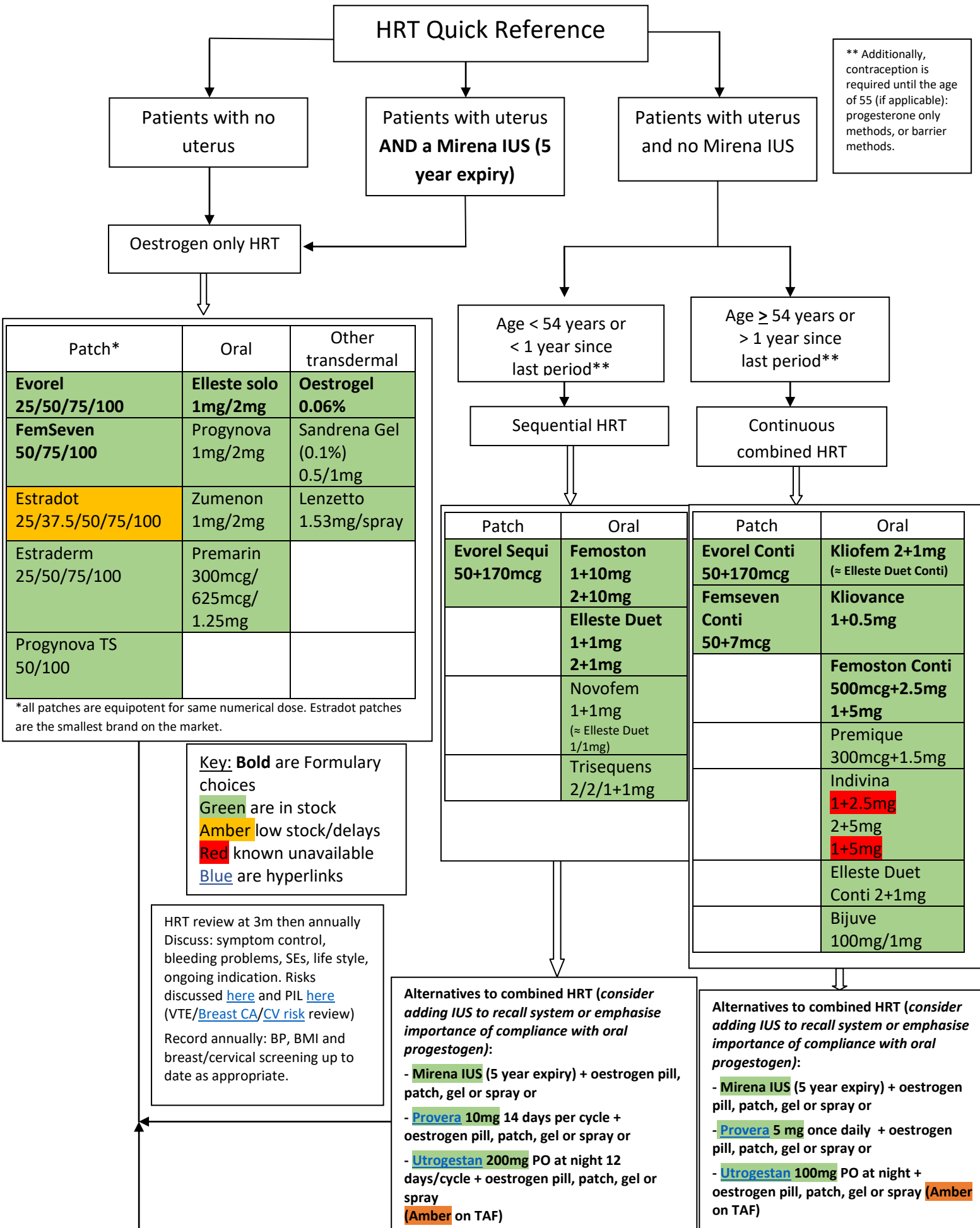


NHST HRT Decision Aid

Original by Dr S Carter, adapted by Dr S Jamieson with input from Dr H Gleser



Prescribing tips

- If persistent/abnormal bleeding patterns >3m after starting: investigate the cause and consider change of HRT- see Tayside Menopause Guideline. Could ask Menopause clinic for advice via Trakcare/SCI gateway.
- If persisting >6 months- refer to the Postmenopausal Bleeding Clinic (Gynaecology).
- Bleeding after starting continuous combined: if doesn't settle after 3-6m, consider moving 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 (utrogestan often better tolerated) or use the Mirena.
- **Testogel sachet concentration is changing from March 2022. The new, more concentrated and also smaller sachets are more difficult to dose correctly for menopausal patients. Please change the prescription from Testogel 1% to Testim 1% (use 1/10 tube per day, one small pea size, unless otherwise told by menopause specialist) or Tostran 2% (use one pump application every other day, unless otherwise told by menopause specialist).**

