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Department of Endocrinology
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Saturday, June 22, 2019

14:25 - 14:50 How to Prescribe Menopausal Hormone Therapy (MHT)
How To Prescribe Menopausal Hormone Therapy

Clinical  A/Prof Amanda Vincent

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Endocrinologist, Menopause Unit, Monash Health, Clayton, Victoria, Australia
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Disclosures

• Honorarium from Novo Nordisk, Amgen, Merck
• Grant funding from NHMRC, Osteoporosis Australia-Amgen-ANZBMS
Claire: 54 years FMP 2 years ago. Smoker. Hot flushes and night sweats, insomnia last 2 years.

Alice: 64 years FMP 13 years ago. Vaginal dryness, dysparunia.


Jen: 38 years BSO and hysterectomy for Endometriosis.

Lucy: 25 years Spontaneous POI. Depression. Prefers periods.

Jen: 38 years BSO and hysterectomy for Endometriosis.

Jen: 48 years Irregular periods, hot flushes for last year. Married.

Lucy: 25 years Spontaneous POI. Depression. Prefers periods.

Claire: 54 years FMP 2 years ago. Smoker. Hot flushes and night sweats, insomnia last 2 years.
Step by step guide to MHT

• Step-1: Assess indications for MHT
  – Menopausal symptoms
  – Premature Ovarian Insufficiency (POI)
  – (Low bone density without fracture)

• Step 2: Clinical assessment
  – Contra-indications to MHT
  – Risk/ benefit evaluation
  – Factors that may affect choice of MHT preparation
Step by step guide to MHT

- Step 3: Prescribe MHT if no contra-indications and individualise
  - Discuss individual risk/benefit profile and woman’s preferences
  - Combined MHT (if intact uterus) or E-only MHT (if hysterectomy)
  - Contraception required?
  - Provide information

- Step 4: Review initially at 8-12 weeks and then yearly

- Step 5: Adjust/continue MHT depending on response/adverse effects/risk profile
Initial menopause consultation- Step 1 and 2

• Focus on what matters to the patient (shared decision-making)
  – Concentrate initially on the top three concerns
  – Menopause score chart may be helpful
• Determine if any contraindications to MHT
  – Investigate abnormal bleeding first
• Assess factors that will influence MHT preparation choice
  – Need for contraception/ VTE risk factors
• MHT is part of an overall strategy to optimise health/QOL
  – consider psychosocial issues and lifestyle measures (smoking, exercise, calcium, alcohol, weight)
• Set expectations for 2nd visit to review results & initiate therapy
• Provide written information (patient may feel quite desperate)
  www.menopause.org.au; www.jeanhailes.org
What do you need to know?

Medical History
- Current menopausal symptoms
- Relevant gynecological history
  - LMP and bleeding pattern
  - Hysterectomy / oophorectomy
  - Current use of Hormone therapy
  - Contraceptive needs
  - Parity

Major Medical illnesses
- VTE / PE
- Breast / endometrial cancer
- Thyroid disease
- Cardiovascular disease
- Osteoporosis / fracture
- Diabetes
- Depression
- Liver or Renal disease

Significant Family History
- Cardiovascular
- Osteoporosis / fracture
- Cancer
- Dementia

Social history

Smoking/ Alcohol use

Medication

Examination
- Height/ Weight
- Blood Pressure
- Cardiovascular
- Breast check
- Thyroid
- Pelvic examination/ Pap smear


NZ Health Pathways Menopause
What do you need to know?

