Tayside

Menopause Guidelines

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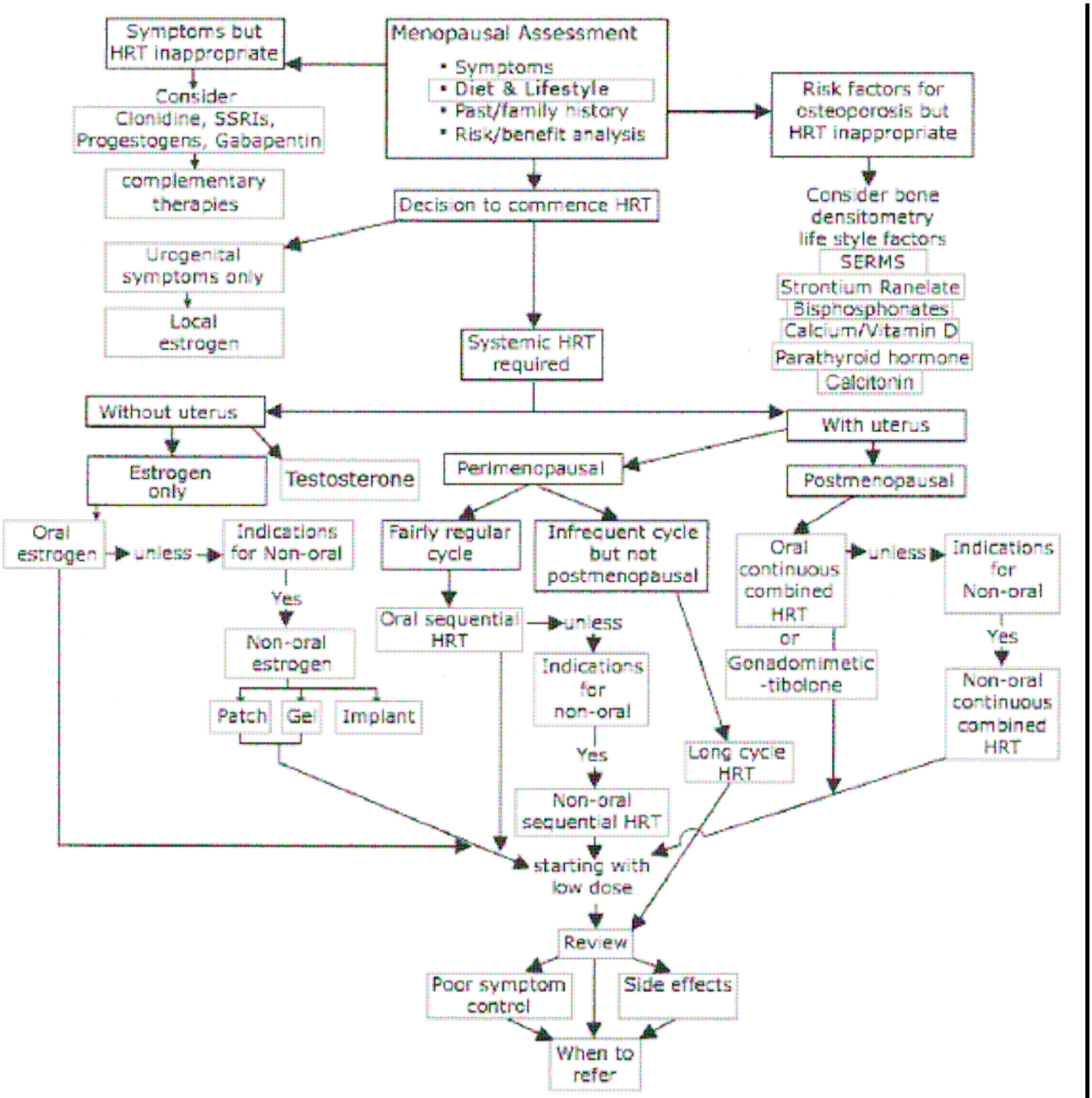

Decision Tree with kind permission of Dr Heather Currie, Menopause Matters

An interactive version is available on www.menopausematters.co.uk

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Menopause Guidelines

1. The risks and benefits of hormone replacement therapy (HRT) will vary in importance for each woman and needs to be assessed on an individual basis with a fully informed woman, and reviewed regularly (once a year).
2. The risk: benefit ratio of HRT is favourable for the treatment of menopausal symptoms.
3. The minimum effective dose should be used for the shortest duration. (CSM 2004)
4. a) HRT may have a protective role in prevention of coronary heart disease (CHD) in women aged 50-59. (Nurses Health Study 2006)
   b) Women who start combined HRT within 10 years of the menopause have a lower risk of CHD than women who start later (WHI 2003)
5. The small additional risk of breast cancer should be discussed with women prescribed HRT.
6. The small additional risk of stroke should be discussed with women prescribed HRT
7. The small additional risk of VTE with HRT should be discussed. This may be reduced with the use of transdermal and estrogen only preparations.
8. Women who are receiving HRT for menopausal symptoms will benefit from the effect of HRT on osteoporosis whilst on treatment.
9. There is little evidence that HRT can be used to prevent or treat Alzheimer's Disease.

