents were unsure as to the length of time women had to wait, more than 50% said they expected women in their care to see a specialist within 6 months.

Of course, as demonstrated by the response to Question 5, the big issue is access. If health professionals aren't aware – or an NHS menopause clinic simply does not exist in your area – then it limits the care options available to patients.

There was much more consensus on Question 7, which asked if the menopause should be managed in primary care.

Q7. DO YOU THINK THE MENOPAUSE SHOULD BE MANAGED IN PRIMARY CARE?



Despite a high number of GPs taking part in the Here, 86% of respondents said they felt the menopause should be managed in primary care. This may reflect the audience (after all, it tallies rather nicely with the number of GPs who responded), but it does show that, at the very least, frontline primary care workers, who are often asked about symptoms of the menopause, are well placed to manage the condition, especially considering they may often have long-standing relationships with the patients in question.

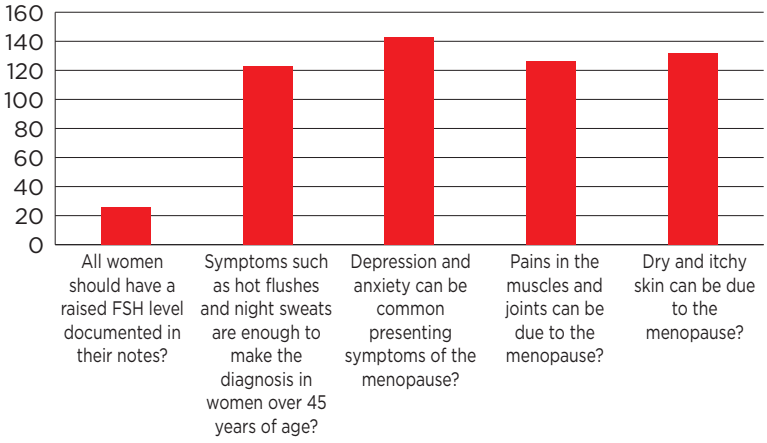
Interestingly, though, while 86% believe it should be managed in primary care, only 66% of health professionals are confident in managing the condition (Q2), while only 52% have had training in the management of the menopause. Clearly, there is a disconnect, and more work needs to be done to ensure this desire can be successfully achieved.

This needs to be done with more training opportunities and a cascade of education lead by GPs with a particular interest in the menopause. Many GPs have sound underlying knowledge of the menopause, but still lack confidence regarding prescribing HRT based on the current evidence. Appropriate training and education for these GPs would make a hugely positive difference to menopause care in the UK.

Q8. WHAT ARE YOUR VIEWS REGARDING DIAGNOSING THE MENOPAUSE?

Pleasingly, most of our respondents picked out the four correct answers, and only a small number said that all women should have raised FSH levels documented in their notes. The remaining four statements are all true regarding the menopause, and most respondents selected at least three out of the four options.

An estimated national saving of £9.6 million has been predicted by reducing unnecessary FSH testing in primary care,[1] so it is essential that GPs are not inappropriately undertaking blood tests for perimenopausal and menopausal women. There are still a huge number of women who are offered or prescribed antidepressants for their low mood associated with their perimenopause or menopause, which contradicts NICE guidance. In addition, many women are misdiagnosed with fibromyalgia, rheumatological or dermatological conditions when their symptoms are related to their changing hormone levels. It is really important that GPs are constantly thinking about menopause in many of their patients with these types of symptoms, to reduce the risk of incorrect diagnosis and inappropriate treatment. NICE guidelines (NG23)[2] recommend the following:



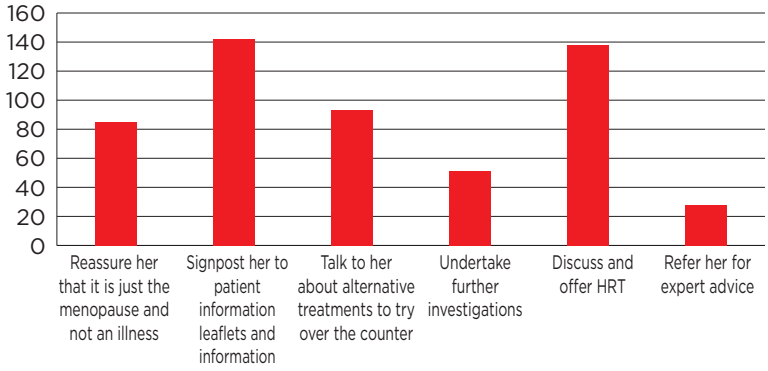
Consider using an FSH test to diagnose menopause only:

- In women aged 40 to 45 years with menopausal symptoms, including a change in their menstrual cycle, and
- In women aged under 40 years in whom menopause is suspected.

