DURING perimenopause and after menopause many women experience vasomotor, musculoskeletal, psychological and genito-urinary symptoms, as well as reduced libido. Postmenopause, women have increased risk of cardiovascular disease (CVD) and osteoporosis.

The approach to perimenopausal and menopausal patients varies widely among doctors. GPs have previously been faced with confusing and conflicting information about menopausal hormone therapy (MHT), but there is now guidance with good quality information, allowing shared decision-making with patients.

These are 11 common pitfalls to avoid in providing appropriate care:

1. **NOT FULLY ASSESSING THE PATIENT**

   Patients may present with a long list of symptoms. A full assessment cannot be tacked onto the end of another consultation, or dealt with in a few minutes. Let the patient know their concerns are important and warrant further, probably long, consultations.

   Use a symptom scorecard and ask the woman to identify her top three concerns to focus on initially.

   The consultation should include a review of general medical history, with particular attention to CVD, venous thromboembolism (VTE), osteoporosis and cancer.

   Patients need quality information to help them make decisions and this is available at the Australasian Menopause Society (AMS) and Jean Hailes websites, along with advice and algorithms for GPs.

2. **OVERSTATING THE RISKS OF MHT**

   Following publication of the results of the Women’s Health Initiative (WHI) trial in 2002, there was a dramatic fall in MHT prescription around the world. Concerns about reported increases in risk for breast cancer, CVD and VTE deterred doctors from prescribing MHT, and women from taking it.

   More recently it has become clear that reported claims of harm arising from the WHI were a misunderstanding. Harms...
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will vary with the age of women and the type of progestogen used. Most importantly, they do not apply to women typically seen around the time of menopause.8

The International Menopause Society now advises that MHT carries few risks if prescribed for healthy, symptomatic women when initiated under the age of 60 or within 10 years of menopause.9 In fact, the benefits of MHT may outweigh the risks in most of these women.8

There is a distinct difference between the risk: benefit ratio of oestrogen-only MHT and that of combined (oestrogen plus progestogen) treatment.

The revised global consensus statement from 2016 states: “The risk of breast cancer in women over 50 years of age associated with MHT is a complex issue with decreased risk reported fromRCTs for oestrogen alone [conjugated equine oestrone in the WHI] in women with hysterectomy and a possible increased risk when combined with a progestogen (medroxyprogesterone acetate in the WHI) in women without hysterectomy.”

“The increased risk of breast cancer thus seems to be primarily, but not exclusively, associated with the use of a progestogen with oestrogen therapy in women without hysterectomy. However, the risk of breast cancer attributable to MHT is rare. It equates to an incidence of less than 2 per 1000 women per year of use. This is similar to or lower than the increased risk associated with common factors such as sedentary lifestyle, obesity, and alcohol consumption.”

Recent data suggest that using dydrogesterone or micronised progesterone may be safer options in terms of breast cancer risk.10

There is also a new option of TSEC (Tissue Selective Estrogen Complex), which is an MHT containing oestrogen and bazedoxifene, a SERM that is used instead of a progestogen to protect the endometrium from oestrogenic stimulation.

For symptomatic women with contra-indications to MHT, or who prefer not to use MHT, non-hormonal options should be discussed. SIBI and SNRI antidepressants, gabapentin and clonidine have evidence of benefit for vasomotor symptoms. Note that use of these medications for menopausal symptoms is off-label apart from clonidine. There is also an information sheet on non-hormonal medications.11

4 NOT DIAGNOSING OR TREATING PREMATUR E MENOPAUSE

Early menopause is defined as menopause occurring before the age of 45. Premature menopause, or premature ovarian insufficiency (POI), is defined as a woman having her final menstrual period when younger than 40. It can be spontaneous or iatrogenic e.g. as a result of surgery, chemotherapy or radiotherapy.

Spontaneous POI occurs in about 5% of women and can be diagnosed when there is greater than four months of amenorrhoea, with FSH greater than 40U, at an at least two occasions, at least one month apart and if other causes of secondary amenorrhoea have been excluded.12 Hormone blood tests are indicated in these younger women. When seeing a patient with amenorrhoea, even if very young, after excluding pregnancy, POI should always be considered.13 POI can be a difficult diagnosis. Women need comprehensive assessment, management and support, including addressing concerns regarding fertility, if relevant.

Women with POI have increased risks of CVD and osteoporosis. They should receive MHT as appropriate for them. If a GP doesn’t feel confident to prescribe MHT, then the woman should be referred to a specialist or a GP with an interest in this area. AMS provides a Find A Doctor service on its website.

5 PRESCRIBING OR ENDORsing BIODE tical Hormones

Bioidentical hormones are hormones that have the same structure as those naturally occurring in the body. Bioidentical hormones differ from synthetic hormones in that they are engineered to the prescription of individual compounded troches or creams containing various combinations of oestrogen, progesterone, testosterone, DHEA and other substances. The increasing use of these compounded therapies may have been partly a response to fears about conventional MHT in the wake of WHI, and a result of a demand for so-called natural therapies.

