TAYSIDE MENOPAUSE GUIDELINE

REFERENCE GUIDE FOR PRIMARY CARE

TAYSIDE SEXUAL & REPRODUCTIVE HEALTH SERVICE

AUGUST 2018

Abbreviations

BMI	body mass index
BMS	British Menopause Society
BP	blood pressure
BSO	bilateral salpingo-oophorectomy
CBT	cognitive behavioural therapy
CCT	continuous combined treatment (HRT)
CE	conjugated (o)estrogen
CHC	combined hormonal contraception
CI	contraindication
CVD	cardiovascular disease
DMPA	depot medroxyprogesterone acetate
E	estradiol
FHx	family history
FSH	follicle-stimulating hormone
FSRH	Faculty of Sexual & Reproductive Healthcare
GSM	genitourinary syndrome of the menopause
HRT	hormone replacement therapy
IUS	intrauterine system
LMP	last menstrual period
LNG	levonorgestrel
MPA	medroxyprogesterone acetate
NAAT CT/GC	nucleic amplification acid test for chlamydia and gonorrhoea
NET	norethisterone
O&G	obstetrics & gynaecology
OTC	over the counter
P	progestogen
PMB	postmenopausal bleeding
PMHx	personal medical history
POI	premature ovarian insufficiency
STI	sexually transmitted infection
TFT	thyroid function test
TSRHS	Tayside Sexual & Reproductive Health Service
Tx	treatment
VVA	vulvovaginal atrophy
VTE	venous thromboembolism

Tayside Menopause Guideline

1. Introduction

Welcome to the new edition of the "Tayside Menopause Guideline"! This guideline is a (relatively quick) reference guide directed at Primary Care staff (GPs and practice nurses) although other specialities might find it useful too.

As the Tayside Menopause Clinic Team, we wanted to share some of our experience in specialist menopause care with you as we are aware that there is still some uncertainty around the topic amongst healthcare providers. The content tries to cover the most common queries we receive from Primary Care via referrals, e-mail advice line or TrakCare advice requests. In addition, this update takes into account the recent change in the NHS Tayside Formulary on which we worked together with our colleagues from Ninewells Pharmacy and Primary Care.

Of course, these pages will not replace a Menopause textbook and can be easily be outdated by the newest research. We therefore strongly suggest keeping up to date with this ever-changing topic by attending the Tayside Sexual & Reproductive Health GP Update Day and the conference and courses organised by the British Menopause Society (BMS), the Faculty of Sexual & Reproductive Healthcare (FSRH) and Royal College of Obstetricians & Gynaecologists (RCOG).

Please use your own clinical judgement when using our guideline and don't hesitate to contact us with any feedback, corrections or suggestions to make the guideline more useful. Please write to Heike Gleser, consultant Sexual & Reproductive Health at heikegleser@nhs.net.

For any clinical queries, follow-up questions after a consultation or if you are not sure if a patient needs specialist advice (see section 3 for more details): please use the TSRHS e-mail advice service by writing to Tay-UHB.TSRH@nhs.net (answer within five working days) or the advice option on TrakCare.

Dr Heike Gleser
Dr Dianna Reed
Dr Elizabeth Cockburn
Dr Jo Green
Dr Jane Reid
Dr Laura Jarvis

Dundee, August 2018

2. General Advice

These are our (and some of NICE's) top recommendations around the menopause and menopause care:

1. Women with premature ovarian insufficiency (POI) (under the age of 40) and early menopause (under the age of 45) should be started on HRT, even if not symptomatic, unless they have an absolute contraindication.
2. Women with POI and early menopause should be advised to continue HRT until at least the age of natural menopause (around 51).
3. Do not measure FSH routinely for diagnosis of the menopause in women > 45.
4. Offer women HRT as first line treatment for vasomotor symptoms and low mood or anxiety related to menopause after discussing the short-term and longer-term benefits and risks.
5. Symptomatic women in the perimenopause can take HRT and do not have to wait until their periods stop. FSH levels fluctuate in the perimenopause and are, therefore, of little clinical significance before considering a therapeutic trial with HRT.
6. Consider CBT to alleviate low mood or anxiety that arise because of the menopause.
7. Consider transdermal rather than oral HRT for menopausal women as first line, especially to women who are at increased risk of VTE, including those with a BMI over 30 kg/m^2. Transdermal HRT leads often to better symptom control and carries a lower VTE, CVD and breast ca risk.
8. HRT does not increase cardiovascular disease risk when started in women aged < 60 years.
9. Any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT.
10. Offer vaginal oestrogen to women with urogenital atrophy (including those on systemic HRT), but only after examining them first to exclude other pathology.
11. Continue vaginal oestrogen treatment for as long as needed to relieve symptoms, which might be many years.
12. There is no arbitrary time limit for HRT: HRT does NOT have to be stopped after 5 years.
13. Offer women who are stopping HRT a choice of gradually reducing or immediately stopping treatment. HRT does not delay the menopausal symptoms.
14. The Mirena® IUS alone does not help with menopausal symptoms. If used for endometrial protection should not be used beyond 5 years.
15. 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. Please remember that loss of sexual desire is a common SE of SSRIs.

3. Referral Pathways to Local Clinics

Referral criteria to the <u>Tayside Menopause Clinic</u> which provided by the Tayside Sexual & Reproductive Health Service and located at Ninewells, Drumhar HC (Perth) and Abbey HC (Arbroath):

Unfortunately, due to our long waiting list, we are only able to accept referrals of complex menopausal patient to this specialist clinic. Please consider referring women with:

- premature ovarian insufficiency (under the age of 40) or early menopause (under the age of 45),
- persistent side effects with several types and routes of HRT (minimum of three),
- poor symptom control after trying out several types and routes of HRT (minimum of three),
- relative and absolute contraindications to HRT including PMHx of hormone dependent cancer,
- complex medical history,
- persisting vaginal bleeding problems on <u>sequential</u> 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 <u>before taking HRT</u> should be referred to gynaecology,

- women aged >60 who are keen to continue with HRT or those with intolerable menopausal symptoms, despite non-hormonal treatment or when non-hormonal treatment is no acceptable or appropriate,
- low sex drive after excluding non-organic causes and when a therapeutic trial with transdermal testosterone might be indicated.

Alternatively, you might want to discuss a patient using the TSRHS e-mail advice service by writing to: Tay-UHB.TSRH@nhs.net (answer within five working days) or request advice via TrakCare.

Referral criteria to the Postmenopausal Bleeding Clinic (provided by the Gynaecology Department, Ninewells Hospital) for urgent assessment:

Refer women with:

- postmenopausal bleeding (> 12 months after LMP),
- vaginal bleeding on continuous HRT more than six months after start or change of HRT (with or without IUS),
- vaginal bleeding persisting six weeks after stopping continuous HRT.

Referral Criteria for (peri)menopausal women to the Sexual Problem Clinic (provided by the Tayside Sexual & Reproductive Health Service)

Many women experience loss of libido, vaginal dryness and discomfort with intercourse around the time of the menopause. Some may benefit from psychosexual counselling in addition to or instead of medical treatment of their menopausal symptoms.

Women who have experienced gynaecological surgery, chronic disease or cancer treatment and those with a history of gynaecological cancer experience higher rates of psychosexual problems.

The following criteria are a guide for a referral to the sexual problem clinic:

1) Sexual problems which predates the menopause (e.g. dyspareunia, vaginismus, loss of libido or difficulties with orgasm),
2) Sexual problems not responding to HRT,
3) The patient feels that their sexual problem has a psychological element.

4. Benefits of systemic HRT

The main benefits of systemic HRT are:

1. Reduction of vasomotor symptoms,
2. Improvement of low mood associated with the (peri-)menopause,
3. Prevention and treatment of vulvovaginal/urogenital atrophy (genitourinary syndrome of the menopause),
4. Reduction of osteoporosis risk and fragility fractures,
5. Improvement of sexual function.