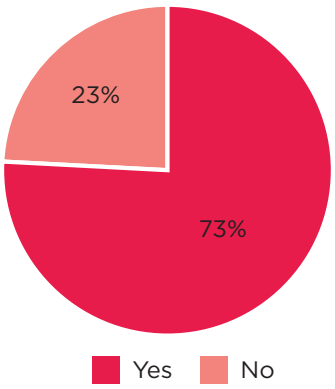
It is essential that women are given clear, easy-to-read information that is accurate and based on the current available evidence

Q9. IF YOU DIAGNOSE THE MENOPAUSE IN ONE OF YOUR PATIENTS, WHAT WOULD YOU DO?

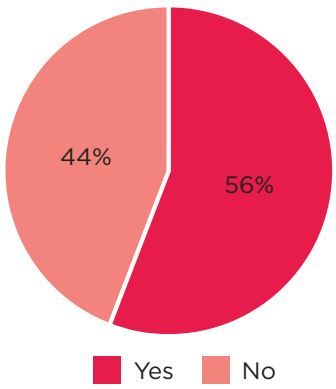
This question asked our health professionals how they'd proceed once they'd diagnosed the menopause. The responses would arguably depend on the individual patient – and in some cases further investigations would be warranted. Generally, however, the options of signposting, reassurances and discussion of treatment – HRT or otherwise – is logical. It is essential that women are given clear, easy-to-read information that is accurate and based on the current available evidence. They should also be signposted to appropriate websites.



Q10. ARE YOU CONFIDENT IN PRESCRIBING HRT TO OTHERWISE HEALTHY WOMEN?



Q11. ARE YOU CONFIDENT IN PRESCRIBING HRT TO YOUNGER WOMEN (UNDER 45 YEARS)?



These two questions both asked regarding the diagnosis of the menopause in two key groups; otherwise healthy women, and women under the age of 45. Understandably, more people were confident regarding the diagnosis of the menopause in healthy women than they were in women under the age of 45. Around 1 in 100 women under 40 years have an early menopause[3], so it is really important that GPs are more confident at diagnosing and managing these women. Currently, the average time to diagnosis is about 7 years for women with POI,[4] which is unacceptable and needs to change. Women with early menopause have an increased risk of heart disease and osteoporosis without treatment, so it is imperative that more training is available in this area.

SMOOTH HER JOURNEY THROUGH THE MENOPAUSE

Many women experience ups and downs during the menopause, with up to 80% suffering from symptoms. For those experiencing hot flushes and night sweats, NICE recommends HRT* as a first-line treatment.[1]

Identical to the hormones produced by the body, Oestrogel® relieves symptoms, while Utrogestan® 100mg helps protect women with a uterus from the increased risk of endometrial cancer.[2,3]

Guide your female patients through the menopause with the support of two body-identical HRT that you can tailor to each woman's needs.

Abbreviated Prescribing Information
Oestrogel Pump-Pack

For full prescribing information, including side effects, precautions and contraindications, please consult the Summary of Product Characteristics (SPC).