Investigations

Blood
• TSH
• Fasting BSL
• Lipids
• Renal/ Liver function
• Vitamin D
• FBE/ Ferritin

Mammogram
Bone Density

Practice point:
• Diagnosis of menopause in women > 45 years is a clinical one
• FSH, LH, oestradiol –
  • rarely needed unless hysterectomy or POI?
• Progesterone- no value
• AMH – not useful for diagnosis
• Do not check hormone levels if taking hormonal medication

A Practitioner’s tool kit. Jane F M and Davis S R Climacteric 2014;17:1-16
**Indications**

- Menopausal symptoms adversely impacting QOL
- POI
- Low bone density

**Risk factor assessment**

- **Contraindications:**
  - Undiagnosed vaginal bleeding
  - Breast or endometrial cancer
  - Active VTE, CVD or liver disease

**Initiate MHT**

- **Recommend:** Age <60 years or menopause within 10 years
- **Caution:**
  - Age ≥ 60 years or menopause onset >10 years ago
  - Moderate risk of breast cancer or CVD
- **Avoid:** High risk of breast cancer or CVD

Shifren et al., JAMA 2019
Review menopause consultation: Steps 3-5

• Focus on what matters to patient and treat as partnership
• Review results to individualise MHT
  – Woman’s preferences
  – Risks and benefits of MHT
  – Uterus intact (combined MHT) or hysterectomy (E only)
  – Vaginal oestrogen if only urogenital symptoms
  – Start at low dose and titrate up according to symptoms
• Set expectations:
  – Plan to reduce symptoms, not necessarily eradicate.
  – Initial trial of 8-12 weeks
  – May have to try other combinations MHT or non-hormonal therapies
  – Advise about possibility of abnormal bleeding in first 6 months of combined MHT
• Provide information
Prescribing MHT: Dose, delivery systems and regimens matter

Low dose therapy has:
• Less effect on breast density and pain.
• Less break through bleeding.

Transdermal therapy has:
• Less effect on thromboembolic risk
• A more stable hormone delivery profile

Estrogen alone has:
• Greater cardiovascular benefits
• Less effect on VTE risk
• Less effect on breast cancer risk

Not all progestins are created equal
• Micronised progesterone & dydrogesterone appear safer for breast and CVD health.
Global Consensus on MHT: Risks and Benefits

✓ MHT is the most effective treatment for menopausal VMS.
✓ Benefits are greatest and risks least when initiated within 10 years of the LMP.
✓ Quality of life and other menopausal symptoms may improve with MHT.
✓ MHT reduces the risk of osteoporosis related fractures at the hip, spine and other sites.
✓ MHT is effective in the treatment of symptoms of VVA (GSM).
✓ Estrogen therapy may decrease the risk of CHD when initiated in women within 10 years of the LMP.
✓ Data on estrogen plus progestogen shows a less compelling trend towards CHD benefit.

x The risk of VTE is increased with oral MHT.
x The risk of Breast Cancer with MHT is rare and equates to an incidence of < 1:1000 w/yr.
x This risk is related to the use of a progestogen with estrogen and perhaps duration of use.

Santen et al., J Clin Endocrinol Metab 2010
**A Progestogen is essential for endometrial safety**

**The Pepi Trial**  
596 women, 3 year follow up of endometrial safety

<table>
<thead>
<tr>
<th>Condition</th>
<th>Placebo</th>
<th>CEE alone</th>
<th>CEE+MPA sequential</th>
<th>CEE+MPA continuous</th>
<th>CEE+MP</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>119</td>
<td>119</td>
<td>118</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Normal</td>
<td>97.5%</td>
<td>37.8%</td>
<td>94.9%*</td>
<td>99.2%*</td>
<td>95.0%*</td>
</tr>
<tr>
<td>Simple hyperplasia</td>
<td>0.8%</td>
<td>27.7%**</td>
<td>3.4%</td>
<td>0.8%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Complex hyperplasia</td>
<td>0.8%</td>
<td>22.7%**</td>
<td>1.7%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Atypia</td>
<td>0%</td>
<td>11.8%**</td>
<td>0%</td>
<td>0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Adenocarcinoma</td>
<td>0.8%</td>
<td>0%</td>
<td>0%</td>
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**Minimum progestogen dosing requirements**  
for endometrial protection with standard oestrogen dosing (CEE 0.625 or equiv.)