HRT does not increase cardiovascular risk in women under 60 and oestrogen-only HRT may offer some protection. The effect on the brain is unknown.

5. Risks of systemic HRT

The risks highlighted below are mainly applicable to women aged over 50 and should not be extrapolated to women with premature ovarian insufficiency (POI) or early menopause in which the benefits of HRT usually outweigh the risks until the age of a natural menopause**.**

Table 1: Number of cases of diseases per 1000 women aged 50-59 over 7.5 years with or without systemic HRT

	No systemic HRT use	Oestrogen-only HRT	Combined HRT
Breast cancer *	**22.5**	**4 fewer**	**5 more**
Cardiovascular disease *	**26**	**6 fewer**	**5 more**
Stroke *	**11**	**no change**	**6 more**
Venous thrombo-embolism **	**1.7**	**4 to 6**	**4 to 6**

* Data summarised from RCTs, NICE Menopause Guideline (NG23)

** https://thebms.org.uk/_wprs/wp-content/uploads/2016/04/HRT-Guide-160516.pdf

Breast cancer

HRT increases the incidence of breast cancer among women taking it but not the mortality due to breast cancer. Large observational data suggests that micronised progesterone (Utrogestan®) and dydrogesterone (Femoston® products) may be associated with a lower risk of invasive breast cancer.

Figure 1 shows a useful infographic which can be used for counselling patients.

Ovarian cancer

There may be a slight increased risk of ovarian cancer in women who use HRT. This may not differ between oestrogen-only or combined HRT.

Endometrial cancer

Unopposed oestrogen increases the risk of endometrial cancer. Use of sequential HRT for >5 years maybe associated with a minor increase in risk. Continuous combined preparations are associated with significantly lower risk.

Stroke

Oral, but not transdermal oestrogen, is associated with a small increased risk of stroke. The risk is less likely to be increased if commenced under the age of 60, or within 10 years of the onset of the menopause. Transdermal HRT may be preferable in those with stroke or other CVD risk factors. Micronised progesterone (Utrogestan®) and dydrogesterone (Femoston® products) may be associated with a lower risk of stroke and CVD.

Other cardiovascular disease (CVD)

Recent studies suggest that oestrogen – only HRT is associated with either no, or reduced risk of cardiovascular disease and combined HRT is associated with little or no increase in risk, when started in women under the age of 60, or within 10 years of the onset of the menopause.

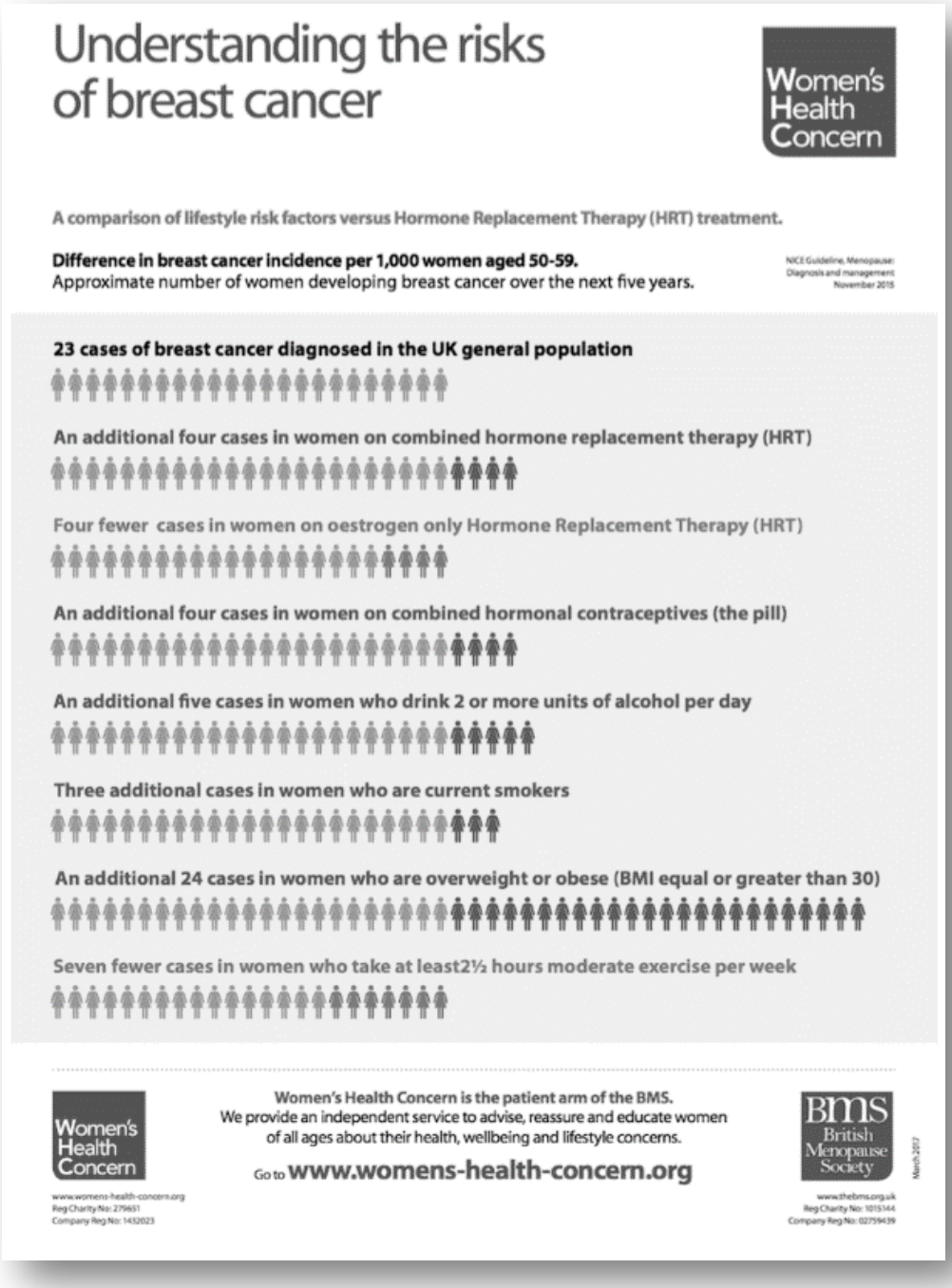
Venous thromboembolism (VTE)

Although the risk of venous thromboembolism (VTE) is increased with oral HRT, the risk does not appear to be any more than baseline with transdermal, if given at standard therapeutic doses. The greatest risk is within the first 12 months of HRT use. Repeated stopping and starting of HRT should therefore be avoided. Consider referral to a haematologist if the patient is of high VTE risk (e.g. a PMHx or strong FHx of VTE or hereditary thrombophilia).

Type 2 diabetes

HRT is not associated with an increased risk of type 2 diabetes. In women with type 2 diabetes, HRT is generally not associated with an adverse effect on blood glucose control, but other comorbidities should be considered when prescribing,

Figure 1: BMS Infographic for patient counselling "Understanding the risks of breast cancer"



Available to download at: https://thebms.org.uk/publications/tools-for-clinicians/

6. Pre-existing conditions and HRT

Apart from hormone-dependent cancers there are no absolute or relative contraindications to topical (local) oestrogen as there is only minimal systemic absorption.

The very few absolute contraindications to systemic HRT are:

- active liver disease with abnormal liver function tests,
- acute phase myocardial Infarction,
- active thromboembolic disease,
- pregnancy,
- prophyria cutanea tarda,
- suspected or active breast or endometrial cancer (including undiagnosed vaginal bleeding, especially if there are risk factors).

