Menopause

This guideline covers diagnosis and management of menopause, including premature ovarian insufficiency.

**Definition of terms**

<table>
<thead>
<tr>
<th>HRT</th>
<th>hormone replacement therapy</th>
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<tr>
<td>FSH</td>
<td>follicle-stimulating hormone</td>
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<tr>
<td>COC</td>
<td>combined oral contraceptive</td>
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<tr>
<td>SSRI</td>
<td>selective serotonin reuptake inhibitor</td>
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<tr>
<td>SNRI</td>
<td>serotonin and norepinephrine reuptake inhibitor</td>
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<tr>
<td>CV</td>
<td>cardiovascular</td>
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<tr>
<td>CHD</td>
<td>coronary heart disease</td>
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<tr>
<td>CI</td>
<td>contraindication</td>
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<tr>
<td>U</td>
<td>unlicensed indication</td>
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**Diagnosis**

**Perimenopause and menopause**

- In healthy women, aged >45 years, with menopausal symptoms diagnose the following without laboratory tests:
  - perimenopause based on vasomotor symptoms and irregular periods,
  - menopause in women without a period for at least 12 months and who are not using hormonal contraception,
  - menopause based on symptoms in women without a uterus.
- Consider using a FSH test to diagnose menopause only:
  - in women aged 40 to 45 years with menopausal symptoms, including change in menstrual cycle,
  - women aged <40 years in whom menopause is suspected.
- Do NOT use a serum FSH test to diagnose menopause in women using COC or high-dose progestogen. Take into account that it can be difficult to diagnose menopause in women taking hormonal treatments.

**Premature ovarian insufficiency**

- In women aged <40 years diagnose premature ovarian insufficiency based on:
  - menopausal symptoms, including no or infrequent periods (taking into account if woman has a uterus), AND elevated FSH levels on two blood samples taken 4 to 6 weeks apart.
- Take into account the woman’s clinical history (e.g. previous medical or surgical treatment) and family history.
- Do NOT diagnose on basis of a single blood test.
- Do NOT routinely use anti-Müllerian hormone testing to diagnose premature ovarian insufficiency.
- Refer to a specialist with expertise in menopause or reproductive medicine if there is doubt about diagnosis.

**Treatment and management**

**Premature ovarian insufficiency**

- Offer sex steroid replacement with a choice of HRT or a COC, unless CI.
- Explain to women:
  - importance of starting hormonal treatment with HRT or a COC and continuing treatment until at least the age of natural menopause,
  - that baseline population risk of diseases such as breast cancer and CV disease increases with age and is very low in women aged <40 years,
  - that HRT may have a beneficial effect on blood pressure compared with a COC,
  - that both HRT and COC offer bone protection,
  - HRT is not a contraceptive.

**Menopause**

- Adapt treatment based on changing symptoms.

**Vasomotor symptoms**

- Offer HRT after discussing short-term (up to 5 years) and longer-term benefits and risks.
- Offer a choice of:
  - oestrogen and progestogen to women with a uterus,
  - oestrogen alone to women without a uterus.
- Do NOT routinely offer SSRI s, SNRI s or clonidine as first-line treatment for vasomotor symptoms alone.
- Explain there is some evidence that isoflavones or black cohosh may relieve vasomotor symptoms. However:
  - multiple preparations are available and their safety is uncertain,
  - different preparations may vary,
  - interactions with other medicines have been reported.

**Psychological symptoms**

- Consider HRT to alleviate menopausal low mood.
- Consider cognitive behavioural therapy to alleviate low mood or anxiety arising as a result of menopause.
- There is no clear evidence that SSRI s/SNRI s ease low mood in menopausal women without a diagnosis of depression.

**Altered sexual function**

- Consider testosterone supplementation for menopausal women with low sexual desire if HRT alone is not effective.

**Urogenital atrophy**

- Offer vaginal oestrogen (including those on systemic HRT) and continue for as long as needed to relieve symptoms.
- Consider vaginal oestrogen for women in whom systemic HRT is CI, after seeking specialist advice.
- If vaginal oestrogen does not relieve symptoms, consider increasing dose after seeking specialist advice.
- Explain to women with urogenital atrophy that:
  - symptoms often come back when treatment is stopped,
  - adverse effects from vaginal oestrogen are very rare,
  - they should report unscheduled vaginal bleeding to GP.
- Advise that moisturisers and lubricants alone or in addition to vaginal oestrogen can be used to treat vaginal dryness.
- Do NOT offer routine monitoring of endometrial thickness during treatment for urogenital atrophy.

**Complementary and unregulated therapies**

- Explain that efficacy and safety of unregulated compounded bioidentical hormones are unknown.
- Explain that quality, purity and constituents of complementary therapies may be unknown.
- Advise women with history of, or at high risk of, breast cancer, that although there is some evidence that St. John’s wort may relieve vasomotor symptoms, there is uncertainty about:
  - appropriate doses, persistence of effect, variation in nature and potency of preparations and potential serious interactions with other drugs.

**Recommendations** — wording used such as ‘offer’ and ‘consider’ denote the strength of the recommendation.

**Drug recommendations** — the guideline assumes that prescribers will use a drug’s Summary of Product Characteristics (SPC) to inform treatment decisions.
NICE Bites

Menopause continued ...........