Presentation: Transdermal gel containing 17β-estradiol 0.06% w/w. Each measure from the dispenser is 1.25 g of Oestrogel. **Indication: 1:** Hormone Replacement Therapy (HRT) for oestrogen deficiency symptoms in postmenopausal women. 2: Prevention of osteoporosis in postmenopausal women at high risk of future fractures who are intolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis. The experience treating women older than 65 years is limited. **Dosage and Administration:** An oestrogen-only product to be administered daily on a continuous basis for women without a uterus. In women with an intact uterus, a progestogen should be added for at least 12 days each month. The gel should be applied to at least 750 cm2 of clean, dry, intact areas of skin (e.g. arms, shoulders, inner thighs). It should not be applied on or near the breasts or on the vulval region. The patient should apply the gel herself and avoid skin contact with others, particularly a male partner, for at least 1 hour. *Menopausal symptoms:* The usual starting dose is 2 measures (2.5 g containing 1.5 mg estradiol) once daily. If effective relief if not obtained after one month's treatment, this may be increased to a maximum of 4 measures (5 g containing 3.0 mg estradiol) daily. For initiation and continuation of treatment, the lowest effective dose for the shortest duration should be used. *Prevention of osteoporosis:* The minimum effective dose is 2.5 g Oestrogel once daily. For full details of usage please refer to the SPC. **Contraindications:** Hypersensitivity to estradiol or any of the excipients; known, past or suspected breast cancer; known or suspected oestrogen-dependent malignant tumours (e.g. endometrial cancer); undiagnosed genital bleeding; untreated endometrial hyperplasia; previous or current venous thromboembolism (deep vein thrombosis, pulmonary embolism), known thrombophilic disorders, active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction); acute liver disease or history of liver disease whilst liver function tests are abnormal; porphyria. **Warnings and Precautions:** HRT should only be initiated for symptoms that adversely affect quality of life. The risks and benefits should be reviewed annually and HRT only continued as long as the benefit outweighs the risk. A personal and family medical history should be taken before initiating or reinstituting HRT. Periodic check-ups are recommended during treatment. Physical examination and investigations including appropriate imaging tools should be carried out according to the clinical needs of the patient. Patients should be closely supervised if any of the following conditions are present, have occurred previously and/or have been aggravated during pregnancy or previous hormone treatment since they may recur or be aggravated during treatment with Oestrogel: leiomyoma (uterine fibroids) or endometriosis; risk factors for thromboembolic disorders; risk factors for oestrogen-dependent tumours; hypertension; liver disorders; diabetes mellitus with or without vascular involvement; cholelithiasis; migraine or severe headache; systemic lupus erythematosus; history of endometrial hyperplasia; epilepsy; asthma and otosclerosis. Oestrogel should be discontinued if a contraindication is discovered or the following occur: jaundice or deterioration in liver function; significant increase in blood pressure; new onset of migraine-type headache; pregnancy. In women with an intact uterus the risk of endometrial hyperplasia and carcinoma is increased when oestrogens are administered for prolonged periods of time. Break through bleeding and spotting may occur during the first months of treatment but if they occur after some time on therapy or continue after treatment has been discontinued the reason should be investigated. Unopposed oestrogen stimulation may lead to premalignant or malignant transformation in the residual foci of endometriosis. Evidence suggests an increased risk of breast cancer in women taking combined oestrogen-progestogen and possibly oestrogen-only HRT that is dependent on the duration of taking HRT. HRT increases the density of mammographic images which may adversely affect the radiological detection of breast cancer. Evidence suggests a slight increased risk of ovarian cancer in women taking oestrogen-only or combined oestrogen-progestogen HRT. HRT is associated with a 1.3 to 3-fold risk of developing venous thromboembolism (i.e. deep vein thrombosis or pulmonary embolism) especially in the first year of use. HRT should be stopped 4 to 6 weeks prior to elective surgery if prolonged immobilisation is to follow. The benefit-risk of HRT should be considered in women already on chronic anticoagulant treatment. If venous thromboembolism occurs during treatment, HRT should be discontinued. Patients should contact their doctors immediately if they have potential thromboembolic symptoms (painful swelling of a leg, sudden chest pain or dyspnoea). There is no evidence of protection against myocardial infarction with HRT and no increase in coronary artery disease in hysterectomised women using oestrogen-only therapy. Combined oestrogen-progestogen and oestrogen-only therapy are associated with up to a 1.5-fold increase in risk of ischaemic stroke. The risk increases with age. Care should be taken with women with cardiac or renal dysfunction since oestrogens may cause fluid retention. Women with pre-existing hypertriglyceridaemia should be followed closely during oestrogen replacement or HRT since pancreatitis can result from rare cases of large increases in plasma triglycerides. Oestrogens increase binding proteins such as thyroid, corticoid and sex-hormone binding globulins leading to increased circulating hormones. HRT does not improve cognitive function. There is some evidence of increased risk of probable dementia in women who start HRT after the age of 65. **Interactions:** Patients should avoid strong skin cleaners and detergents, skin products of high alcoholic content (e.g. astringents, sunscreens) and keratolytics. Also, any skin medication which alters skin production (e.g. cytotoxic drugs) should be avoided. The metabolism of oestrogens may be increased, (leading to a decreased effect and changes in the uterine bleeding profile) by enzyme-inducing products (e.g. phenobarbital, phenytoin, carbamazepine, rifampicin, rifabutin, nevirapine, efavirenz, ritonavir, nelfinavir and St John's wort). As transdermal administration avoids the first pass effect in the liver, transdermally applied oestrogens may be less affected by enzyme inducers than oral hormones. **Pregnancy and breastfeeding:** Oestrogel is not indicated in pregnancy or during breastfeeding. If pregnancy occurs during medication with Oestrogel, the treatment should be withdrawn immediately. **Undesirable effects:** The undesirable effects usually occur during the first months of treatment, are generally mild and rarely require treatment withdrawal. The following commonly (>1/100; <1/10) occur with HRT: headache, nausea, abdominal pain, breast swelling/pain, breast enlargement, dysmenorrhoea, menorrhagia, metrorrhagia, leucorrhoea, endometrial hyperplasia, weight change (increase or decrease), water retention with peripheral oedema. There is a risk of the following with HRT: breast cancer; endometrial cancer; ovarian cancer; venous thromboembolism; coronary artery disease; ischaemic stroke. For further information on side effects and risk estimates, please consult the SPC. **Overdose:** Symptoms may include breast pain, excessive production of cervical mucous, nausea, and break through bleeding. **NHS Price:** 80g dispenser £4.80. **Legal category:** POM. **Marketing Authorisation number:** PL 28397/0002. **Marketing Authorisation Holder:** Besins Healthcare, Avenue Louise, 287, Brussels, Belgium. **Date of preparation of Prescribing Information:** July 2017.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Besins Healthcare (UK) Ltd, 28 Poland Street, London, W1F 8QN, UK. Tel: 0203 862 0920 Email: drugsafety@besins-healthcare.com

Abbreviated Prescribing Information
UTROGESTAN 100mg CAPSULES (Utrogestan 100mg)