There are some conditions in which systemic HRT could be only given with caution and after considering getting specialist advice:

- **Angina**: consider non-hormonal therapies initially; HRT may be considered after specialist advice; possible increased MI risk in the 1st year of HRT use; the Q-risk2 tool or the ASSIGN score may be helpful to assess cardiovascular risks.
- **Diabetes**: low dose oestrogen and transdermal preparation preferred.
- **Endometriosis**: small risk of reactivation of endometriosis with HRT use; if HRT started after hysterectomy for endometriosis choice of HRT used should be influenced by extent of endometriosis and CCT (at least for the first year postop) might be indicated.
- **Epilepsy**: liver-enzyme inducing antiepileptic drugs can increase the breakdown of HRT; low or standard dose oral HRT may be therefore ineffective and transdermal route is preferred. Lamotrigine levels can be reduced by HRT and may require specialist advice and monitoring when starting, changing the dose of or stopping HRT.
- **HIV**: liver-enzyme inducing antiretroviral drugs can increase the breakdown of HRT; low or standard dose oral HRT may be therefore ineffective, and the transdermal route is preferred.
- **Fibroids**: size of fibroids maybe increased with the use of HRT.
- **Gall bladder disease**: increased risk with HRT; transdermal preparations preferred.
- **Hyperlipidaemia**: triglycerides can increase with oral oestrogen: transdermal preparations preferred.
- **Hypertension**: hypertension should be controlled prior to starting HRT.
- **Migraine** (simple or complicated): may be worsening with fluctuation in hormones: transdermal preparations preferred (see https://thebms.org.uk/publications/factsheets/migraine-and-hrt/ for more info).
- **Stroke**: consider non-hormonal therapies initially; HRT may be considered after specialist advice.
- **Thyroid disease**: patients on thyroxine should have their TFT rechecked 3 months after starting or stopping HRT to see if dose needs adjusting as HRT affects the thyroid-binding globulin and therefore might decrease free thyroxine; transdermal HRT preferred.
- **VTE, thrombophilia or conditions with increased VTE risk** (e.g. SLE): consider non-hormonal therapies initially; transdermal HRT may be considered after specialist advice.
- **Family history of VTE**: if HRT is used transdermal route is preferred; consider specialist advice (menopause team/haematologist).
- **History of uterine cancer**: consider non-hormonal therapies initially; HRT may only be considered after specialist advice (menopause team/ gynaecology).
- **History of breast cancer**: use non-hormonal therapies- systemic HRT usually contraindicated; vaginal oestrogen may be considered after specialist advice (menopause team/breast surgeon/oncologist/pathologist).

7. Premature Ovarian Insufficiency (POI) and Early Menopause

Premature Ovarian Insufficiency (POI) (menopause in women below the age of 40)

Women with POI should be referred on for specialised advice to the Menopause Clinic and will be followed up at least yearly until the age of 45.

Recommended investigations: 2 x FSH levels 4 to 6 weeks apart (menopausal levels: ≥ 30 mIU/mL), testosterone, sex hormone binding globulin, prolactin and TFT. Consider autoimmune studies and, if below the age of 30, chromosomal studies.

Issues to consider: bone health (risk of osteoporosis), cardiovascular health/risk of CVD, cognitive function, fertility wishes, contraceptive needs, mental/emotional impact.

Management: lifestyle advice, HRT or combined hormonal contraception (CHC) (preferable continuous, unless contraindicated). Both HRT and CHC give bone protection. Women with POI might still get a spontaneous ovulation and HRT is not a contraceptive. Nonetheless, HRT maybe indicated rather than CHC in women with an elevated BP or cardiovascular risks. HRT or CHC till the age of 50 years.

Hormone replacement is strongly advised in women with POI even without symptoms.

Early Menopause (menopause in women between 40 and 44)

Women with early menopause are treated similarly to women with POI (see above). Fewer investigations are recommended though: 2 x FSH levels 4 to 6 weeks (menopausal levels: ≥ 30 mIU/mL) apart to confirm diagnosis.

Hormone replacement is strongly advised in women with early menopause even without symptoms. Consider a therapeutic trial with HRT (unless absolute CI) in symptomatic women with normal FSH.

Women entering the menopause prematurely or early due to surgery, chemo- and/or radiotherapy should also be started on HRT unless absolutely contraindicated, but usually in consultation with the specialist(s) treating her.

8. Genitourinary Syndrome of the Menopause (GSM)

Vulval, vaginal and urinary symptoms (see Table 2) caused by oestrogen deficiency are very common in menopausal women and easily treatable. Patients need to be examined for the diagnosis of the genitourinary syndrome of the menopause (GSM)[1] as other vulval conditions like lichen sclerosus or vulval intra-epithelial neoplasia (VIN) could be otherwise missed.

With time, most women “grow out” of vasomotor symptoms but not of symptoms of urogenital atrophy. Topical vulvovaginal oestrogen has minimal risks and is safe for most of women as long as required which might be many years. There are very few contraindications to topical oestrogen- the only relative contraindication is a past medical history of a hormone-dependent tumor. Consider prescribing vaginal oestrogen with GSM in patients when systemic HRT is contraindicated after seeking specialist advice.

[1] Genitourinary syndrome of the menopause (GSM) replaces the term vulvovaginal atrophy (VVA) as it is more comprehensive and accurate.

Lubricants and moisturizers can be used additionally to topical oestrogen.

Table 2: Signs and symptom of the genitourinary syndrome of the menopause (GSM)

Symptoms	Signs
Vulvovaginal dryness	Decreased moisture
Vulvovaginal itchiness, burning and irritation	Decreased elasticity
Dysuria	Pallor or erythema
Urinary frequency, urgency and urge incontinence	Tissue fragility, fissures and/or petechia
Recurrent UTIs	Urethral eversion
Decreased sexual lubrication	Loss of hymenal remnants and vaginal rugae
Superficial dyspareunia	Labia minora resorption
Postcoital bleeding	Vaginal shortening and narrowing