BENEFITS & RISKS OF HORMONE REPLACEMENT THERAPY

EARLY BENEFITS

1. Symptom relief	Vasomotor symptoms
2. Psychological	Mood swings, insomnia, depression, poor memory, loss of concentration

INTERMEDIATE BENEFITS

3. Urogenital symptoms	Vaginal dryness/atrophy dyspareunia, urinary frequency/urgency
4. Aches & pains	Loss of collagen from skin, muscle and bone

LATE BENEFITS

5. Osteoporosis	May reduce incidence of fractures
6. Colorectal cancer	May reduce incidence of colorectal carcinoma
7. Coronary Heart Disease	May have a protective role in healthy women aged 50-59 (see below)

RISKS

This data is the most recent evidence regarding risk factors and HRT and may change with future research.

1 – CORONARY HEART DISEASE (CHD)

The risk of CHD largely depends upon the age of the woman and the number of years since the menopause. There is lower risk and some evidence of benefit for CHD in women aged 50-59 years with the menopause in the previous 10 years. The highest risk is in women aged 70-79 with the menopause 20 or more years previously. Data does not currently support HRT use for primary prevention of CHD at any age, and a woman's overall CHD risk must be evaluated. (J Manag Care Pharm. 2008 Apr; 14(3 Suppl): 7-13. and Menopause Int. 2008 Mar; 14(1): 40-5.)

2 - STROKE

Age range (years)	Time on HRT (years)	Background incidence per 1000 women in Europe	Approximate additional cases per 1000 HRT users	
			Estrogen only HRT	Estrogen- Progestogen HRT
50-59	5	4	1	1
60-69	5	9	3	3

In randomised controlled trials, estrogen-only and combined HRT increased the risk of stroke (mostly ischaemic) compared with placebo. Although the increase in relative risk seems to be similar irrespective of age, baseline risk of stroke increases with age and therefore older women have a greater absolute risk. Limited observational data suggest that this risk may depend on estrogen dose. (MHRA Sept 2007)

3 - VENOUS THROMBOEMBOLISM (VTE)

Age range (years)	Time on HRT (years)	Background incidence per 1000 women in Europe	Approximate additional cases per 1000 HRT users	
			Estrogen only HRT	Estrogen- Progestogen HRT
50-59	5	5	2	7
60-69	5	8	2	10

Oral HRT has been associated with an increased risk of VTE in randomised controlled trials and observational studies. Evidence suggests that the risk is higher with combined HRT than with estrogen-only HRT, and that these events are more likely in the first year of use.

The level of risk associated with other routes of administration has not been clearly established, although it may be lower with transdermal HRT. (MHRA Sept 2007) If women have risk factors for VTE, a transdermal preparation may be preferable. (Lancet 2003; 362:428-32)

4 - ENDOMETRIAL CANCER

Age range (years)	Time on HRT (years)	Background incidence per 1000 women in Europe	Approximate additional cases per 1000 HRT users	
			Estrogen only HRT	Estrogen- Progestogen HRT
50-59	5	2	4	Non-significant difference
60-69	5	3	6	
50-59	10	4	32	
60-69	10	6	48	

In women with a uterus, use of estrogen-only HRT substantially increases the risk of endometrial hyperplasia and carcinoma in a way that depends on dose and duration. Addition of progestogen cyclically for at least 10 days per 28-day cycle greatly reduces the risk, and addition of progestogen every day eliminates the risk. (MHRA Sept 2007). It is therefore recommended that a woman should be changed to a continuous combined therapy (CCT) 1 year after her last natural period. If this is not known then a continuous combined regime could be tried after 2 years of cyclical HRT. However, if the woman is not truly post-menopausal, breakthrough bleeding may be a problem in which case she should revert to a cyclical regime for another 2 years before trying again, if HRT is continued.

5 - BREAST CANCER

Age range (years)	Time on HRT (years)	Background incidence per 1000 women in Europe	Approximate additional cases per 1000 HRT users	
			Estrogen only HRT	Estrogen- Progestogen HRT
50-59	5	10	2	6
60-69	5	15	3	9
50-59	10	20	6	24
60-69	10	30	9	36

The risk of breast cancer is increased in women who take HRT for several years:
• Combined HRT has been associated with the highest risk
• For estrogen-only HRT, risk is lower than with combined HRT. Some studies have shown no increased risk for estrogen-only HRT
• Risk increases with duration of use and returns to baseline within a few years of stopping treatment

HRT, especially combined therapy, may increase mammographic density, which may adversely affect radiological detection of breast cancer. In the Women's Health Initiative trial, conjugated equine estrogens (CEE) and CEE plus medroxyprogesterone acetate increased the likelihood of having an abnormal mammogram that needed further evaluation. (MHRA Sept 2007)

Women with previous breast cancer who wish to use HRT should consult their Oncologist.