Unfortunately there is lack of quality information on the safety and efficacy of these therapies. Of particular note, there is concern that progestergone delivered via troches or creams may not result in the same levels that provide endometrial protection.14 A recent position statement by the Endocrine Society states that bioidentical compounded hormone preparations are untested, unregulated and potentially harmful and should not be prescribed.15

6 PRESCRIBING MHT TO PATIENTS WITH CONTRAINDICATIONS

The following conditions are contraindications to the prescription of MHT:

1. Undiagnosed vaginal bleeding.
2. Current cardiovascular disease (stroke, TIA, MD). Note that treated hypertension is not a contraindication.
3. Breast or endometrial cancer.
4. Venous thromboembolic disease. In some circumstances transdermal MHT may be prescribed and this should be discussed with a specialist in menopause.
5. Active liver disease. Consider non-hormonal options.

7 GETTING PROGESTOGEN PRESCRIBED IN PARTICULAR

Sometimes women are not prescribed a progestogen when indicated as they may not be prescribed a progestogen when it is not needed.

Patients with an intact uterus require a progestogen in addition to oestrogen. The progestogen protects against the development of endometrial cancer.16 In perimenopausal woman the progestogen is usually prescribed for a synchromous cycle. Alternatively, patients with a history of endometrial cancer may be prescribed a progestogen for a cyclical treatment a swap to continuous combined treatment can be trialled. For women whose final menstrual period was more than a year ago, continuous combined oestrogen plus progestogen therapy should be used. MHT is also recommended for women with POI.

The combination of conjugated oestrogen plus bazedoxifene, known as a TACE, is another option which will provide endometrial protection.

The levonorgestrel-containing intrauterine system (Mirena) is an option for the progestogen component of MHT for both peri- and postmenopausal women, and has the added advantage of potential contraception and control of heavy menstrual bleeding.

Women who have had a hysterectomy do not require a progestogen (except as stipulated by a specialist in rare situations of significant symptoms). MHT formulations and dosages are listed on the AMS website.16

7 USING VAGINAL OESTROGEN ONLY

Women using vaginal oestrogen only do not require a progestogen, even if they have an intact uterus.

8 ARBITRARILY STOPPING MHT AFTER A SET DURATION

There is no set minimum or maximum duration of MHT therapy. Women taking MHT should be reviewed yearly and the indications, risks and benefits should be considered on an individual basis. Women can be encouraged to consider a dosage reduction or a trial off MHT every year or two. However, there is no need to stop MHT after a set duration (eg five years). Some women continue to have menopausal symptoms for many years, and if they are benefiting from MHT, can continue treat.

It is recommended to initiate MHT for the first time before the age of 60 (or less than 30 years from the final menstrual period) but it is acceptable to continue MHT in women in their 60s or older if it is indicated and risks and benefits have been assessed, usually annually.

9 NOT ASKING ABOUT OR TREATING GENITOURINARY SYMPTOMS

Women will often not volunteer information regarding vaginal dryness, painful intercourse or urinary symptoms, such as recurrent UTI.

They should have the opportunity to discuss this in a sensitive manner. Some will benefit from vaginal lubricants. If a woman has systemic symptoms, and chooses to use MHT, her symptoms may improve, but sometimes topical oestrogen is needed. This is helpful for treatment of vaginal atrophy and may reduce urinary tract infections and urgency.

Women who have genito-urinary symptoms alone can be prescribed topical oestrogen treatments without the need for a progestogen. In women with a history of breast cancer, any proposed topical oestradiol treatment should be discussed with the patient’s treating specialist.

ORDERING UNNECESSARY BLOOD TESTS

It is not necessary to do hormone blood tests in women around the normal age of menopause (45 to 50) to assess if their symptoms are menopausal or if they can start MHT.

At perimenopause there are wide fluctuations in symptoms and hormone levels and doing FSH or oestradiol levels is confusing. It shouldn’t change management. Use symptom scores and bleeding patterns to determine the diagnosis of perimenopause or menopause. The indications for intervention are clinical and GPs do not need to wait for changes in hormone levels or for cessation of periods to start MHT.

NOT CONSIDERING CONTRACEPTION AT PERIMENOPAUSE

MHT is not contraceptive. Women should be offered contraception for 3 years following the last menstrual period (LMP) if younger than 50 and 12 months post-LMP of 50. Mirena as part of MHT offers contraception as does the oral contraceptive pill used at perimenopause for women without contraindications.

CONCLUSION

The conclusions with a perimenopausal or menopausal woman provide an opportunity for a comprehensive assessment of health, and are an ideal time to promote healthy lifestyle changes.

Women who are symptomatic need to be listened to, and provided with evidence based, individualised information on the risks and benefits of MHT or non-hormonal treatments if desired. The decision to start, continue or stop MHT needs to be made with the patient. GPs are in an ideal position to assist patients through this time and can be confident with revised guidelines that menopause treatment is mainstream again.