Table 3: NHS Tayside Formulary: topical HRT choices

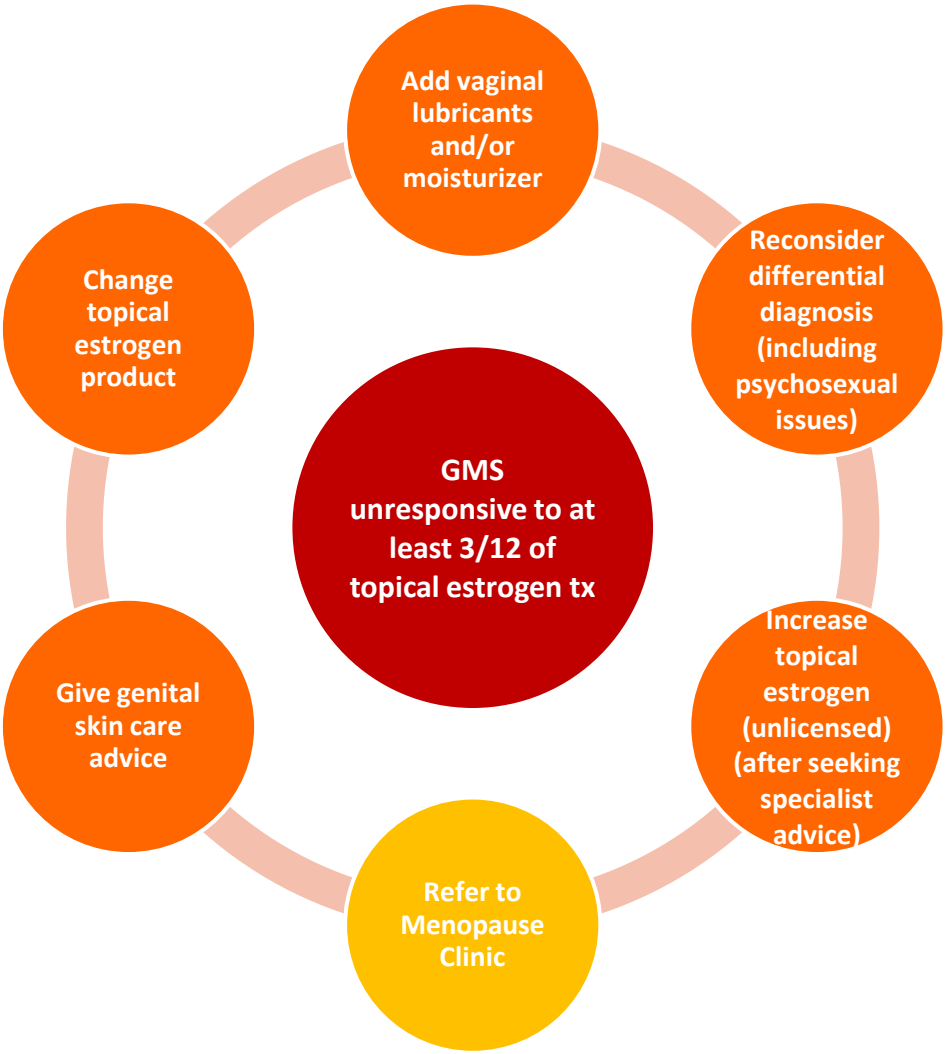
Name	Topical oestrogen	Type	Use	Comments
First choice				
Ovestin®	**Estriol 0.1%**	Intravaginal cream	One applicator nightly for 2-3/52, then twice weekly maintenance	Most cost-effective topical HRT
Vagifem®	**Estradiol (10 mcg)**	Intravaginal tablets	One tablet nightly for 2/52, then twice weekly maintenance	More expensive than Ovestin® but often more acceptable as less "messy".
Other choices				
Estring®	**Estradiol (7.5 mcg/24 hours)**	Intravaginal ring	One ring in the upper third of vagina every three months	Maximal licensed duration: two years. Can stay in situ during sexual intercourse
Gynest®[1] (or generic equivalent)	**Estriol 0.01%**	Intravaginal cream	One applicator nightly until improvement occurs, then twice weekly maintenance	Most expensive option. Topical oestrogen with lowest systemic absorption (clinically rarely relevant)

[1] Gynest® is being discontinued but a generic version of the product is available.

Table 4: Topical oestrogen versus lubricants and moisturizers

Topical oestrogens	Lubricants and moisturizers
• More efficient tx. For VVA/GSM than lubes and moisturizers. • Safe for almost all women, independent of age. • Adverse effects are rare. • Can be given to women on systemic HRT. • Continue tx. as long as needed (usually years). • There is no upper age or length of tx. limit. • Often takes weeks or months to work. • Symptoms tend to back when tx. discontinued. • Unscheduled vaginal bleeding should be reported. • No routine monitoring of endometrial thickness required. • Vagifem® is compatible with latex condoms. • Intravaginal creams can damage latex condoms for up to 72 hours after use.	• Less efficient tx. than topical oestrogen: provide symptoms relief rather than tx. • Can be given to women with CI to topical oestrogen (for example: breast ca). • Can be used alone or additional to topical oestrogen. • Some lubes (Sylk®, Yes WB®) can be prescribed. • Both Sylk® and Yes® lubes are now available with applicators. • Replens®, Regelle®, Hyalofemme®, Yes VM® vaginal moisturizers are compatible with latex condoms. • Lubes can enhance sexual pleasure. • Yes WB® and Sylk® are compatible with latex condoms. Oil-based lubes like Yes OB® can damage latex condoms.

Table 5: Options for the treatment of GSM/VVA unresponsive to topical oestrogen treatment



9. Menopause Assessment and systemic HRT

9.1 Routine Menopausal Assessment

Initial history:

- Symptoms (consider using the Menopause Symptoms Chart- Appendix 18.1.) – characteristics, severity, onset and effect on quality of life- Please consider non- menopausal causes of hot flushes and night sweats
- Past and current remedies (behavioural, OTC, herbs, HRT etc.)
- External stressors (partner, family, work), mental health issues
- LMP and bleeding pattern including any abnormal vaginal bleeding needing investigated
- Current meds and allergies
- PMHx
- FHx (breast, ovarian and bowel cancer, CVD, VTE, osteoporosis)
- O&G history
- Cervical cancer screening
- Contraceptive needs and STI risks
- Social history- relationship(s), support network, work
- Alcohol and smoking

- Diet (including dairy products), (weight-bearing) exercise, outdoor activities and other lifestyle factors
- Osteoporosis risk (consider using the QFracture tool at http://www.qfracture.org/ or the FRAX score)
- CVD risk (consider using the QRisk2 tool or the ASSIGN score)
- Breast screening and breast awareness
- ICE (ideas, concerns and expectations) around the menopause and HRT

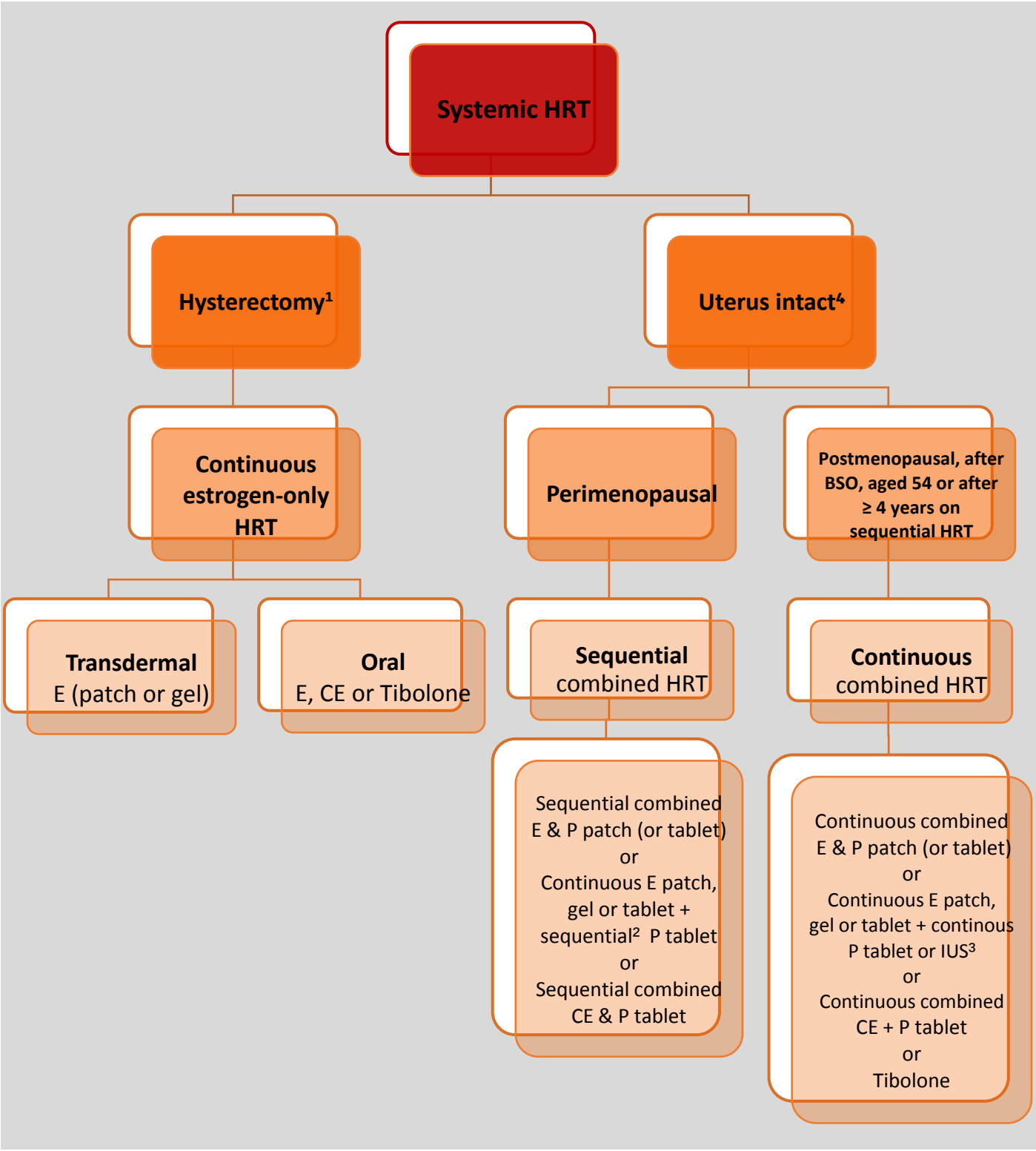
Initial examination:

- BP
- BMI
- Consider blood tests:
    - FBC and TFT to exclude other causes of her vasomotor symptoms;
    - lipid profile and glucose for CVD risk assessment;
    - thrombophilia screen with PMHx or FHx of VTE.
- Consider baseline DEXA (in women with additional osteoporosis risk factors, POI, early menopause, long-term DMPA use and/or delayed start of HRT).

See 9.5 for "Follow-up after starting HRT"

9.2 Flow Chart for systemic HRT prescription

Table 6: Flow chart for systemic HRT prescription



Abbreviations:

BSO bilateral salpingo-oophorectomy
CE conjugated oestrogen
E estradiol
IUS intrauterine system (Mirena®)
LMP last menstrual period
P progestogen

[1] Consider giving continuous combined HRT to women who had a hysterectomy for endometriosis, at least in their first postoperative year. Give three months of sequential HRT after a subtotal hysterectomy. If there is no vaginal bleeding: change to oestrogen-only HRT after that.

[2] Give cyclical progestogen for 12-14 days in every 28 days cycle.

[3] The Mirena® IUS (52 mg LNG) is the only IUS licensed as part of HRT and needs to be changed every 5 years (licensed for 4 years; recommended by the FRSH for 5 years). Levosert®, Kyleena® and Jaydess® IUS are not licensed to be used for endometrial protection in women taking HRT. Consider using a recall system to make sure the IUS is replaced in time to guarantee endometrial protection.

[4] Women with a Mirena® IUS in situ (which was inserted within the past 5 years) can have continuous oestrogen-only HRT. Women who have undergone an endometrial ablation or resection for heavy menstrual bleeding are treated like women with an intact uterus, even if not having any period since the operation (in which case a continuous combined preparation might be tried, irrespective of her menopausal status). A Mirena® IUS is usually contraindicated in these women.

In general, start with a low or medium dose preparation. Women with premature ovarian insufficiency (POI) (< 40 years), early (between 40- 44 years) or surgical menopause often require higher doses for symptom control.

Women who start sequential HRT before their periods stop may consider changing to a continuous combined therapy when they are 54 or after four years of taking sequential HRT. When switching from sequential HRT to continuous combined HRT a change at the end of a withdrawal bleed is recommended, when the endometrium is at its thinnest.

Continuous combined HRT can be given to postmenopausal women (LMP ≥ 1 year ago), after BSO, women aged ≥ 54 or after ≥ 4 years on sequential HRT. Giving continuous combined HRT to a woman with breakthrough ovarian activity is not dangerous but can be bothersome as irregular PV bleeding is likely.

9.3 Choice of systemic HRT preparations (NHS Tayside Formulary)

Table 7: Choice of systemic HRT preparations in the NHS Tayside Formulary

Type	First Choice	Second choice*
Estradiol only HRT		
Transdermal estradiol patches	Evorel® patch 25 mcg, 50 mcg, 75 mcg or 100 mcg/24 h	FemSeven® patch 50 mcg, 75 mcg or 100 mcg/24 h
Transdermal estradiol gel	Oestrogel® (0.06%) (1-4 measures≈ 0.75- 3 mg)	-
Oral estradiol	Elleste Solo® 1 mg or 2 mg	-
Sequential combined HRT		
Sequential combined patches	Evorel Sequi®[1] (50 mcg/170 mcg)	FemSeven Sequi®[2] (50 mcg/10 mcg)
Sequential combined tablets	Elleste Duet®[1] 1mg/1 mg or 2 mg/1 mg	Femoston®[3] 1 mg/10 mg or 2 mg/10 mg
Continuous combined HRT		
Continuous combined patches	Evorel Conti®[1] (50 mcg/170 mcg)	FemSeven Conti®[2] (50 mcg/7 mcg)
Continuous combined tablets	Kliovance®[1](1 mg/0.5 mg) Kliofem®[1] (2 mg/1 mg) (≈ Elleste Duet Conti®[1])	Femoston Conti®[3] (0.5mg/2.5mg) or (1mg/5mg)
Type	**First Choice**	**Second choice***
Progestogen as part of HRT (for endometrial protection)		
Intrauterine system (IUS)	Mirena® IUS (52 mg LNG) (for 5 years-unlicensed)	-
Progestogen tablets	Provera®[4] (MPA) 2.5 mg, 5 mg or 10 mg	-
Other		
Synthetic steroid (gonadomimetic)	Livial®[5] (2.5 mg)	-

* "Second choice" only due cost implications

Please see Appendix 18.3. for other HRT products

Bioidentical HRT

"Bioidentical hormones" refer to exogenous hormones that are biochemically similar to those produced endogenously by the ovaries or elsewhere in the body. Custom compounding of HRT may combine several hormones (eg, estradiol, estrone, and estriol) and use nonstandard routes of administration (eg, suppositories or lozenges). Prescribing of individually compounded bioidentical hormone treatment is not recommended due to the lack of quality control and regulatory oversight associated with these products, together with lack of evidence of safety and efficacy.

[1] Estradiol and norethisterone
[2] Estradiol and levonorgestrel
[3] Estradiol and dydrogesterone
[4] Medroxyprogesterone acetate (MPA): for sequential HRT to be given 5-10 mg/d on day 15- 28 day of each 28-day cycle; for continuous HRT to be given 2.5- 5 mg/d, depending on the estradiol dosage – see Appendix 18.3. for more info
[5] Tibolone

On the other hand, there are 17β-estradiol and progesterone products commercially available that have been tested and approved: estradiol and Utrogestan® (micronized progesterone) (see section 10 and Appendix 18.3. for more details).

See these links for more info: http://wwwmenopausematters.blogspot.co.uk/2017/01/bio-identicals.html and https://thebms.org.uk/2017/03/bms-council-issues-consensus-statement-bioidentical-hormones/

9.4 Choice of pharmaceutical route for systemic HRT

Indications for transdermal oestrogen (patch or gel)

Transdermal estradiol is usually regarded as first choice as this route avoids the first pass metabolism through the liver, leads to more stable circulating hormone levels and therefore better symptom control. The transdermal route is also regarded as being more breast-friendly and reducing CVD and VTE risks due to a better lipid and clotting profile compared to oral estradiol.

Transdermal estradiol dosage can also be more easily titrated than oral estradiol to get the balance right between symptom control and side effects by changing the amount of gel applied or cutting the estradiol-only patch smaller. Do not cut down combined HRT patches as endometrial protection cannot be guaranteed.

Transdermal estradiol also has less effect on the sex hormone binding globulin (SHBG) and therefore is less likely to reduce free testosterone levels in comparison with oral estradiol.