6 - OVARIAN CANCER

Age range (years)	Time on HRT (years)	Background incidence per 1000 women in Europe	Approximate additional cases per 1000 HRT users	
			Estrogen only HRT	Estrogen- Progestogen HRT
50-59	5	2	<1	<1
60-69	5	3	<1	<1
50-59	10	4	1	1
60-69	10	6	2	2

Observational studies suggest that long-term use of estrogen-only or combined HRT may be associated with a small increased risk of ovarian cancer, which returns to baseline a few years after stopping treatment. (MHRA Sept 2007)

TIBOLONE
Benefit-risk balance:

CHD	insufficient data
Stroke	significantly higher risk: additional 9 cases per 1000 in 50-59 years of age additional 20 cases per 1000 in 60-69 years of age
VTE	insufficient data
Breast cancer	comparable risk to estrogen-only HRT
Endometrial cancer	risk may be increased, but insufficient data
Ovarian cancer	insufficient data

COMPARISON OF OVERALL BALANCE OF RISKS AND BENEFITS ASSOCIATED WITH ESTROGEN-ONLY AND COMBINED HRT IN DIFFERENT PRESCRIBING SCENARIOS

(MHRA Sept 2007)

Baseline risk obtained by adding the baseline rates for breast cancer, endometrial cancer (in women with a uterus), ovarian cancer, colorectal cancer, VTE, CHD, stroke and fracture of femur in non-HRT users

Absolute risk obtained by subtracting the number of cases of colorectal cancer and fracture prevented from the total number of cases of breast cancer, endometrial cancer (in women with a uterus), ovarian cancer, VTE, CHD, stroke in HRT users

Attributable risk obtained by subtracting the baseline risk in non-HRT users from the absolute risk in HRT users

1. 5 years HRT use in women younger than age 60 years

Type of HRT	Baseline risk per 1000 women	Absolute risk in 1000 HRT users	Attributable risk in 1000 HRT users
Estrogen-only (women without uterus)	42	47	5
Combined HRT	37	51	14

2. 5 years HRT use in women aged 60-69 years

Type of HRT	Baseline risk per 1000 women	Absolute risk in 1000 HRT users	Attributable risk in 1000 HRT users
Estrogen-only (women without uterus)	82	88	6
Combined HRT	70	92	22

3. 10 years HRT use in women aged 50-59 years

Type of HRT	Baseline risk per 1000 women	Absolute risk in 1000 HRT users	Attributable risk in 1000 HRT users
Estrogen-only (women without uterus)	83	95	12
Combined HRT	73	113	40

4. 10 years HRT use in women aged 60-69 years

Type of HRT	Baseline risk per 1000 women	Absolute risk in 1000 HRT users	Attributable risk in 1000 HRT users
Estrogen-only (women without uterus)	163	181	18
Combined HRT	139	203	64

CONTRAINDICATIONS TO HRT
HRT and PRE-EXISTING CONDITIONS

ABSOLUTE

1. Acute phase myocardial infarction, pulmonary embolism or VTE
2. Active endometrial or breast cancer
3. Pregnancy
4. Undiagnosed breast lump / nipple discharge
5. Undiagnosed abnormal vaginal bleeding
6. Severe active liver disease with abnormal LFTs

HRT IS NOT CONTRAINDICATED IN WOMEN WITH:

1. Controlled hypertension
2. Abnormal cervical cytology
3. Benign breast disease
4. Varicose veins

HRT and PRE EXISTING CONDITIONS

1. ***Previous history of cardiovascular disease (CVD)***
   HRT should not be initiated for secondary prevention

2. ***Untreated hypertension***
   Treat BP and then consider HRT

3. ***Endometriosis***
   Consider CCT or Tibolone initially after total abdominal hysterectomy (TAH) and bilateral salpingo-oophorectomy (BSO) if endometriosis active at time of surgery

4. ***Personal/Family history of VTE***
   Seek advice from haematologist or specialist clinic

5. ***Breast Cancer***
   Vaginal estrogens not contraindicated. Seek advice of oncologist or specialist clinic if systemic HRT is considered.

6. ***Diabetes***
   HRT may alter insulin resistance
   Associated with increased risk of osteoporosis

7. ***Fibroids***
   Monitor yearly

8. ***Gallstones/ liver disease***
   Increased risk of gallbladder disease. Non-oral route preferred

9. ***Hyperlipidaemia***
   Non-oral routes may be preferable

10. ***Crohn's / coeliac disease***
    Increased risk of osteoporosis. Non-oral route preferred

11. ***Migraine***
    Not contraindicated. Transdermal route preferred

12. ***Malignant Melanoma***
    No association with HRT from epidemiological studies

13. ***Otosclerosis***
    Insufficient evidence to contraindicate use of HRT

IT CAN BE APPROPRIATE TO PRESCRIBE HRT TO SYMPTOMATIC PREMENOPAUSAL WOMEN

ASSESSMENT, REGIME and ADMINISTRATION

PATIENT ASSESSMENT PRIOR TO TREATMENT

1. MENOPAUSAL STATUS
   History more relevant than hormone levels, as a wide variation of levels around the menopause. FSH estimation helpful in cases of premature menopause. Two levels of FSH > 30 U/l 6 weeks apart is consistent with ovarian failure.