For full prescribing information, including side effects, precautions and contraindications, please consult the Summary of Product Characteristics (SPC). **Presentation:** Soft white capsule contains 100 mg micronised progesterone. **Indication:** Adjunctive use with oestrogen in post-menopausal women with an intact uterus as HRT. **Dosage and Administration:** Oral capsules which should not be taken with food as this increases the bioavailability of the capsules. The recommended dose is 2 capsules daily at bedtime for twelve days in the last half of each therapeutic cycle (Day 15 to 26). Withdrawal bleeding may occur in the follow ing week. Alternatively 1 capsule can be given at bedtime from Day 1 to Day 25 of each therapeutic cycle, withdrawal bleeding being less with this treatment schedule. Dose for elderly is the same. Not indicated in children. For full details of usage see SPC. **Contraindications:** Known past or suspected breast cancer; hypersensitivity to progesterone or any of the excipients; undiagnosed genital bleeding; known or suspected oestrogen-dependent malignant tumours (e.g. genital tract carcinoma); thrombophlebitis; thrombophylic disorders; acute liver disease or history of liver disease; previous or current thromboembolism disorders; cerebral haemorrhage; porphyria. **Warnings and Precautions:** HRT should only be initiated for symptoms that adversely affect quality of life. A careful appraisal of the risks and benefits should be undertaken at least annually and HRT should only be continued as long as the benefit outweighs the risk. Women should be encouraged to be aware of their breasts and report any changes to their doctor or nurse. Utrogestan 100mg is not a treatment for premature labour or as a contraceptive. The following may recur or be aggravated during treatment with Utrogestan 100 mg: leiomyoma or endometriosis; hypertension, liver disorders (e.g. liver adenoma); diabetes mellitus; cholelithiasis; migraine or severe headache; systemic lupus erythematosus; endometrial hyperplasia; epilepsy; asthma; otosclerosis; fluid retention (e.g. cardiac disease; renal disease); depression; photosensitivity. Women with risk factors for thromboembolic disorders or oestrogen dependant tumours (e.g. 1st degree heredity for breast cancer) should be closely supervised. If unexplained loss of vision, proptosis or diplopia, papilloedema, retinal vascular lesions, migraine, jaundice or deterioration in liver function occur during therapy, the drug should be immediately discontinued. The use of HRT is associated with an increased risk of deep vein thrombosis (DVT) or pulmonary embolism. The overall evidence suggests an increased risk of breast cancer in women taking combined oestrogen-progestagen and possibly also oestrogen-only HRT, that is dependent on the duration of taking HRT. Combined oestrogen-progestagen are associated with an increased risk of ischaemic stroke. **Interactions:** Drugs known to induce the hepatic CYP450-3A4 (e.g. barbiturates, anti-epileptic agents (phenytoin, carbamazepine), rifampicin, phenylbutazone, spironolactone, griseofulvin, some antibiotics (ampicillins, tetracyclines) and herbal products containing St. John's wort, may increase metabolism and the elimination of progesterone. Ketokonazole and other inhibitors of CYP450-3A4 such as ritonavir and nelfinavir may increase bioavailability of progesterone. Utrogestan 100mg may interfere with the effects of bromocriptine and may raise the plasma concentration of ciclosporin. They may also affect the laboratory tests of hepatic and/or endocrine functions. **Pregnancy and lactation:** Utrogestan 100mg is not indicated during pregnancy. If pregnancy occurs during medication, Utrogestan 100mg should be withdrawn immediately. Prescription of progesterone beyond the first trimester may reveal gravidic cholestasis. Utrogestan 100mg is not indicated during breast feeding. Detectable amounts of progesterone enter the breast milk. **Effects on ability to drive and use machines:** Utrogestan 100mg may cause drowsiness and/or dizziness in a minority of patients. Taking the capsules at bedtime should reduce these effects during the day. **Undesirable effects:** *Common:* Altered periods, amenorrhoea, intercurrent bleeding, headaches. *Uncommon:* Mastodynia, drowsiness, dizziness, vomiting, diarrheoa, constipation, cholestatic jaundice, pruritus, acne. When used in conjunction with oestrogen, there is a risk of the following with HRT: breast cancer; endometrial cancer; ovarian cancer; venous thromboembolism; coronary artery disease; ischaemic stroke. For further information on side effects and risk estimates please consult the SPC of both products. **Overdose:** Symptoms may include somnolence, dizziness, euphoria or dysmenorrhoea. **NHS Price:** Utrogestan 100 mg capsules - £5.13 for 30 capsules. **Legal category:** POM. **Marketing Authorisation Number:** Utrogestan 100 mg capsules - PL 28397/0003. **Marketing Authorisation Holder:** Besins Healthcare, Avenue Louise, 287, Brussels, Belgium. **Date of preparation of prescribing information:** November 2016.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Besins Healthcare (UK) Ltd, 28 Poland Street, London, W1F 8QN, UK. Tel: 0203 862 0920 Email: drugsafety@besins-healthcare.com

References: 1. NICE Guideline. Menopause: diagnosis and management (NG23). 2015. Available at: https://www.nice.org.uk/guidance/ng23/resources/menopause-diagnosis-and-management-1837330217413. Accessed: September 2017. **2.** Oestrogel Summary of Product Characteristics, May 2017. Available at: https://www.medicines.org.uk/emc/medicine/19898. **3.** Utrogestan 100mg Summary of Product Characteristics, July 2017. Available at: https://www.medicines.org.uk/emc/medicine/19895.