<table>
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<tr>
<th>Type of Progestogen</th>
<th>Cyclic oral 12-14 days per month</th>
<th>Continuous daily</th>
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<tbody>
<tr>
<td>Medroxyprogesterone (MPA)</td>
<td>10mg</td>
<td>2.5-5mg</td>
</tr>
<tr>
<td>Dydrogesterone</td>
<td>10mg</td>
<td>5mg</td>
</tr>
<tr>
<td>Norethisterone (NETA)</td>
<td>2.5mg</td>
<td>1mg</td>
</tr>
<tr>
<td>Micronised Progesterone</td>
<td>200mg</td>
<td>100mg</td>
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Writing Group for the PEPI Trial. *JAMA* 1996;275:370–375  
Furness et al., Cochrane Review CD 402. 2012
## Use of MHT and risk of VTE: Nested Case Control Studies

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<tr>
<th>Intervention</th>
<th>Cases/controls</th>
<th>Odds Ratio</th>
<th>P</th>
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<tbody>
<tr>
<td><strong>Oral Estrogen</strong></td>
<td>1297/4568</td>
<td>1.40 (1.32-1.48)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Conjugated Estrogens</td>
<td>786/2692</td>
<td>1.49 (1.39-1.60)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Estradiol</td>
<td>511/1876</td>
<td>1.27 (1.16-1.39)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Oral Estrogen Combined with progestogen</strong></td>
<td>1910/6770</td>
<td>1.73 (1.65-1.81)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Conjugated Estrogens + MPA</td>
<td>501/1438</td>
<td>2.10 (1.92-2.31)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Estradiol + dydrogesterone</td>
<td>101/520</td>
<td>1.18 (0.98-1.42)</td>
<td>0.09 ns</td>
</tr>
<tr>
<td>Estradiol + MPA</td>
<td>51/215</td>
<td>1.44 (1.09-1.89)</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Combined cyc</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conjugated Estrogens with or without MPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estradiol plus dydrogesterone continuous</td>
<td>63/312</td>
<td>1.13 (0.84-1.53)</td>
<td>0.4 ns</td>
</tr>
<tr>
<td><strong>Transdermal preparations</strong></td>
<td>640/3519</td>
<td>0.93 (0.87-1.01)</td>
<td>0.07 ns</td>
</tr>
<tr>
<td>Estradiol only</td>
<td>503/2646</td>
<td>0.96 (0.88-1.04)</td>
<td>0.3 ns</td>
</tr>
<tr>
<td>Estradiol combined with progestogen</td>
<td>137/873</td>
<td>0.86 (0.73-1.01)</td>
<td>0.06 ns</td>
</tr>
<tr>
<td>Transdermal estradiol &lt; 50ug</td>
<td>377/2110</td>
<td>0.94 (0.85-1.03)</td>
<td>0.2 ns</td>
</tr>
<tr>
<td>Transdermal estradiol &gt; 50ug</td>
<td>126/536</td>
<td>1.05 (0.88-1.24)</td>
<td>0.6 ns</td>
</tr>
<tr>
<td>Tibolone</td>
<td>224/1218</td>
<td>1.02 (0.90-1.15)</td>
<td>0.8 ns</td>
</tr>
</tbody>
</table>

Conjugated Estrogens with or without MPA were associated with the highest risks. No increased risk of VTE was found for transdermal preparations.

Vinogradova Y et al. BMJ 2019;364:4810
Variations in Breast Cancer Risk Between CE and CE/MPA

Cumulative hazards, adjusted for age and race/ethnicity, for invasive breast cancer by randomization assignment in the WHI CE-alone and CE/MPA trials

CE alone:
- lower risk of invasive breast cancer
  (HR 0.77, 95% CI 0.62–0.95; P=0.02)
- fewer deaths from breast cancer
  (HR 0.37, 95% CI 0.13–0.91; P=0.03)
- lower all cause mortality.
  (HR 0.62, 95% CI 0.39–0.97; P=0.04)

CE + MPA
- increased breast cancer risk
  (HR 1.25 (95%CI 1.07-1.46)
- No increase in breast cancer mortality.