2. PAST AND CURRENT MEDICAL HISTORY

3. FAMILY HISTORY

4. RISK FACTORS FOR CARDIOVASCULAR DISEASE
   Raised blood sugar, abnormal lipids, hypertension

5. RISK FACTORS FOR OSTEOPOROSIS

6. INITIAL EXAMINATIONS
   Body mass index (BMI) and BP. Clinical examination of the breasts and pelvis is not routinely necessary, but should be performed if clinically indicated.
   Cervical smears and mammograms as per National Screening Programmes.

7. CAREFUL COUNSELLING ABOUT RISKS AND BENEFITS AND POSSIBLE SIDE EFFECTS

8. FOLLOW UP ARRANGEMENTS
   Early support important, initial review within three months, then 6 monthly moving to annual review when appropriate.

9. DISCUSS CONTRACEPTION

CHOOSING THE CORRECT SYSTEMIC REGIME

ESTROGEN

Types

Estradiol, Estradiol valerate, Conjugated equine estrogens

Routes

Oral, Transdermal (patch & gel), Implant

PROGESTOGEN

Types

(C19 testosterone derivatives) Norethisterone, Levonorgestrel

(C21 progesterone derivatives) Dydrogesterone, Medroxyprogesterone acetate (MPA)

Routes

Oral, Transdermal, Intrauterine system (IUS) (licensed for 4 years endometrial protection)

Regime

Cyclical, Long cycle, Continuous combined

GONADOMIMETIC

Type

Tibolone

Route

Oral

CHOICE OF PREPARATION

1. TOTAL HYSTERECTOMY

Estrogen only, unless hysterectomy was for extensive endometriosis, in which case consider CCT or tibolone initially.

2. SUB TOTAL HYSTERECTOMY

Trial of cyclical regime for three months (in case of any residual endometrial tissue in the cervical stump). If bleeding occurs use continuous combined therapy. If no bleeding occurs only estrogen required

3. INTACT UTERUS

Requires estrogen and progestogen. Progestogen in adequate doses and for adequate length of time (12-14 days each cycle) to protect endometrium.
Norethisterone 1mg: MPA 5-10mg: Dydrogesterone 10-20mg: Daily for 12-14 days each cycle
Mirena IUS

REGIME

a) If less than one year since last period prescribe cyclical regime

b) If more than one year since last period prescribe CCT or gonadomimetic

c) It is advised to switch to CCT at age 54. If have been on HRT for some time, or no bleeding on sequential regime, can be considered earlier. Note possibility of irregular bleeding on CCT especially if switched too early.

MANAGEMENT OF BLEEDING PROBLEMS

1. IRREGULAR BLEEDING

- Check compliance and advise accordingly
- If diarrhoea/vomiting whilst on treatment bleeding should be an isolated event. If it recurs after the symptoms settle, refer for investigation*
- Bleeding may occur due to inadequate progestogen therefore increase the dose and/or duration
- If irregular bleeding continues after 3 cycles or there is suspected pathology, refer for investigation*

2. HEAVY BLEEDING

- Too much estrogen/insufficient progestogen, therefore alter dose and/or duration
- If heavy bleeding continues after 3 cycles or there is suspected pathology, refer for investigation*

3. NO WITHDRAWAL BLEEDING

- Not uncommon especially in post-menopausal women. Consider trial of CCT.
  No need to investigate
- If bleeding occurs after prolonged amenorrhoea, refer for investigation*

4. BLEEDING ON CONTINUOUS COMBINED THERAPY

- This is not unusual in the first 3-6 months of treatment.
  If persistent or occurs after cessation of bleeding on a CCT, refer for investigation*

WITH ANY ABNORMAL BLEEDING ALWAYS CHECK THE CERVIX

*** INVESTIGATION as per SIGN GUIDELINES FOR INVESTIGATION OF POST-MENOPAUSAL BLEEDING (September 2002)**

- Transvaginal scan is the first-line procedure to identify which women with abnormal bleeding are at higher risk of endometrial cancer. This will be arranged by Gynaecology.
- In women using CCT, endometrial thickness of >3mm requires endometrial sampling.
- In women using sequential combined HRT, endometrial thickness of >5mm requires endometrial sampling.