A GUIDING PARTNERSHIP

Oestrogel® ESTRADIOL-17ß

UTROGESTAN® Oral 100mg
Natural Micronised Progesterone

Date of Preparation: November 2017

OES/2017/043e

Q12. WHAT ARE YOUR VIEWS REGARDING HRT IN WOMEN UNDER 60 YEARS?

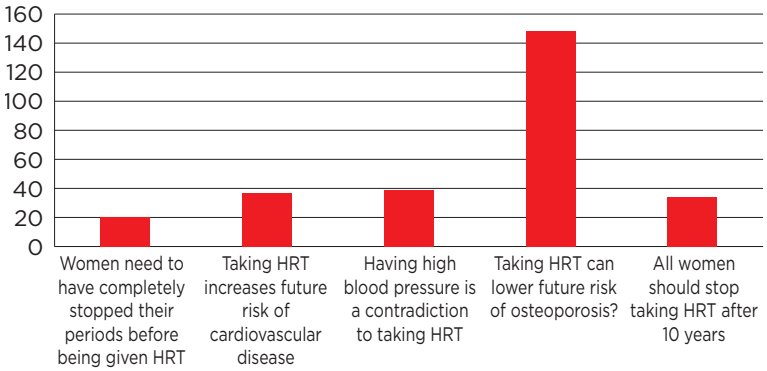
Pleasingly, most of our respondents picked out the There is still much confusion regarding correct diagnosis of menopause and also regarding length of time for taking HRT. The evidence regarding HRT is discussed in the NICE[2] and IMS[5] guidance, but unfortunately many GPs and health professionals are not aware of them. There is increasing evidence that taking HRT early, in the perimenopause, affords the greatest benefit in terms of reduction of future conditions such as cardiovascular disease, osteoporosis and diabetes. Therefore women should not be denied HRT waiting for their periods to stop completely. There is very clear evidence that starting HRT within 10 years of the menopause reduces future risk of CVD, but many health professionals are still confused about this.

NICE guidance clearly states that having hypertension (or any other cardiovascular disease risk factors) is not a contraindication for starting or continuing HRT. In fact, having transdermal oestrogen and micronised progesterone can be associated with a lowering of blood pressure.

Some 1 in 2 women in the UK have a fragility fracture and it is really important that we all consider bone health in menopausal women. Taking HRT has been shown to reduce the risk of a fragility fracture as well as improving bone mineral density.

All the current guidelines are clear that there is no maximum age for taking HRT and also no maximum length of time for taking HRT. All women need to have individualised consultations to discuss their benefits and potential risks of taking HRT on an annual basis. Many women are still being given incorrect advice and being asked to stop HRT when there is no indication to do so.

Overwhelmingly, most respondents said that taking HRT can lower future risk of osteoporosis. However, looking at the comments, many respondents were eager to stress that treating the menopause should be an individualised approach to treatment, working with the patient and with her best interests at heart. In the over 60s, however, the benefits of HRT in relation to osteoporosis are well-documented – and, pleasingly, this message is getting through.



Of course, there are a number of extenuating factors that need to be considered, and these are covered in the NICE Guideline and outlined below:

Cardiovascular disease

Regarding cardiovascular disease, menopausal women and health professionals should understand that HRT:

- Does not increase cardiovascular disease risk when started in women aged under 60 years
- Does not affect the risk of dying from cardiovascular disease.[2]

Osteoporosis

It should be explained to women that their risk of fragility fracture is decreased while taking HRT and that this benefit:

- Is maintained during treatment but decreases once treatment stops
- May continue for longer in women who take HRT for longer.[2]

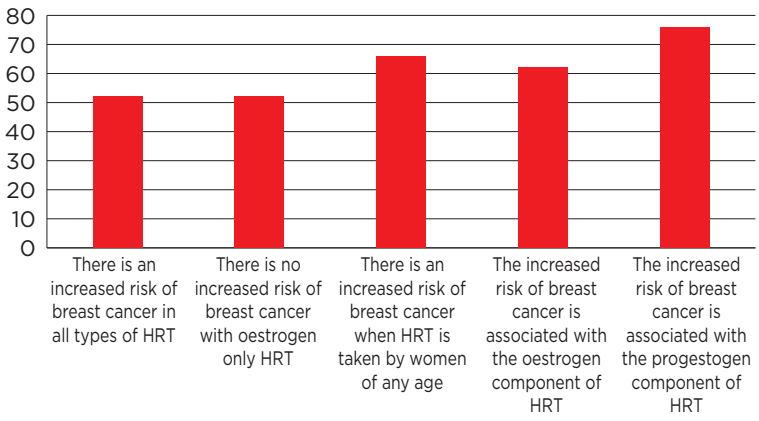
Stopping HRT

NICE recommends that women who are stopping HRT are offered a choice of gradually reducing or immediately stopping treatment. There is no arbitrary limit mentioned.[2]

All the other statements in this case are false – so it was again pleasing to see such low levels of response to these overall.