CE/MPA:   HR 1.25 (1.07-1.46 nCI)
         HR 1.25 (0.83-1.92 adCI)

CEE:         HR 0.77 (0.62-0.95 nCI)

Langer R. Climacteric 2016;20:91-96
Fracture risk reduction with different therapies

6.1 In postmenopausal women at high risk of fracture and with the patient characteristics below, we suggest menopausal hormone therapy, using estrogen only in women with hysterectomy, to prevent all types of fractures. (2|△△△O)

**Patient characteristics:** Under 60 years of age or <10 years past menopause; at low risk of deep vein thrombosis; those in whom bisphosphonates or denosumab are not appropriate; with bothersome vasomotor symptoms; with additional climacteric symptoms; without contraindications; without prior myocardial infarction or stroke; without breast cancer; willing to take menopausal hormone therapy.
# MHT Absolute risks/ Benefits

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Difference from placebo/10 000 women year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E+P: Overall ¹</td>
</tr>
<tr>
<td>Breast cancer</td>
<td></td>
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<tr>
<td></td>
<td>+9</td>
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<tr>
<td></td>
<td>(+9 at 13 years FU)</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td></td>
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<tr>
<td></td>
<td>+8</td>
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<tr>
<td></td>
<td>(-11 at 13 years FU)</td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>VTE (DVT + PE)</td>
<td></td>
</tr>
<tr>
<td>Gall Bladder disease</td>
<td></td>
</tr>
<tr>
<td>Self reported Diabetes</td>
<td>-14</td>
</tr>
<tr>
<td>All Fractures</td>
<td>-44</td>
</tr>
<tr>
<td></td>
<td>(-6 vertebral fractures)</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>-6</td>
</tr>
<tr>
<td>Overall mortality</td>
<td>NS</td>
</tr>
</tbody>
</table>

Adapted from: 1. Gartlehner et al., JAMA 2017 (Meta-analysis of 18 trials n=40 058 women ages 53-79 years); 2. Manson et al., JAMA 2013 (Extended follow-up of WHI)

Adverse drug event frequency between 1/1000-1/10 000 classified as “RARE” by WHO
What preparations are available?

**Cyclical combined MHT**
- Peri-menopausal
- < 12 months since FMP
- Woman prefers a monthly withdrawal bleed
- Persistent abnormal bleeding on combined continuous therapy
- E+P transdermal patch - fixed dose
- Oral E+P –fixed dose combination
- Oral/patch/gel E + oral P -customized

**Continuous combined MHT**
- > 12 months since FMP
- Switch from cyclical therapy after 12 months
- Woman prefers no withdrawal bleed
- E+P transdermal patch
- Oral E+P –fixed dose combination
- Oral/patch/gel E + oral P -customised
- LNG-IUS+ oral/gel/patch E
- Tibolone
- Duavive

**Practice Point:** Need 10-14 days of progestogen for endometrial protection.

**Practice Point:** Increase progestogen dose with increasing dose of estrogen

www.menopause.org.au
What preparations are available?: Alternatives to combined E+P MHT

**Tibolone**
- Synthetic steroid derived from Mexican yam
- Oestrogenic, androgenic and progestogenic effects
- Used in women >12 months FMP
- Similar prescribing cautions/contraindications similar
- Reduced VTE risk
- Helpful in women with:
  - Low libido
  - Breast tenderness/increased breast density
- May reduce HDL cholesterol level