TROUBLESHOOTING HRT

INADEQUATE SYMPTOM CONTROL

CAUSE	ACTION
Unrealistic expectations	Counsel
Poor compliance	Check taking medication and ensure patient fully understands regime
Drug interactions	Short course of broad spectrum antibiotics may cause breakthrough bleeding (BTB). Consider increasing dose of HRT with long term liver enzyme inducers
Altered absorption	Change route to non-oral
Other conditions (e.g. depression)	Consider treatment of underlying problem
Consider other diseases	Investigate appropriately (e.g. Thyroid/ carcinoid/ phaeochromocytoma)
Inadequate dose	Increase dose. Assess response to dose for 3 months before changing

MANAGEMENT OF SIDE EFFECTS

CAUSE	ACTION
ESTROGENIC	
Fluid retention, breast tenderness, leg cramps*	Reduce dose of estrogen
Nausea*	Change timing, dose or route of estrogen

* These are common side effects in the first 3 months. DO NOT change too soon.

PROGESTOGENIC	
PMS type symptoms	Change regime. If suitable change to CCT; consider IUS plus estrogen.
Headaches	Change to non-oral route of administration

STOPPING HRT

Stopping HRT is a decision to be made between patient and prescriber after discussion of relevant risks and benefits.

Women should be warned that rebound symptoms, particularly vasomotor symptoms are not uncommon when HRT is stopped. This problem can be minimised by gradually reducing the dose of HRT in stages, allowing three months for each stage. If symptoms are unbearable, maintain original dose and try a reduction of dose again in 6-12 months. The dose of oral estrogen should be reduced to 1mg whether on sequential or combined regimes and transdermal patches to 25mcg. To achieve lower doses with CCT or estrogen only, women can halve tablets, take on alternate days, and cut up matrix patches (not reservoir patches). These are all unlicensed uses of HRT. If this is tried with sequential preparations, irregular bleeding will occur. If symptoms remain troublesome after stopping HRT, non-hormonal or medical alternatives can be tried. (See relevant section.)

If continued bone protection is required, see NICE guidelines.

ALTERNATIVES TO HORMONE REPLACEMENT THERAPY

There is a lack of robust data about the efficacy of all complementary and alternative preparations. They are not as strictly controlled as prescribed medicines and they may be of poor quality. They may interfere with other treatments

Many women decide against HRT either due to a contraindication or through personal choice. Dietary and lifestyle changes require a more active involvement and need a lifelong commitment to be effective.

1) DIET

Phytoestrogens are plant substances with effects similar to but weaker than those of human estrogen. They are found in soyabeans, chickpeas, red clover, legumes (beans and peas), oil seeds (linseed and flax), cereal bran, whole cereals, vegetables, fruit, soya milk and certain 'fortified' foods.

Reducing alcohol, salt, spicy foods, caffeine and cholesterol is beneficial. Increase water and fish oil intake. Best advice as women age is to reduce the amount eaten.

2) LIFESTYLE AND EXERCISE

All exercise is beneficial. Weight bearing exercise such as walking maintains bone strength. Non-weight bearing exercise such as swimming and cycling maintains flexibility and muscle strength. Pelvic floor exercises can prevent bladder problems.

STOP SMOKING, REDUCE WEIGHT, AVOID STRESS

3) SUPPLEMENTS

a) RED CLOVER May be useful for hot flushes. Isoflavone 40mg daily for three months initially

b) EVENING PRIMROSE OIL May be useful for breast tenderness. GLA 80mg three times per day for three months initially.

c) GLUCOSAMINE and CHONDROITIN May be useful for joint pains

d) ST JOHNS WORT May be useful for mild depression

e) VITAMIN E May be useful for skin problems

f) VITAMIN B 6 May be useful for PMS. Pyridoxine 50mg daily for three months initially

Many other supplements are sold such as Menopace, Melbrosia, Osteocare and Anti Oxidants.

ALL THESE SUPPLEMENTS CAN INTERACT WITH OTHER DRUGS

4) HERBAL TREATMENTS

a) BLACK COHOSH May be useful for hot flushes and vaginal dryness
b) FEVERFEW May be useful for headaches
c) VALERIAN May be useful for insomnia
d) GINSENG May be useful for stress and to improve sexual function
e) GINKO BILOBA May be useful to improve concentration and memory
f) AGNUS CASTUS (Chaste Berry) May be useful for PMS and mood swings
g) DONG QUAI (Angelica) May be useful for hot flushes
h) PASSION FLOWER May be useful for pain relief
i) SAW PALMETTO May help urinary symptoms
j) SAGE May help hot flushes
ALL OF THESE HERBAL TREATMENTS CAN INTERACT WITH OTHER DRUGS. CONSULT A MEDICAL HERBALIST

5) HOMEOPATHY

a) SEPIA May reduce dryness and skin irritation
b) LACHESIS May reduce stress and irritability
c) BYRONIA May help with joint pain
d) AMYL NITROSUM May help with hot flushes
CONSULT A MEDICAL HOMEOPATH