Although generally recommended for all women on HRT, transdermal estradiol is particularly indicated for women with:

- Individual preference,
- Poor symptom control with oral oestrogen,
- Oestrogenic side effects on oral oestrogen (nausea, headaches etc.),
- Migraine (simple or complicated),
- Family history of VTE or other VTE risk factors (raised BMI, age etc.),
- Variable blood pressure control, diabetes or other CVD risk factors,
- Current use of liver enzyme inducing medication,
- Gall bladder disease,
- Malabsorption,
- Lactose intolerance and
- Reduced sex drive since starting oral HRT (other causes excluded).

9.5 Follow-up after starting HRT

Patients commenced on HRT or HRT changed should be reviewed after three months. Patients established on HRT should be reviewed at least annually.

Each review should:

- assess current menopausal symptoms (consider using the symptom chart),
- assess compliance, effectiveness and side effects of therapy,
- discuss any vaginal bleeding pattern,
- recheck BP and BMI,
- review HRT type, dosage and route,
- reassess risk/benefit balance, especially considering her VTE, CVD and breast cancer risks,
- check adherence to cervical and breast cancer screening programmes,
- encourage breast awareness,

- encourage lifestyle changes (healthy calcium-rich diet, weight-bearing exercise, no smoking, no or little alcohol) and
- review any contraceptive needs (if appropriate),
- check ICE (ideas, concerns and expectations).

If there is poor response to systemic HRT please consider the following causes:

- wrong expectations around the benefits of HRT,
- oestrogen dose too low or wrong route for individual patient,
- progestogenic SE dominate over oestrogenic benefits (usually worse on sequential than on continuous combined HRT),
- wrong diagnosis- consider other causes of her symptoms (DM, thyroid problems, carcinoid, anxiety, alcohol, spices, mastocytosis, drugs like vasodilators, calcium chancel blocker, steroids, morphine etc.),
- poor compliance or patch adherence issues or absorption issues,
- interfering non- HRT medication like liver-enzyme inducing drugs, including St John's Wort.

There is no arbitrary time limit set to how long a woman can be on HRT. In general, HRT is safe and recommended until the age of the natural menopause (around 51) as it only provides hormones the body would normally produce naturally. The time between the age of 50 and 60 (or 10 years from the start of the menopause) is called "window of opportunity" as HRT is safe for most women. After that time, the risk-benefit ratio changes slowly over time.

10 Assessing abnormal vaginal bleeding in women using systemic HRT

Unscheduled bleeding is a common side effect within the first months of starting cyclical HRT or continuous combined HRT. A patient can therefore usually be reassured and might be given a menstrual chart to fill out which helps to monitor her bleeding (see Appendix 18.4.).

After around three months of unscheduled bleeding on systemic HRT:

- Take her medical, O&G (including smears) and sexual history.
- Do pelvic exam, vulval and cervical inspection.
- Do pregnancy test and sexual health screen (NAAT CT/GC) and do smear if due (if applicable).

Other issues to explore are:

- current bleeding pattern +/- pelvic pain +/- dyspareunia,
- bleeding pattern before the start of HRT,
- previous history +/- investigation for bleeding problems (pre-, peri- and postmenopausal) (?history of polyps or fibroids, ?recent pelvic USS),
- understanding of current HRT regime and compliance ("weaning off" HRT by intermittent use of combined HRT or cutting down combined patches is not recommended),
- HRT type (estradiol-only vs. sequential combined vs. continuous combined HRT: is she on the correct HRT type? risk of breakthrough ovarian activity? subtotal hysterectomy?),
- risk factors of endometrial cancer (obesity, PCOS, DM, tamoxifen etc.),
- drug interactions (including over the counter drugs like St. John's Wort),
- HRT patch adherence (if applicable),
- malabsorption (if applicable),
- license limit of Mirena® IUS (if applicable) (licensed for 4 years as part of HRT, off license but recommended by the FSRH for 5 years max.) (other IUSs are not licensed for endometrial protection as part of HRT),
- position of Mirena® IUS (fundal position or within 2 cm from fundus?) (a normal thread length does no guarantee a correctly positioned device),

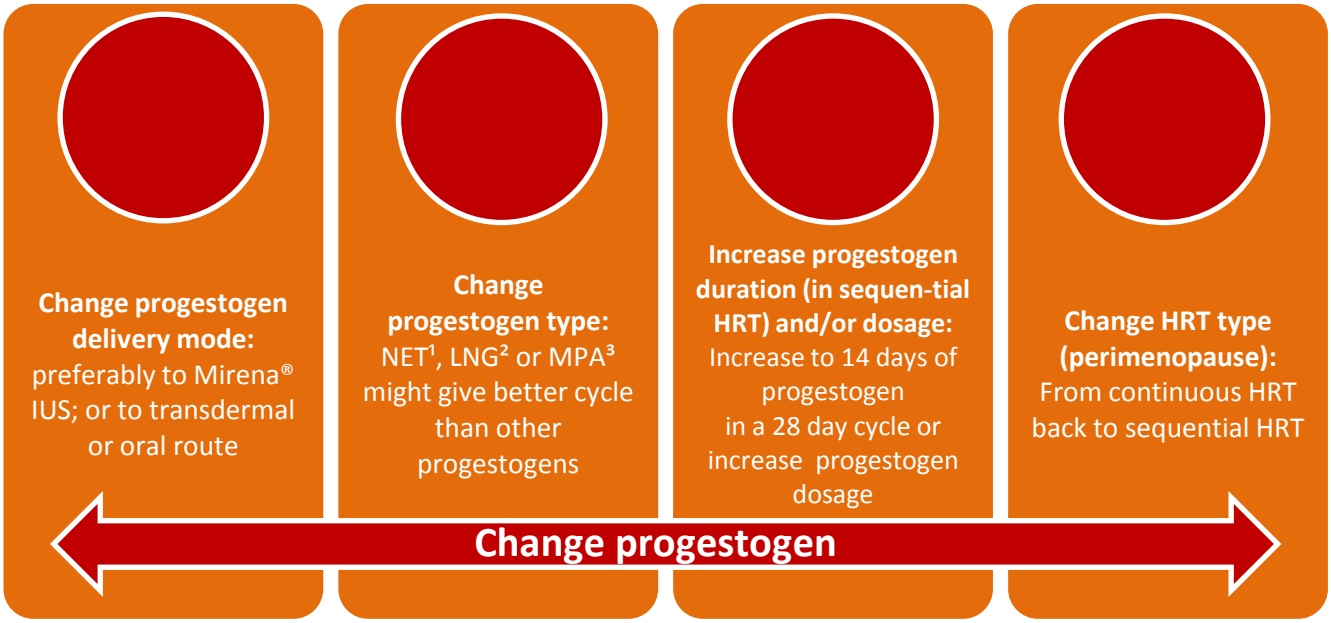
- STIs (causing cervicitis or endometritis) (if applicable),
- local trauma (during sexual intercourse etc.) due to the genitourinary syndrome of the menopause (vulvovaginal atrophy), leading to postcoital bleeding +/- superficial dyspareunia,
- other gynaecological pathology,
- possibility of rectal bleeding or haematuria misinterpreted as vaginal bleeding.

Consider requesting a pelvic USS if her LMP was under one year, especially if she had bleeding problems before starting HRT. One year after her LMP your request is likely to be rejected by the ultrasound department and a referral to the Postmenopausal Bleeding Clinic (gynaecology) is usually recommended.

Consider treating any atrophic vulvovaginal changes with topical estrogen and recommend the use of lubricants, even if already on systemic HRT.

Once any pathology is excluded and the patient is on combined HRT consider the options from Table 8. In general, the best bleeding control is usually achieved using the Mirena® IUS for endometrial protection if acceptable and patient is suitable.