**TSEC (Duavive)**
- CEE 0.45mg+bazedoxifene 20mg once daily
- Alternative to progestogen-containing MHT
- Used in women with >12 months FMP
- Similar prescribing cautions/contraindications similar
- Metabolism of bazedoxifene may be increased by rifampicin, anti-convulsants potentially decrease concentration
- Helpful in women with:
  - Mastalgia/increased breast density
  - Bleeding problems (increases amenorrhoea)
Use Oestrogen-alone MHT if post-hysterectomy

### Post Hysterectomy

- **Transdermal Oestradiol**
  - Weekly patch (Climara)
  - Twice weekly patch (Estradot)
  - Daily gel (Sandrena)
- **Oral Oestrogen**
  - Oestradiol
  - CEE

---

#### Low dose

<table>
<thead>
<tr>
<th>Product</th>
<th>Presentation Composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrofen*</td>
<td>tablet 1mg 17β oestradiol</td>
</tr>
<tr>
<td>Progynova</td>
<td>tablet 1mg oestradiol valerate</td>
</tr>
<tr>
<td>Premarin*</td>
<td>tablet 0.3mg conjugated equine oestrogen</td>
</tr>
<tr>
<td>Estradot 25</td>
<td>transdermal patch 25/24hrs 17β oestradiol (twice weekly patch application)</td>
</tr>
<tr>
<td>Climara 25*</td>
<td>transdermal patch 25mcrg/24hrs 17β oestradiol (weekly application)</td>
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#### Medium dose

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<th>Presentation Composition</th>
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<tbody>
<tr>
<td>Progynova</td>
<td>tablet 2mg oestradiol valerate</td>
</tr>
<tr>
<td>Estradot 50</td>
<td>transdermal patch 50mcrg/24 hours 17β oestradiol (twice weekly application)</td>
</tr>
<tr>
<td>Premarin*</td>
<td>tablet 0.625mg conjugated equine oestrogens</td>
</tr>
<tr>
<td>Sandrena*</td>
<td>gel 1mg oestradiol (daily application)</td>
</tr>
<tr>
<td>Climara 50*</td>
<td>transdermal patch 50mcrg/24hours 17β oestradiol (weekly application)</td>
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#### High dose

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<th>Presentation Composition</th>
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<tr>
<td>Estradot 75</td>
<td>transdermal patch 75 or 100mcrg/24 hours (twice weekly patch application)</td>
</tr>
<tr>
<td>Estradot 100</td>
<td>transdermal patch 75mcrg/24hours oestradiol (weekly patch application)</td>
</tr>
<tr>
<td>Climara 75*</td>
<td>transdermal patch 75mcrg/24hours oestradiol (weekly patch application)</td>
</tr>
<tr>
<td>Climara 100*</td>
<td>transdermal patch 100mcrg/24hours oestradiol (weekly patch application)</td>
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[www.menopause.org.au](http://www.menopause.org.au)
Treating Perimenopausal women

**Combined Oral Contraceptive**
- First exclude contraindications
- Regulates cycle
- Controls HMB
- May help mastalgia / PMS symptoms

**LNG –IUS + Estrogen**
- Will minimise bleeding
- Will not regulate menstrual cycle
- Will not help cyclical symptoms e.g. PMS

**Sequential MHT**
- Try to ‘match’ to cycle to minimize breakthrough bleeding
- Change to continuous combined after 1 year of regular withdrawal bleeds

**Practice Point:** MHT is not contraceptive.
- Risk of pregnancy in women over 45 is low (1 - 2%), however risk of complications is high
- Contraception for: women < 50 years until 2 years post-LMP
  women >50 years for 1 year post-LMP
Prescribing MHT: Different Clinical Scenarios

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<th>Management options</th>
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<td>Low dose estrogen, micronized progesterone, tibolone, Duavive</td>
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<tr>
<td>Endometriosis</td>
<td>Use continuous combined MHT even if hysterectomy</td>
</tr>
</tbody>
</table>
## Prescribing MHT: Different Clinical Scenarios