6) OTHER COMPLEMENTARY THERAPY

a) ACUPUNCTURE Balances hormone systems and may reduce hot flushes
b) REFLEXOLOGY Foot massage which is linked to pelvic organs
c) AROMATHERAPY May reduce stress by scent
d) REIKI Healing treatment using spiritual practice
e) HYPNOTHERAPY Unconscious mind. May help weight reduction and smoking cessation, headaches and panic attacks
f) TRADITIONAL CHINESE MEDICINE Harmony balance
g) AYURVEDA Indian traditional medicine using diet and massage

See 'Self Management of Menopause Symptoms, My Choices' on Intranet

PRESCRIBABLE MEDICAL OPTIONS

a) **Bisphosphonates are used to increase bone density and help prevent and treat osteoporosis.**

b) **Clonidine (Dixarit) is often used for prevention of flushing. There is very little evidence that this is effective.**

c) **Progestogens (Norethisterone 5mg per day) can help to reduce hot flushes. However, therapeutic doses increase the risk of VTE.**

d) **Selective serotonin reuptake inhibitors (SSRI's) -Venlafaxine, Fluoxetine and Paroxetine can help to reduce hot flushes, but may increase sweats in some women.**

e) **Vaginal moisturisers - 'Senselle' or 'Replens' are bioadhesive and longer acting than simple lubricants and can reduce discomfort during sex.**

f) **Vaginal estrogens can be used in some cases when systemic HRT is not required, not acceptable or contraindicated. Licensed for 2 years of use but can be used for longer.**

g) **Calcium (1000mg-1500mg per day) and Vitamin D are important for bone strength for all women and have been shown to prevent bone loss in high doses in elderly women.**

CHOICE OF CONTRACEPTION IN THE PERIMENOPAUSE

Method	Advantages	Disadvantages	Treats Menopausal symptoms?	Bone Sparing?
COC (Combined Oral Contraceptive)	Convenient. Regular menses, less menorrhagia. Protection against ovarian and endometrial cancer. Unrelated to intercourse.	As background risk of breast cancer and arterial disease are relatively high in this group it is suitable for a smaller number of people. Not suitable for women who smoke or have other arterial or venous risk factors. For the above reasons it is accepted that COC should be stopped at age 50 and an alternative method found. COC masks the menopause. No protection against carriage of STIs	Yes	Yes
POP (Progestogen Only Pill)	No increased risk of arterial or venous disease or cancer, over 99% efficacy in this age group. Suitable alternatives if contraindications to estrogen. Unrelated to intercourse. Does not alter FSH levels. HRT can be used concurrently.	Irregular bleeding in some (which may mask pathology); amenorrhoea in about 10%. Debate continues as to whether prolonged period of amenorrhoea may lead to an increased risk of osteoporosis. 15-30% risk of functional ovarian cysts. No protection against carriage of STIs.	In some women	No evidence
Subdermal Implant (Implanon)	Very effective, long duration, 3 years. Suitable alternative if contraindications to estrogen. Alternative to sterilisation. Unrelated to intercourse.	May cause irregular or prolonged bleeding. Amenorrhoea in 20-25%. Short-term data shows no effect on bone mineral density (BMD). No protection against carriage of STIs.	No	Yes
Injectables (Depo-Provera)	No increased risk of arterial or venous disease or cancer, over 99% efficacy. Suitable alternative if contra-indications to estrogen, amenorrhoea in over 70%. Unrelated to intercourse.	May cause irregular bleeding. Cause reduction in bone mineral density. Risk/benefits of long-term use should be discussed. If risk factors for osteoporosis present, consider other methods of contraception. No protection against carriage of STIs	No	No Can cause reduction in bone mineral density.

IUD (Intra Uterine Device)	Effective, convenient and safe. Allows concurrent use of HRT. Unrelated to intercourse.	May increase menstrual blood loss. Not ideal in women with fibroids. No protection against carriage of STIs.	No	No
IUS (Intra Uterine System)	Effective, convenient and safe. Reduces menstrual blood loss. Allows use of systemic estrogen replacement. Unrelated to intercourse. More effective than sterilisation.	Fitting may be problematic if there is distortion of the uterine cavity. No protection against carriage of STIs.	No	No
Barriers (condoms, diaphragms, FemCap)	Offers some protection against STIs and can be used in conjunction with HRT. Effective and safe if already familiar with method.	May be difficult to use if unfamiliar with the method. May affect sexual enjoyment.	No	No

LIST OF USEFUL CONTACTS

1) **For information about Herbal Medicine:**
   National Institute of Medical Herbalists
   56, Longbrook St
   Exeter
   Devon EX4 6AH
   Telephone: 01392426022
   www.nimh.org.uk

2) **For information about Homeopathy:**
   The Society of Homeopaths
   11 Brookfield
   Duncan Close, Moulton Park
   Northampton NN3 6WL
   Telephone: 08454506611
   www.homeopathy-soh.org.uk

   ALSO:
   Glasgow Homeopathic Hospital
   1053 Gt Western Road
   Glasgow G12 0XQ
   Telephone: 01412111600