Estradiol equivalents (approximates, can vary individually)

Route	Ultra low dose	Low dose	Medium dose (Standard dose)	Moderate dose	High dose
Transdermal- patch	12.5 mcg/d (½ of a 25 mcg/d patch)	25 mcg/d	50 mcg/d*	75 mcg/d	100 mcg/d
Transdermal- gel (Oestrogel®) (estradiol 0.06%) (one squirt: 0.75 mg estradiol)	½ squirt (0.38 mg estradiol)	1 squirt (0.75 mg estradiol)	2 squirts ** (1.5 mg estradiol)	3 squirts ** (2.25 mg estradiol)	4 squirts ** (3 mg estradiol)
Transdermal- gel (Sandrena®) (estradiol 0.1%)	0.25 mg (¼ of a 0.5 mg sachet)	0.5 mg	1 – 1.5 mg	2 mg ** off-license but can be considered	3 mg ** off-license but can be considered
Transdermal- spray (Lenzetto®)	na	1-2 sprays (21- 29 mcg/d)	3 sprays (40 mcg/d)	4-5 sprays- off-license but can be considered	6 sprays off-license but can be considered
Oral estradiol***	0.5 mg (1/2 of a 1 mg tablet or Femoston conti® 0.5/2.5)	1 mg	2 mg	3 mg off-license, rarely needed, indicated, or recommended- involve BMS approved menopause specialist	4 mg off license, rarely needed, indicated, or recommended- involve BMS approved menopause specialist
Conjugated equine estrogen (CEE)***	na	0.3 mg	0.625 mg	1.25 mg	Usually not needed, indicated, or recommended

* All combined sequential and continuous HRT patches currently on the UK market contain 50 mcg/d estradiol

** If using more than minimal dose- consider dividing application of estradiol gel into two takes- AM and evening.

*** Oral route is contraindicated in women with a BMI ≥ 30 or with increased VTE or CVD risk factors. The 0.625 mg of conjugated equine estrogen (CEE) table is a low dose, approx. the equivalent of a 1 mg estradiol tablet.

**** Only exists as combined continuous HRT pill (Femoston conti® 0.5/2.5)

Top recommendations from the Tayside Menopause Guideline

1. Patients 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 patients > 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 patients in the perimenopause can take HRT – they don't have to wait until their periods stop.
5. Consider CBT to improve mood/anxiety due to the menopause. Evidence for SSRIs/SNRIs to help menopause symptoms is poor. First line tx for new onset depression/ anxiety is HRT, especially <51. Reduced sexual desire is a common SE.
6. Transdermal estradiol is first line, especially in women with higher VTE and CVD risk and migraines. Symptoms often are better controlled but transdermal progestogen might not be that well absorbed and compliance with oral progestogen can be a concern when HRT is given as two products.
7. HRT does not increase cardiovascular disease risk when started in patients aged < 60 years.
8. Any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT- MHRA now suggest this can persist for up to 10 years.
9. Offer [topical HRT](#) (vaginal) to patients 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 patients 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 patients 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

Tayside Menopause Clinic staff is happy to give advice about any patients via SCI-gateway, including about women with bleeding issues waiting to be assessed by gynaecology. However, due to staff capacity issues, the specialist clinic only accepts referrals of patients with:

- premature ovarian insufficiency (< 40)
- 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 and non hormonal treatment options not working, suitable or acceptable
- complex medical history
- low sex drive after excluding non-organic causes - transdermal testosterone may be indicated

Referral criteria to the Postmenopausal Bleeding Gynaecology Clinic for urgent assessment (2 weeks pathway):

- 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)
- 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