HRT Decision aid. Original by Dr S Carter. Adapted by Dr S Jamieson with input from Dr H Gleser.

Stock levels correct at manufacturer as at 7th December 2020

HRT Quick Reference

Women with uterus

Women with uterus AND a Mirena IUS (5 year expiry)

Women with uterine and no Mirena IUS

Oestrogen only HRT

Age <54 Years & <1 year since last period**
Sequential HRT

Age > 54 Years or >1 year since last period
Continuous combined HRT

Patch* | Oral | Gel
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Elleste Solo MX 40/80 | Progynova 1mg/2mg | Oestrogel 0.06%
Progynova TS 50/100 | Premarin 300mcg/625mcg | Sandrena Gel 0.5/1mg
Estradot 25/37.5/50/75/100 | Zumenon 1mg/2mg | 
Estraderm 25/50/75/100 | Elleste solo 1mg/2mg | 
Evorel 25/50/75/100 | Bedol 2mg | 
FemSeven 50/75/100 | 

*all patches are equipotent for same numerical dose

Key: Bold are Formulary choices
Green are in stock
Amber low stock/delays
Red known unavailable
Blue are hyperlinks

HRT Review at 3m then annually
Discuss: symptom control (bleeding problems), SEs, ongoing indication. Risks discussed here and PIL here (VTE/Breast CA/CV risk review)

Record annually: BP, BMI and breast/cervical screening up to date as appropriate.

Alternatives to equally consider:
- Mirena IUS (5 year expiry) + oestrogen pill/patch or gel
- Provera 10mg 14 days per cycle plus an oestrogen pill/patch or gel
- Utrogestan 200mg at night 12 days/cycle + oestrogen pill/patch/gel. Amber on TAF

Alternatives to equally consider:
- Mirena IUS (5 year expiry) + oestrogen pill/patch or gel
- Provera 5 mg once daily with oestrogen pill/patch or gel
- Utrogestan 100mg at night with oestrogen pill/patch or gel. Amber on TAF

** If <55, sexually active and menstruating offer CHC (if <50 & eligible) or oestrogen + Mirena or sequential HRT + progesterone only contraception or advise barrier method. Stop hormonal contraception age 55.
Prescribing tips

***Tridesta has low progesterone load over prolonged cycle. Consider for post menopause/sub-total TAH [but if no bleeding on sequential HRT can have oestrogen only]/post ablation/ progestogen SEs++. Possible increased risk of endometrial hyperplasia.

If persistent/abnormal bleeding patterns >6m after starting: investigate the cause/refer.

Bleeding after starting continuous combined: if doesn’t settle after 3-6m, move back to sequential HRT for another 12 months.

Heavy prolonged bleeding on sequential HRT: increase the dose/duration of the progesterone.

Progesterone side effects: switch the progesterone or use the Mirena.

Top recommendations from Tayside Menopause Guideline

1. Women with premature ovarian insufficiency (<40) or early menopause (< 45) should be started on HRT, even if not symptomatic, unless they have an absolute contraindication. This should be continued until at least the age of natural menopause (around 51).

2. Do not measure FSH for diagnosis of menopause in women > 45 as levels fluctuate in the perimenopause and are of little clinical significance before considering a trial of HRT if indicated.

3. Offer HRT first line treatment for vasomotor symptoms & menopause related low mood/anxiety after discussing short-term and longer-term benefits/risks. Treatment can be continued as long as needed.

4. Symptomatic women in the perimenopause can take HRT – don’t wait until periods stop.

5. Consider CBT to improve mood/anxiety due to the menopause. Evidence for SSRIs to help menopause symptoms is poor, but in practice can be effective, though reduced libido is a SE.

6. Transdermal is first line as it has a lower VTE, CVD and breast cancer risk.

7. HRT does not increase cardiovascular disease risk when started in women aged < 60 years.

8. Any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT and the MHRA now suggest this can persist for up to 10 years.

9. Offer topical HRT to women with urogenital atrophy (including those on systemic HRT) after examining to exclude other pathology. This can be continued for as long as needed with no fixed time limit.

10. Offer women who are stopping HRT a choice of gradually reducing or immediately stopping.

11. The Mirena® IUS alone does not help with menopausal symptoms. If used for endometrial protection must be changed every 5 years (even when over 45).

12. Adding testosterone in women on HRT is unlicensed in the UK and will not resolve sexual boredom, sexual trauma, gender-based violence, relationship problems, communication failure or body image issues which need to be excluded before prescribing it.

Referral criteria to the Tayside Menopause Clinic

Due to the long waiting list, they can only accept referrals for:
- premature ovarian insufficiency (< 40) or early menopause (< 45)
- persistent side effects or symptom control despite several types and routes of HRT
- relative or absolute contraindications to HRT including PMHx of hormone dependent cancer
- complex medical history
- persisting vaginal bleeding problems on sequential HRT (after 6/12 of start or change of HRT) (e.g. increase in heaviness or duration of bleeding, or if bleeding irregular)- however, women whose bleeding problems started before taking HRT should be referred to gynaecology
- women >60 who wish to continue on HRT or those with intolerable menopausal symptoms, despite non-hormonal treatment or when non-hormonal treatment is no acceptable/appropriate
- low sex drive after excluding non-organic causes - transdermal testosterone may be indicated

Alternatively, e-mail: Tay-UHB.TSRH@nhs.net (answer within 5 working days) or via SCI-gateway

Referral criteria to the Postmenopausal Bleeding Gynaecology Clinic for urgent assessment:
- postmenopausal bleeding (> 12 months after LMP)
- vaginal bleeding on continuous HRT > 6 months after start or change of HRT (with or without IUS)
- vaginal bleeding persisting six weeks after stopping continuous HRT