<table>
<thead>
<tr>
<th>Clinical Presentation</th>
<th>Management options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine</td>
<td>Transdermal oestrogen, continuous progestogen</td>
</tr>
<tr>
<td>Older women</td>
<td>Lower doses of estrogen preferably transdermal</td>
</tr>
<tr>
<td>Increased VTE risk</td>
<td>Transdermal estrogen, micronized progesterone</td>
</tr>
<tr>
<td>Malabsorption</td>
<td>Transdermal preparation</td>
</tr>
<tr>
<td>Progestogen sensitive</td>
<td>Micronized progesterone, tibolone, Duavive</td>
</tr>
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<tr>
<td>Premature Ovarian Insufficiency</td>
<td>Higher doses of estrogen. Some young women may prefer COC</td>
</tr>
<tr>
<td></td>
<td>Continue until age 50 years.</td>
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</table>
How long to continue treatment for menopause symptoms?

• No set minimum or maximum duration for using MHT
  – Depends on persistence of symptoms and overall risk profile
    • ↑ risk of adverse events with ↑ age
    • ↑ risk of breast cancer with ↑ duration of combined MHT

• Recommend yearly review
  – Reassess updated risk/benefit profile
  – Consider trial of lower dose, change MHT preparation (oral to transdermal) or stopping
    • Little evidence for weaning vs abrupt stop; consider cooler months
    • If symptoms recur then recommence / change MHT or consider other options

• Premature ovarian insufficiency - continue MHT until at least age 51 years
## Referral:

<table>
<thead>
<tr>
<th>Who</th>
<th>Where</th>
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</thead>
<tbody>
<tr>
<td>- Women unable to take MHT</td>
<td>- Menopause clinic</td>
</tr>
<tr>
<td>- Women with high risk of CVD</td>
<td>- Osteoporosis or Endocrinology Clinic</td>
</tr>
<tr>
<td>- Women with high risk of breast cancer (eg BRCA positive)</td>
<td>- Endocrinologist or Gynaecologist</td>
</tr>
<tr>
<td>- Women with abnormal vaginal bleeding</td>
<td>- AMS “Find a Doctor”-</td>
</tr>
<tr>
<td>- Women with persistent symptoms despite MHT</td>
<td></td>
</tr>
<tr>
<td>- Women with POI</td>
<td></td>
</tr>
</tbody>
</table>
Claire: 54 years FMP 2 years ago. Smoker. Hot flushes and night sweats, insomnia last 2 years.

Alice: 64 years FMP 13 years ago. Vaginal dryness, dysparunia.


Jen: 38 years BSO and hysterectomy for Endometriosis.

Lucy: 25 years Spontaneous POI. Depression. Prefers periods.

Jen: 38 years BSO and hysterectomy for Endometriosis.

Vaginal oestrogen

LNG-IUD + 50mcg E patch

100mcg E patch + continuous Micronised P

100mcg E patch + cyclical Micronised P

Combined Estalis continuous 50/140 patch

Lucy: 25 years Spontaneous POI. Depression. Prefers periods.

Jen: 38 years BSO and hysterectomy for Endometriosis.

Vaginal oestrogen

LNG-IUD + 50mcg E patch

100mcg E patch + continuous Micronised P

100mcg E patch + cyclical Micronised P

Combined Estalis continuous 50/140 patch
MHT: an overview

- Principal indications: Menopausal symptoms and POI

- MHT is the most effective treatment for vasomotor/urogenital symptoms with additional benefits related to osteoporosis prevention

- MHT is part of an overall strategy including lifestyle recommendations

- Individualise MHT according to women’s personal preferences and risk/benefit profile
  - Risks vary with age/ type of MHT/ other health issues
  - Need for contraception

- Benefits > risks in most symptomatic women <60 years of age or within 10 years of menopause
Step by step guide to prescribing MHT