All the current guidelines are clear that there is no maximum age for taking HRT and also no maximum length of time for taking HRT

Q13. WHAT ARE YOUR VIEWS REGARDING HRT AND BREAST CANCER RISK?



The most common reason why women are scared of HRT and GPs are not prescribing HRT is the perceived risk of breast cancer with taking HRT. The facts regarding breast cancer are very clear and it is essential that women and health professionals know them to dispel any myths.

HRT with oestrogen alone (given to women who have had a hysterectomy) is not associated with an increased risk of breast cancer and the WHI study showed these women actually had a lower risk of breast cancer.[6] HRT containing oestrogen and a progestogen may be associated with a very small increased risk of breast cancer in some women.

However, it is important to know that there are other risk factors for developing breast cancer which include being overweight, not exercising and drinking a couple of glasses of wine in the evenings.[7] Many women who are menopausal put on weight, often as they "comfort" eat as their symptoms make them feel so dreadful. They also reduce their exercise as they feel so tired and often have muscle and joint pains. In addition, many women increase their alcohol intake to help them sleep. This means that these women are increasing their risk of breast cancer by doing nothing about their menopause, often without realising.

The increased risk of breast cancer associated with these lifestyle changes is actually similar to the risk with taking combined HRT for more than five years, highlighting how small the actual risk of breast cancer with taking HRT is. Reassuringly, there has never been a study to show an increased risk of death from breast cancer in women who take HRT.

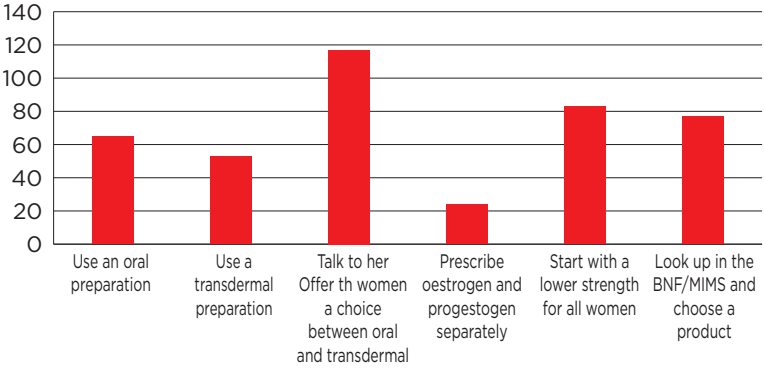
All women who are under 45 years of age taking HRT do not have any increased risk of breast cancer as the HRT is simply replacing the hormones that their bodies should be otherwise producing.

Question 13 put up some hugely interesting results, with only 10% variance between the most popular and least popular response. The true answer is that there is no increased risk of breast cancer with oestrogen-only HRT – yet this was one of the least popular answers. Clearly, this indicates a greater need regarding the understanding of breast cancer risk, and this is something we will look to address in future content, including an article on HRT and breast cancer.

NICE guidelines state that it should be explained to women around the natural age of the menopause that:

- The baseline risk of breast cancer for women around menopausal age varies from one woman to another, according to the presence of underlying risk factors
- HRT with oestrogen alone is associated with little or no change in the risk of breast cancer
- HRT with oestrogen and progestogen can be associated with an increase in the risk of breast cancer
- Any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT.[2]

Q14. IF YOU PRESCRIBE HRT, WHICH OF THE FOLLOWING DO YOU USUALLY PRESCRIBE?



Again, regarding treatment, we can see a broad spread of answers. Pleasingly, health professionals were keen to offer a choice between transdermal and oral preparations, giving the women the choice over how they receive their treatment. There are many advantages of transdermal oestrogen, including no risk of thromboembolism (at standard doses) and improved absorption.[8] In addition, taking oral oestrogen can increase SHBG, which reduces free testosterone so can lower libido in these women. Regarding dose, it is common for women to be prescribed the lowest dose, which is then titrated up if necessary.[9] However, young women usually need high doses of oestrogen so it is often not appropriate to start these women on low doses of HRT.