3) **For information on other complementary medicine:** **www.the-cma.org.uk**
   www.acupuncture.org.uk
   www.i-c-m.org.uk

4) **For general menopause advice:** **www.menopausematters.org.uk**
   www.the-bms.org
   www.amarantmenopausetrust.org.uk
   www.womens-health-concern.org

5) **For advice on premenstrual symptoms: www.pms.org.uk**

6) **For advice on premature menopause: www.daisynetwork.org.uk**

7) **For advice on osteoporosis: www.nos.org.uk**

8) **For advice on sexual function:**
   Institute of Psychosexual Medicine www.ipm.org.uk
   British Association Sexual Relationship Therapists www.basrt.org.uk
   Relate www.relate.org.uk
   Sexual Dysfunction Association www.sda.uk.net

LOCAL CLINICS

Menopause Clinic
Tayside Sexual and Reproductive Health Service
Drumhar Health Centre
North Methven Street
Perth
PH1 5PD
Tel: 01738 564272

Sexual Health/Menopause Clinic
Tayside Sexual and Reproductive Health Service
Ryehill Health Centre
St Peter Street
Dundee
DD1 4JH
Tel: 01382 646564

PHARMACEUTICAL FORMULATIONS IN THE MENOPAUSE

Please check the current British National Formulary for up-to-date information

ESTROGEN ONLY PREPARATIONS

BRAND NAME	COMPONENTS	DOSE	FREQUENCY
a. TABLETS			
Elleste Solo	Estradiol	1mg or 2mg tablet	Daily
Zumenon	Estradiol	1mg or 2mg tablet	Daily
Climaval	Estradiol valerate	1mg or 2mg tablet	Daily
Progynova	Estradiol valerate	1mg or 2mg tablet	Daily
Premarin	Conjugated equine estrogen	0.3mg, 0.625mg or 1.25mg tablet	Daily
Harmogen	Estrone (as estropipate)	1.5mg tablet	Daily
Hormonin	Estrone/estradiol/estriol	1.4mg/0.6mg/0.27mg tablet	Daily
Bedol	Estradiol	2mg tablet	Daily
b. PATCHES			
Elleste Solo MX	Estradiol	40mcg or 80mcg patch	Twice weekly
Estradot	Estradiol	25, 37.5, 50, 75, 100mcg patch	Twice weekly
Estraderm MX	Estradiol	25mcg, 50mcg, 75mcg, 100mcg Patch	Twice weekly
Estraderm TTS	Estradiol	25mcg, 50mcg, 100mcg Reservoir Patch	Twice weekly
Evorel	Estradiol	25mcg, 50mcg, 75mcg or 100mcg Patch	Twice weekly
Fematrix	Estradiol	40mcg or 80mcg Patch	Twice weekly
FemSeven	Estradiol	50mcg, 75mcg or 100mcg Patch	Weekly
Progynova TS	Estradiol	50mcg or 100mcg Patch	Weekly
c. GELS			
Estrogel	Estradiol	0.06% Gel (1.5mg-3.0mg)	2-4 measures daily
Sandrena	Estradiol	0.1% Gel (0.5mg, 1mg)	0.5mg-1.5mg daily
d. IMPLANTS			
Estradiol	Estradiol	25mg, 50mg or 100mg (25mg and 50mg doses recommended)	6 monthly
e. PESSARIES AND CREAM			
Estring	Estradiol hemihydrate	7.5mcg/24hr Vaginal ring	Quarterly
Ortho Gynest Pessary	Estriol	0.5mg Pessary	Daily initially then twice wkly
Ortho Gynest Cream	Estriol	0.01% Cream with applicator	Daily initially then twice wkly
Ovestin Cream	Estriol	0.1% Cream with applicator	Daily initially then twice wkly
Premarin Vaginal Cream (may have systemic effect)	Conjugated equine estrogen	0.625mg/g Cream with applicator	Daily for 3wks then once wkly
Vagifem	Estradiol	25mcg Vaginal tablet and applicator	Daily for 2wks then twice wkly

