PRIMARY CARE
WOMEN'S HEALTH FORUM

Easy HRT prescribing guide

By: Dr Louise Newson BSc(Hons) MBChB(Hons) MRCP FRCGP

www.menopausedoctor.co.uk

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 menopause [1-3].

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 dementia [4-6]. 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 progestogens [7-8].

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 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 events [9]. This combination should ideally be initiated by healthcare professionals at a primary care level.

I do not prescribe combination products as:

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

I do not usually prescribe oral oestrogen first line as:

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

1.

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!

Patches I usually prescribe:

- Evorel 25 / 50 / 75 / 100mcg patches twice a week
- Estradot 25 / 50 / 75 / 100mcg patches twice a week (smaller in size)
- Elleste 40 / 80mcg patches twice a week.

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.

Gels I usually prescribe:

- Oestrogel 2-4 pumps a day (NB young women often need more)
- Sandrena gel 0.5mg sachets
- Sandrena gel 1mg sachets.

2.

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.

I usually prescribe micronised progesterone (Utrogestan):

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
- Can cause some sedation – take at night time
- Needs to be taken on empty stomach (eating food increases absorption)
- Not a contraceptive.

Ways to prescribe Utrogestan:

- 100mg capsule each evening as continuous (licensed for days 1-25 but easier to take every night)
- 2 x 100mg capsules each evening for 2 out of 4 weeks (licensed for days 15-26 but easier to take for 2 weeks)
- Can be given vaginally on alternate nights as continuous and one every night for 12-14 days each month as cyclical off license.

Mirena - (intra-uterine system)

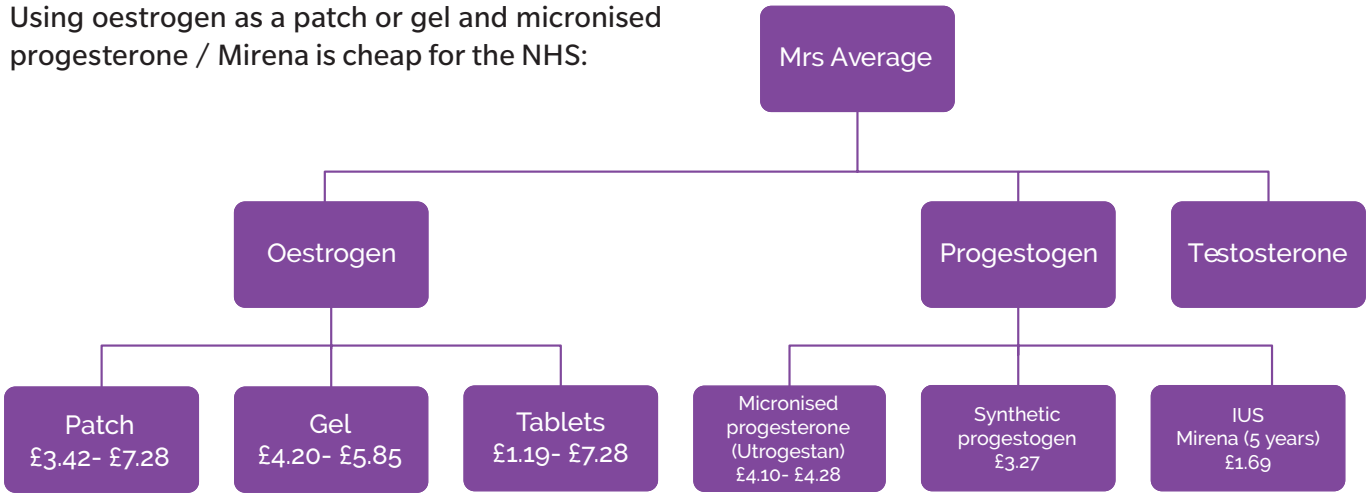
Pros:

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

Cons:

- Systemic side effects in some women (especially first 3-6/12)
- Spotting can occur in first 3-6/12
- Not every woman's choice
- Not always available in primary care

Using oestrogen as a patch or gel and micronised progesterone / Mirena is cheap for the NHS:



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.

References

1. National Institute for Health and Care Excellence. NICE guideline NG23 – Menopause: diagnosis and management 2015 [May 2017]. Available from: https://www.nice.org.uk/guidance/ng23
2. Baber RJ, Panay N, Fenton A, Group IMSW. 2016 IMS Recommendations on women's midlife health and menopause hormone therapy. Climacteric 2016;19:109-50
3. Hamoda H, Panay N, Arya R, Savvas M. The British Menopause Society & Women's Health Concern 2016 recommendations on hormone replacement therapy in menopausal women. Post Reproductive Health 2016;22:165-83
4. 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;288:321-33
5. Manson JE, Aragaki AK, Rossouw JE et al. Menopausal Hormone Therapy and Long-term All-Cause and Cause-Specific Mortality: The Women's Health Initiative Randomized Trials. JAMA. 2017; 318(10):927-938
6. Boardman HM, Hartley L, Eisinga A, Main C, Roque i Figuls M, Bonfill Cosp X, et al. Hormone therapy for preventing cardiovascular disease in post-menopausal women. Cochrane Database Syst Rev 2015:CD002229
7. Stute P, Wildt L, Neulen J. The impact of micronized progesterone on breast cancer risk: a systematic review. Climacteric. 2018 Apr;21(2):111-122. M.
8. L'Hermite. Bioidentical menopausal hormone therapy: registered hormones (non-oral estradiol ± progesterone) are optimal. Climacteric 2017; 20:331-338
9. Newson L, Lass A. Effectiveness of transdermal oestradiol and natural micronised progesterone for menopausal symptoms. BJGP 2018; 68: 499-500.