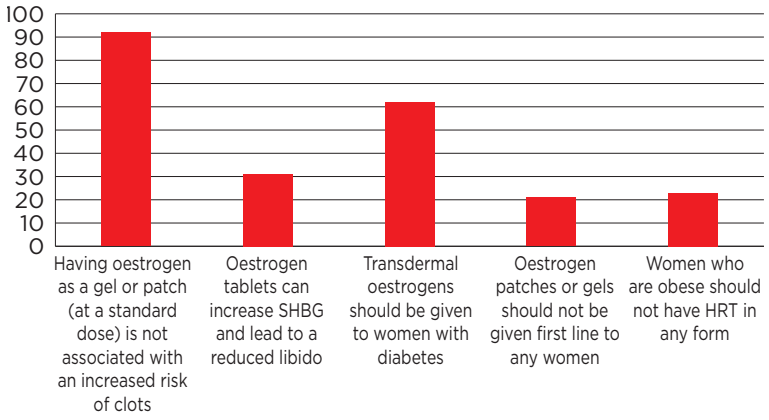
The British Menopause Society has produced an algorithm to help health professionals in the advice they give to women regarding the choice of HRT.[10] For more information visit https://thebms.org.uk/_wprs/wp-content/uploads/2016/04/HRT-Guide-160516.pdf

Q15. WHAT ARE YOUR VIEWS REGARDING GIVING OESTROGEN AS A PATCH OR GEL COMPARED TO AS A TABLET?

Here the first three answers are correct; that having oestrogen as a gel or patch at a standard dose is not associated with increased risk of clots; that oestrogen tablet can increase sex hormone-binding globulin (SHBG) and lead to a reduction in libido; and that transdermal oestrogens should be given to women with diabetes. Reassuringly, these were the three most popular answers.

Per NICE guidelines, health practitioners should remember that:

- The risk of VTE associated with HRT is greater for oral than transdermal preparations
- The risk associated with transdermal HRT given at standard therapeutic doses is no greater than baseline population risk
- Transdermal rather than oral HRT should be considered for menopausal women who are at increased risk of VTE, including those with a BMI over 30 kg/m2, and
- There is no increased risk of stroke with transdermal oestrogen.



These guidelines were set out by NICE in 2015, and we should expect to see an increase in the number of GPs and health professionals prescribing transdermal HRT in the future.

Q16. WHICH TYPE OF PROGESTOGEN DO YOU USUALLY PRESCRIBE FOR ADJUNCT USE IN WOMEN WITH A UTERUS?

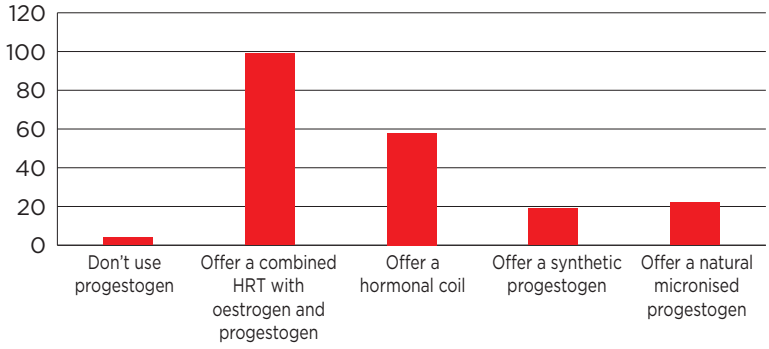
By far the most common treatment was the offer of a combined oestrogen with progestogen, followed by a hormonal coil. It would be interesting to know what informed these decisions, and how much of it was informed by patient choice – something this survey didn't explore.

Not all HRTs have the same risk-benefit profile.

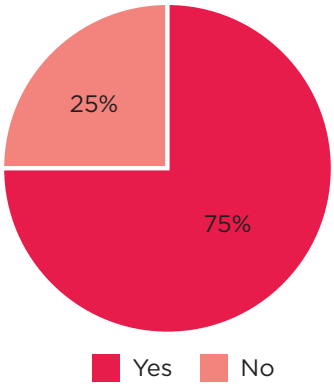
As stated by NICE (NG23),[2] the risk of VTE associated with HRT is greater for oral than transdermal preparations. Transdermal rather than oral HRT must be considered for menopausal women who are at increased risk of VTE, including those with a BMI over 30 kg/m2.

The progestogen component of HRT may also influence the risk of a DVT, which may be greater with androgenic synthetic progestogens than natural progesterone (but findings from observational studies need confirmation).

Micronised progesterone is associated with many advantages including less side effects and observational studies have shown there is not a risk of breast cancer in these women taking it. Older progestogens can be also associated with more side effects and also some cardiovascular and thrombotic risk.

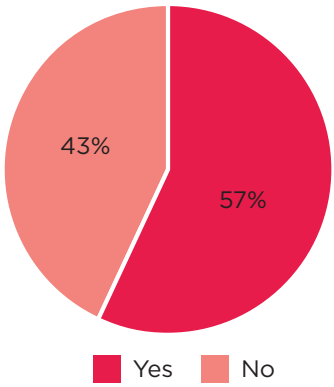


Q17. ARE YOU AWARE OF THE DIFFERENT TYPES AND DOSES OF HRT?



Three-quarters of respondents said they were aware of the different types and doses of HRT, and this is broadly reflected in the knowledge displayed in the survey. Many GPs are still confused regarding the different types of HRT, including some of the combination preparations. Many GPs require more training and education regarding the types of HRT to optimise the treatment for their patients. This would then help to reduce side effects, improve compliance and also reduce future complications.