Table 8: Choices in progestogen change



[1] NET: norethisterone
[2] LNG: levonorgestrel
[3] MPA: medroxyprogesterone acetate (Provera®)

If the patient is on continuous combined HRT or a Mirena® IUS (inserted < 5 years) plus estrogen-only HRT and she is bleeding beyond six months of starting or changing HRT or restarting to bleed after a spell of amenorrhoea of six months or more: please refer her urgently to the Post-Menopausal Bleeding (PMB) Clinic, Gynaecology Department, Ninewells Hospital, Dundee.

Please see Appendix 18.3. regarding the different HRT products prescribable in the UK.

Consider treating any atrophic vulvovaginal changes additionally with topical oestrogen and recommend the use of lubricants (see Table 4).

Women on topical oestrogen only are not expected to bleed and any bleeding should be treated like postmenopausal bleeding in women off HRT.

Amenorrhoea (sequential HRT)

Amenorrhoea with sequential HRT occurs in 5% of women and indicates an atrophic endometrium. If applicable check PT and compliance of progestogen intake and consider change to continuous combined HRT.

11 Side effects on systemic HRT: trouble-shooting

In general:

- Find out if side effects are more likely to be oestrogenic or progestogenic (or both).
- Encourage continuation for 3 months as side effects may resolve.
- The IUS (Mirena®) has usually minimal systemic progestogenic side effects.

Table 9: Side effects of HRT

Side effect	Oestrogenic	Progestogenic
Acne	-	+
Anxiety	-	+
Bloating	+	+
Breast enlargement	+	-
Breast tenderness	+	+/-
Depression	-	+
Fluid retention	+	-
Headaches/migraine	+	+
Hirsutism	-	+
Leg cramps	+	-
Lower abdominal/pelvic/back pain	-	+
Mood swings	+/-	+
Nausea	+	-

Table 10: Options for women with progestogenic side effects on HRT

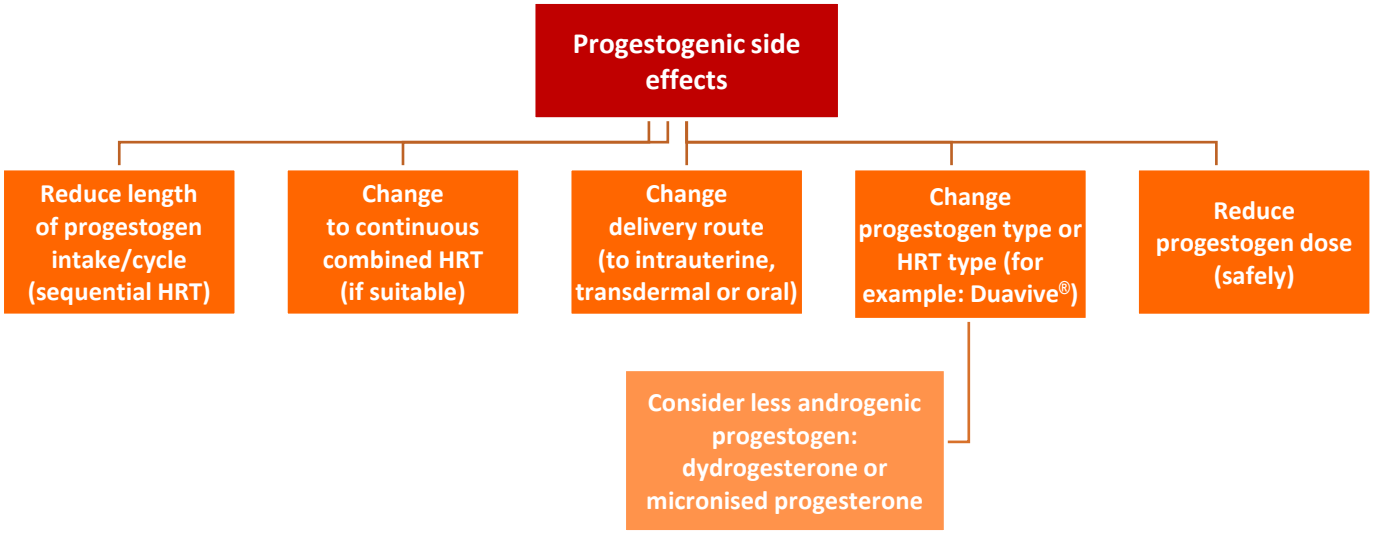


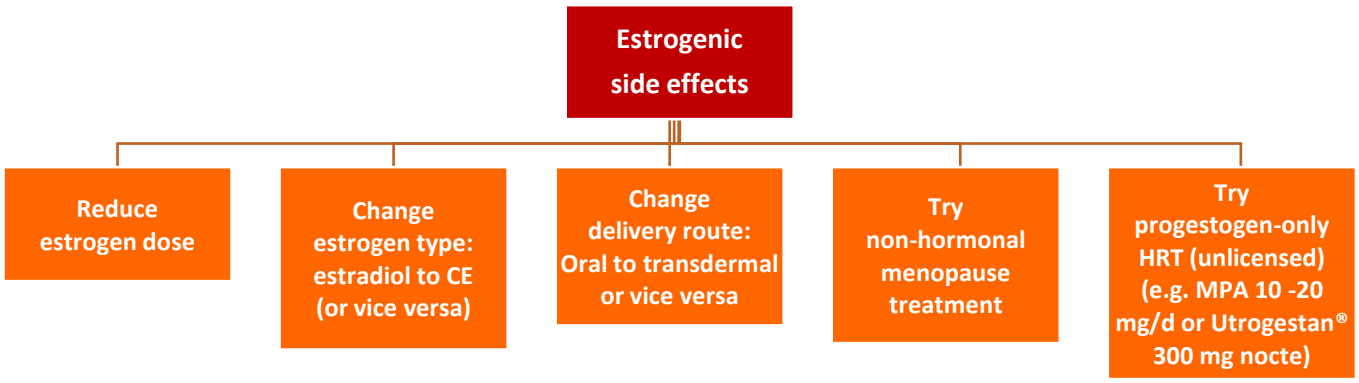
Table 11: Characteristics of different progestogens

Class	Examples	Comment
Synthetic- C19 Testosterone analogues	Norethisterone Norgestrel Levonorgestrel	- Good cycle control - Androgenic - Unfavourable effect on lipids - Only available in combined oral or transdermal preparations as HRT - Systemic absorption of levonorgestrel in women using the Mirena® IUS is minimal
Synthetic- C21 Progesterone analogues	Medroxyprogesterone acetate (MPA) (Provera®)	- Androgenic - Unfavourable effect on lipids - Available as combined HRT or as single tablets for endometrial protection of women on transdermal or oral estradiol - Can be used as progestogen – only HRT (unlicensed)
	Dydrogesterone	- Non-androgenic - Possibly associated with less breast ca, VTE and CVD risk - Currently only available in combined oral HRT
"Bioidentical"	Micronised progesterone (Utrogestan®)	- Fewer side effects - Non-androgenic - No effect on lipids - Possibly associated with less breast ca, VTE and CVD risk - Possibly less effective cycle control - Can be used as progestogen – only HRT (unlicensed) - Can be used vaginally at night (un-licensed), especially if there are side effects - Currently no recommended by the SMC

Utrogestan® (micronised progesterone) is a bioidentical oral progestogen which has a reputation of less progestogenic side effects and might have a lower VTE, CVD and breast ca risk in comparison to Provera® (medroxyprogesterone acetate- MDA) tablets. However, this progestogen is associated with less bleeding control. The recommended dosage is 200 mg po nocte day 15- 26 of a 28-day cycle for sequential HRT or 100 mg po nocte for continuous HRT (unlicensed). As it is slightly more expensive than Provera® (around £15/year) is currently not recommended by the Scottish Medicines Consortium (SMC) and therefore not in the NHS Tayside Formulary.