NICE NG23; 2015

Monitoring

♦ Discuss nationally recommended health screening.
♦ Review each treatment at 3 months to assess efficacy and tolerability and then annually unless there are clinical indications for an earlier review (e.g. treatment ineffectiveness, adverse effects).
♦ Explain to women with a uterus that unscheduled vaginal bleeding is a common adverse effect of HRT within the first 3 months of treatment. Women should report this at 3-month review, or promptly if it occurs after the first 3 months.
♦ Offer women stopping HRT the choice to gradually reduce or immediately stop treatment. Explain that:
  › gradually reducing may limit recurrence of symptoms in the short term,
  › gradually reducing or immediately stopping makes no difference to symptoms in the longer term.

Referral

♦ Refer women to a specialist if treatments do not improve symptoms or if ongoing troublesome adverse effects.
♦ Consider referring women to a specialist if:
  › they have menopausal symptoms and CIs to HRT, OR
  › there is uncertainty about the most suitable treatment.

Benefits and risks of HRT

Breast cancer

See table: ‘difference in breast cancer incidence’

♦ Explain that:
  › baseline risk of breast cancer around menopausal age varies according to presence of underlying risk factors,
  › HRT with oestrogen alone is associated with little or no change in risk of breast cancer but HRT with oestrogen and progestogen can be associated with increased risk,
  › any increase in risk of breast cancer is related to treatment duration and reduces after stopping HRT.
  › For advice on treating menopausal symptoms in women with or at high risk of breast cancer see NICE pathways; ‘Early and locally advanced’ and ‘Familial breast cancer’.

Osteoporosis

See table: ‘difference in any fragility fracture incidence’

♦ Explain that:
  › baseline population risk of fragility fracture around menopausal age is low and varies between women,
  › risk of fragility fracture is decreased whilst taking HRT, benefit is maintained during treatment but benefit decreases once treatment stops.

Dementia

♦ Likelihood of HRT affecting risk of dementia is unknown.

Type 2 diabetes

♦ HRT (oral/ transdermal) is not associated with an increased risk of developing type 2 diabetes.
♦ HRT is not generally associated with an adverse effect on blood glucose control.
♦ Consider HRT for menopausal symptoms in women with type 2 diabetes after taking comorbidities into account and seeking specialist advice if needed.

Venous thromboembolism (VTE)

♦ Explain that risk of VTE:
  › is increased by oral HRT compared with baseline population risk,
  › associated with HRT is greater for oral than transdermal preparations,
  › associated with standard doses of transdermal HRT is no greater than baseline population risk.
♦ Consider transdermal HRT for women at increased risk of VTE, e.g. BMI >30kg/m².
♦ Consider referring women with a high risk of VTE to a haematologist for assessment before considering HRT.

Coronary heart disease

See tables: difference in CHD incidence’ and ‘difference in stroke incidence’

♦ HRT does not increase CV risk in women aged <60 years and does not affect risk of dying from CV disease.
♦ Presence of CV risk factors is not a CI to HRT as long as they are optimally managed.
♦ Explain that:
  › baseline risk of CHD and stroke at menopausal age varies according to CV risk factors,
  › HRT with oestrogen alone is associated with no, or reduced, risk of CHD,
  › HRT with oestrogen and progestogen is associated with little or no increase in risk of CHD,
  › Oral oestrogen is associated with a small increased risk of stroke but baseline population risk of stroke in women aged <60 years is very low.

Muscle mass and strength

♦ There is limited evidence to suggest that HRT improves muscle mass and strength.

Information and advice - see NICE pathway

The table below lists all NICE guidance included in NICE Bites in 2015

<table>
<thead>
<tr>
<th>NICE Guidance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Anemia in CKD</td>
<td>NICE NG8; 2015 August 2015/78</td>
</tr>
<tr>
<td>Antimicrobial stewardship</td>
<td>NICE NG15; 2015 September 2015/79</td>
</tr>
<tr>
<td>Depression in children and young people (updated)</td>
<td>NICE CG28; 2015 June 2015/76</td>
</tr>
<tr>
<td>Diabetes in children and young people (type 1 and 2)</td>
<td>NICE NG18; 2015 November 2015/81</td>
</tr>
<tr>
<td>Diabetes in pregnancy</td>
<td>NICE NG3; 2015 July 2015/77</td>
</tr>
<tr>
<td>Drug allergy: diagnosis and management</td>
<td>NICE CG183; 2014 May 2015/75</td>
</tr>
<tr>
<td>GORD in children and young people</td>
<td>NICE NG1; 2015 March 2015/73</td>
</tr>
<tr>
<td>Irritable bowel syndrome in adults</td>
<td>NICE CG61; 2015 May 2015/75</td>
</tr>
<tr>
<td>Medicines Optimisation</td>
<td>NICE NG5; 2015 April 2015/74</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>NICE CG186; 2014 February 2015/72a</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>NICE CG191; 2014 January 2015/71</td>
</tr>
<tr>
<td>Type 1 diabetes</td>
<td>NICE NG17; 2015 October 2015/80</td>
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This bulletin summarises key prescribing points from NICE guidance. Please refer to the full guidance at www.nice.org.uk for further detail. This is an NHS document not to be used for commercial purposes.