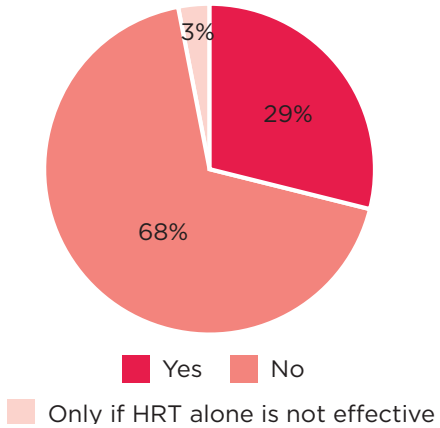
Q18. HAVE YOU GIVEN OR OFFERED ANTIDEPRESSANTS TO WOMEN WHO HAVE SYMPTOMS OF LOW MOOD AND/OR ANXIETY WITH THEIR MENOPAUSAL SYMPTOMS?



NICE guidelines state that, routinely, selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) or clonidine should not be offered as first-line treatment for vasomotor symptoms alone.[2] There is some evidence that low mood associated with menopause can improve with taking HRT and it is really important that GPs consider other symptoms related to the menopause and do not manage the low mood in isolation. Inappropriate prescribing of antidepressants is an increasing problem in primary care.

The use of antidepressants during the menopause should not be first line for the majority of women – on the one hand there is some evidence to support the use of selective serotonin reuptake inhibitors (SSRIs) as they can also alleviate symptoms such as hot flushes, but on the other, they can lead to reduced libido, compounding other symptoms. Again, an individualised approach to care is likely to be the best course of action, and that is reflected in the pretty even split of these results.

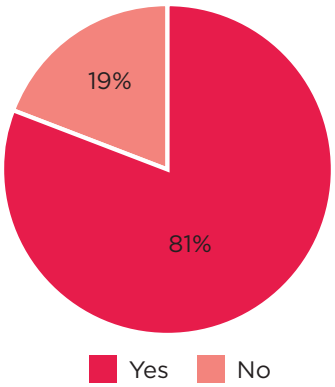
Q19. DO YOU OR ANY DOCTOR IN YOUR PRACTICE PRESCRIBE TESTOSTERONE FOR MENOPAUSAL WOMEN WITH LOW SEXUAL DESIRE?



Following the withdrawal of transdermal testosterone patches subcutaneous implants in the UK, there were no preparations available for use by women in the UK, Europe or USA.

Though 29% of respondents stated they have prescribed testosterone for women, it should be noted that currently there are no licensed testosterone preparation for use in women.

Q20. DO YOU ROUTINELY ASK MENOPAUSAL WOMEN ABOUT VAGINAL DRYNESS?



Our final question looked at whether health professionals routinely asked menopausal women about vaginal dryness. More than three-quarters said they did, which is a reassuring surprise. Often it can be an issue that is ignored, leading women to suffer in silence. Fortunately, by asking and discussing, treatment options can be found and a plan put in place. At least half of menopausal women have this symptom and studies have shown that only a minority of women receive treatment, so it is really important that we are pro-active in diagnosing and managing this in primary care.

This survey has been financed by Besins Healthcare (UK) Ltd who provided input in the content of the questions. BHUK/2017/560b – August 2017

The use of antidepressants during the menopause should not be first line for the majority of women

References

1. NICE. *Costing report: menopause: diagnosis and management—implementing the NICE guideline on menopause (NG23)*. NICE, 2015
2. NICE. Menopause: diagnosis and Management. Nice Guideline https://www.nice.org.uk/guidance/ng23/resources/menopause-diagnosis-and-management-pdf-1837330217413 [Accessed December 2017]
3. https://www.nhs.uk/conditions/menopause/ [Accessed December 2017]
4. Maclaran K, Panay N; Current concepts in premature ovarian insufficiency. *Women's Health* (Lond) 2015; 11(2): 169–182
5. http://www.imsociety.org/manage/images/pdf/4429e3dd302aac259ad68c3be7f60599.pdf [Accessed December 2017]
6. Rossouw JE, Anderson GL, Prentice RL, LaCroix AZ, Kooperberg C, Stefanick ML, et al. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results From the Women's Health Initiative randomized controlled trial. *JAMA* 2002;**288**: 321-337
7. Marsden J. Long-term benefits and risks of HRT (Section 11): Breast Cancer. *Post Reprod Health*. 2016 Jun. **22**(2): 85-91.
8. Canonico M, Plu-Bureau G, Lowe GD, Scarabin PY. Hormone replacement therapy and risk of venous thromboembolism in postmenopausal women: systematic review and meta-analysis. *BMJ* 2008;336:1227-31
9. NHS Choices https://www.nhs.uk/conditions/hormone-replacement-therapy-hrt/ [Accessed December 2017]
10. British Menopause Society. HRT Guide https://thebms.org.uk/_wprs/wp-content/uploads/2016/04/HRT-Guide-160516.pdf [Accessed December 2017]