COMBINED ESTROGEN PROGESTOGEN PREPARATIONS

SEQUENTIAL PREPARATIONS

C 19 PROGESTOGENS

BRAND NAME	COMPONENTS	DOSE	FREQUENCY
a. TABLETS			
Climagest	Estradiol valerate/Norethisterone	1mg/1mg or 2mg/1mg Tablet	Daily
Cyclo Prognova	Estradiol valerate/Levonogestrel	1mg/250mcg or 2mg/250mcg Tablet	Daily (includes 7 day break)
Elleste Duet	Estradiol/Norethisterone	1mg/1mg or 2mg/1mg Tablet	Daily
Novofem	Estradiol/Norethisterone	1mg/1mg tablet	Daily
Prempak C	Conjugated equine estrogen/Norgestel	0.625mg/150mcg or 1.25mg/150mcg Tablet	Daily
Femtab Sequi	Estradiol/Levonorgestrel	2mg/75mcg tablet	Daily
Nuvelle	Estradiol/Levonorgestrel	2mg/75mcg tablet	Daily
Trisequens	Estradiol/Estriol/Norethisterone	2mg, 2mg/1mg, 1mg Tablet	Daily
Clinorette	Estradiol/Norethisterone	2mg/1mg tablet	Daily
b. TABLETS / PATCHES			
Evorel Pak	Estradiol/Norethisterone	50mcg Patch and 1mg Tablet	Patch twice weekly then tablet for 12 days
c. PATCHES			
Estracombi	Estradiol/Norethisterone	50mcg/250mcg Reservoir Patch	Twice weekly
Evorel Sequi	Estradiol hemihydrate/Norethiesterone	50mcg/170mcg Patch	Twice weekly
Femseven Sequi	Estradiol/Levonorgestrel	50mcg/10mcg Patch	Once weekly

C21 PROGESTOGENS

a. TABLETS			
Femoston 1/10	Estradiol/Dydrogesterone	1mg/10mg Tablet	Daily
Femoston 2/10	Estradiol/Dydrogesterone	2mg/10mg Tablet	Daily
Femoston 2/20	Estradiol/Dydrogesterone	2mg/20mg Tablet	Daily
Premique Cycle	Conjugated equine estrogen/MPA	0.625mg/10mg Tablet	Daily
b. TABLETS / PATCHES			
Femapak 40	Estradiol/Dydrogesterone	40mcg/10mg Patch and Tablet	Patch twice weekly then tablet for 14 days
Femapak 80	Estradiol/Dydrogesterone	80mcg/10mg Patch and Tablet	Patch twice weekly then tablet for 14 days
c. TABLETS - LONG CYCLE			
Tridestra	Estradiol valerate/MPA/Placebo	2mg 10 weeks 2mg/20mg 2 weeks Placebo 1 week	Daily (Menses quarterly only)

COMBINED ESTROGEN PROGESTOGEN PREPARATIONS

CONTINUOUS COMBINED PREPARATIONS

BRAND NAME	COMPONENTS	DOSE	FREQUENCY
a. TABLETS			
Climesse	Estradiol valerate/Norethisterone	2mg/0.7mg Tablet	Daily
Elleste Duet Conti	Estradiol/Norethisterone	2mg/1mg Tablet	Daily
Kliofem	Estradiol/Norethisterone	2mg/1mg Tablet	Daily
Kliovance	Estradiol/Norethisterone	1mg/0.5mg Tablet	Daily
Femoston Conti	Estradiol/Dydrogesterone	1mg/5mg Tablet	Daily
Indivina	Estradiol valerate/MPA	1mg/2.5mg, 1mg/5mg or 2mg/5mg Tablet	Daily
Premique	Conjugated equine estrogen/MPA	0.625mg/5mg	Daily
Premique low dose	Conjugated equine estrogen/MPA	0.3mg/1.5mg	Daily
Nuvelle Continuous	Estradiol/Norethisterone	2mg/1mg Tablet	Daily
Angeliq	Estradiol/Drospirenone	1mg/2mg tablet	Daily
b. PATCHES			
Femseven Conti	Estradiol/Levonorgestrel	50mcg/7mcg Patch	Weekly
Evorel Conti	Estradiol/Norethisterone	50mcg/170mcg Patch	Twice weekly

PROGESTOGEN ONLY THERAPIES

Progestogens can also be given with estrogen therapy to make a combined regime. Patients must be given clear instructions how to use for endometrial protection

Provera (also available as Climanor 5mg tablets)	MPA	10mg daily for continuous regime or daily for last 14 days of cycle for cyclical regime	
Utrogestan	Micronised progesterone	100mg daily (days 1-25) or 200mg daily (days 15-26) for cyclical regime	
MIRENA (IUS)	Levonorgestrel	20mcg daily release IUS	Intrauterine for 5 years
GONADOMIMETIC			
Livial	Tibolone	2.5mg Tablet	Daily

The Tayside Menopause Guidelines were initially written and compiled in 2001 by the joint efforts of

Dr. Sheila Bennett
Mrs. Marlene Boyle
Dr. Fiona Clare
Dr. Liz Cockburn
Dr. Elizabeth Kennedy
Dr. Moira Kennedy
Mr. Isaac Kettles
Dr. Sheila Lendrum
Dr. Rona McCarthy
Dr. Margaret Thomson
Dr. Michelle Watts

Reviewed and amended in 2004 by

Dr Elizabeth Kennedy
Dr Sheila Lendrum
Dr Margaret Thomson

Reviewed and amended in 2005 by

Dr. Sheila Lendrum
Dr. Liz Cockburn

Reviewed and amended in 2009 by

Dr Elizabeth Kennedy
Dr Jackie Guest
Dr Dianna Reed
Dr Liz Cockburn
Dr Susan Brownlie