• **Step-1**: What are the indications for MHT?
• **Step 2**: Comprehensive clinical assessment
• **Step 3**: Prescribe MHT if no contra-indications and *individualize*
• **Step 4**: Review initially at 8-12 weeks and then yearly
• **Step 5**: Adjust/ continue MHT depending on response /adverse effects/ risk profile
Acknowledgements

The Australasian Menopause Society gratefully acknowledges the work of Prof Rod Baber, Dr Jane Elliott and Dr Anna Fenton. This presentation includes their slides, and draws on their previous presentations and other work.
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IMS 17 WORLD CONGRESS ON MENOPAUSE
MELBOURNE 30 APRIL–3 MAY 2020
WWW.IMSMELBOURNE2020.COM
Commencing Systemic MHT: Summary

- Woman with menopausal symptoms aged <60 years or < 10 years post menopause
- Woman with POI

Contra-indications:
- Age > 60 years
- Oestrogen-dependent cancer
- Undiagnosed PV bleeding
- Previous VTE or Pulmonary embolus
- Untreated hypertension
- Active liver disease
- Previous stroke
- Significant ↑ triglycerides

Intact uterus:
- YES
- NO

Contraception required:
- YES
- NO

- COCP
- LNG-IUS + E

E alone:
- YES
- NO

Other options:
- E+P
- Tibolone
- Duavive

Contraception required
MHT Trouble shooting

• Abnormal vaginal bleeding on combined MHT
  – If < 6 months since starting MHT: Reassure and try to increase progestogen dose (eg change from 50/140 Estalis continuous to 50/250)
  – If > 6 months since starting MHT then organize vaginal US to exclude uterine pathology
  – Any post-coital bleeding and heavy or irregular bleeding on cyclical therapy needs investigation
  – Change from continuous to cyclical therapy

• Mastalgia
  – Decrease oestrogen dose
  – Change progestogen type or dose
  – Change to Tibolone or Duavive
  – Decrease alcohol/caffeine intake
  – Evening primrose oil may be helpful

Baber et al., IMS recommendations. Climacteric, 2016;
Hamoda et al., BMS and WHC recommendations. Post Reproductive Health, 2016;
MHT Trouble shooting

• Mood disturbance
  – Change oestrogen: oestradiol has better effects on mood
  – Change progestogen: micronized progesterone has least effect on mood
    (can use vaginally 100mg alternate daily)
  – Co-existent depression/anxiety - consider adding SSRI/SNRI

• Androgenic side effects
  – Change progestogen to micronised progesterone

• Fluid retention
  – Change progestogen or decrease dose/ duration

• Symptoms recur when taking inactive pills with COCP
  – Take COCP active pills continuously and skip inactive pills
  – Change to Zoely or Qlaira (fewer inactive pills)
  – Change to LNG-IUS + continuous oestrogen (oral/ patch or gel)

Baber et al., IMS recommendations. Climacteric, 2016;
Hamoda et al., BMS and WHC recommendations. Post Reproductive Health, 2016;
MHT Trouble shooting

• Persistent hot flushes on MHT
  – Change to transdermal therapy if on oral oestrogen
  – Check absorption/ patch application if on transdermal therapy
  – Consider alternative causes of hot flushes

• Medication side-effect (620 drugs; 337 drug interactions)
  – Vasodilators, calcium channel blockers, tamoxifen, raloxifene, aromatase inhibitors, niacin
• Rosacea
• Alcohol consumption
• Narcotic withdrawal
• Hyperthyroidism
• Dumping syndrome
• Carcinoid
• Pheochromocytoma
Trends in Menopausal Hormone Therapy use.

Deborah Grady, JAMA Internal Medicine Editorial, Feb. 2018

“However, I believe that many clinicians and women now fail to distinguish the use of HT for prevention of chronic diseases from its use for relatively short-term treatment to relieve menopausal symptoms”... “But many women have been so scared by the risks associated with preventive HT that they do not seek treatment of symptoms”.