Duavive® is a new type of HRT which pairs conjugated oestrogen (CE) with a selective oestrogen receptor modulator (SERM) called bazedoxifene acetate. It does not contain a progestogen and is indicated for postmenopausal women with a uterus who are intolerant of progestogens. It has not been submitted yet to the Scottish Medicines Consortium.

Table 12: Options for women with oestrogenic side effects on HRT



Additional specific suggestions for oestrogenic side effects:

- Leg cramps: life style, exercise, stretching of calf muscles
- Breast tenderness/enlargement: low-fat high-carb diet, evening primrose, supportive bra
- Nausea: take tablet at night, take tablet with food, change to transdermal oestrogen
- Migraine: use transdermal oestrogen

12 Stopping systemic HRT

Some tips around stopping HRT:

- Most women require 2-5 years of HRT but some women may need longer.
- There is no arbitrary limit to the length of time a woman can take HRT.
- For those with an early menopause or premature ovarian failure, HRT is recommended up to the age of a natural menopause (51 years).
- On stopping HRT symptoms may recur for a short time.
- VTE risk re-starts if HRT is recommenced after stopping for > 1 month.
- Gradually reducing or immediately stopping HRT makes no difference to symptoms in the long term.
- Gradually reducing HRT may limit recurrence of symptoms in the short term.
- Symptoms of urogenital atrophy often come back when treatment with vaginal oestrogen is stopped and for this reason vaginal oestrogens may be required long term.

13 Alternatives to systemic HRT

Non-hormonal treatment for vasomotor symptoms

HRT is the most effective treatment for menopausal symptoms. Alternative therapies can be useful in women who have a relative or absolute contraindication to HRT or who prefer avoiding HRT. Non-hormonal pharmaceutical treatments are up to 50% effective in reducing vasomotor symptoms of the menopause. Most drugs act quickly: if there is no improvement after 2-4 weeks consider a different approach or changing the medication. Please check the current BNF for more details (dose and frequency, contraindications, side effects etc.).

Table 13: Alternatives to HRT

Treatment	Dose (please check BNF)	Comments
SSRI or SNRI (low dose)	Paroxetine 10-20 mg/d Citalopram 10-20 mg/d Venlafaxine 37.5-150 mg/d (sustained release tablets)	Not first line Tx for vasomotor symptoms alone unless HRT CI or unacceptable
Gabapentin	900mg/d	Concern about risk of drug dependence
Pregabalin	50- 300mg/d	Concern about risk of drug dependence
Clonidine	25-75 mcg BD	Not first line Tx for vasomotor symptoms alone
Exercise	na	Weight-bearing exercise prevents osteo-porosis; outdoor activities helps vitamin D metabolism
Weight loss (women with ↑ BMI)	na	Consider referral to dietician
Cognitive Behaviour Therapy (CBT)	na	Availability limited; self-help book available[6]
Hypnotherapy	na	Availability very limited and for specific indications only[7]
Stellate Ganglion Blockade	na	Availability limited- for severe symptoms only

Herbal Remedies

Herbal alternatives such as isoflavones, black cohosh and St John's Wort may relieve vasomotor symptoms. Multiple preparations are available. However, safety is uncertain. Interactions with other medicines have been reported. Phytoestrogens have shown some benefit but less than traditional HRT and long-term safety is unknown.

Lifestyle

Optimisation of diet and lifestyle advice should be incorporated into routine management of all menopausal women in the transition and in the postmenopausal phase.

14 Contraception in the Perimenopause

The general rules around contraception in the perimenopause are:

- Perimenopausal women can get pregnant (and often have poor outcome).
- HRT is not contraceptive, unless using an Mirena® IUS/estradiol regime.
- Contraception needs to be continued for 2 years after LMP < 50 years and for 1 year after LMP ≥ 50 years.
- If LMP is not known, then contraception can be continued to 55 years by which time most of women will be postmenopausal. Even if bleeding continues after this time, contraception is unlikely to be needed due to the poor quality of eggs.

6 "Managing Hot Flushes and Night Sweats: A cognitive behavioural self-help guide to the menopause" (Myra Hunter 2013). For more info, also see: https://thebms.org.uk/publications/factsheets/cognitive-behaviour-therapy-cbt-menopausal-symptoms/

7 Currently offered at the TSRHS for women with severe vasomotor symptoms of the menopause and absolute medical contraindication to HRT- internal referrals accepted only (via Menopause Clinic)- under review.

- CHC and DMPA may be stopped at 50 years but can be continued if benefits outweigh the risks for that individual, for example in women with heavy menstrual bleeding. HMB. These methods should not be used in conjunction with HRT.
- First line combined hormonal contraception in women over 40 contain 30 mcg EE or less and a second-generation progestogen (LNG, NE) to lower VTE and CVD risks.
- A POP, SDI (Nexplanon®) or Cu-IUD can be used in addition to combined HRT, off license, for contraception.
- Progestogen-only contraception, except for the Mirena® IUS, does not provide endometrial protection for women on HRT.
- Women over 40 with menopausal symptoms who are having amenorrhoea on progestogen-only contraception (including the Mirena IUS®) and who do not wish to continue contraception until the age of 55 could have their FSH checked (two samples in women under 50, at least 6 weeks apart or one sample in women aged 50 or above). FSH results of ≥ 30 IU/l count as "the LMP" – apply the rules mentioned above.
- Women with POI (under the age of 40) who do not want to get pregnant should continue contraception until the age of 42 as they might get intermittent ovarian activity.
- FSH levels unreliable in women on CHC or HRT (for at last 4-6 weeks after stopping) but avoid stopping and starting CHC or HRT for FSH measurements as it increases the VTE risk.
- Take FSH levels in women on DMPA when the DMPA levels are low (just before the next injection is due) as there is a risk of "false negative" (low) FSH results.

Method used	41- 49 years old	≥ 50 years old
Combined hormonal contraception (CHC), Depo-Provera®or SayanaPress® (DMPA)	Continue if satisfied with method & there are no CI	Stop & switch method
Condoms, diaphragms, Cu-IUD or Fertility Awareness Methods	Stop two years after LMP	Stop one year after LMP or at the age of 55*
POP, Nexplanon® SDI or IUS-52 mg (Mirena®)	Continue if happy with method and no CI or stop two years after two FSH levels ≥30 IU/L (least 6 weeks apart)	Stop one year after one FSH level ≥30 IU/L or at the age of 55*

Table 14: Contraception in the Perimenopause

* Independent if still getting period or not (at the age of 55)

For more information: www.fsrh.org/standards-and-guidance/documents/fsrh-guidance-contraception-for-women-aged-over-40-years-2017/

15 Sexuality and the Menopause

Women who are in the menopause can experience sexual difficulties. These may be due to physical symptoms such as vulvovaginal atrophy or emotional issues such as low mood. More often it is a combination of both physical and emotional factors and can be a side effect of commonly used

medication like SSRIs. Clinicians should always ask about sexual difficulties, offer advice (see also Toolbox in Appendix 18.2.) and onward referral to the Sexual Problem Clinic (TSRHS) if necessary.

HRT can help with sexual dysfunction due to the menopause. Testosterone supplementation, usually in addition to HRT, can be considered for treatment of low libido, especially in women after bilateral oophorectomy, but only after a thorough specialist assessment to exclude other causes of the sexual problem. Only rarely is testosterone indicated without trying out HRT first. Testosterone treatment of women is currently unlicensed in the UK.

16 Further information

Websites for clinicians and patients:

1. **British Menopause Society (BMS)**
   Website: https://thebms.org.uk/
   Includes fact sheets, consensus statements and tools for clinicians and information about relevant Scottish and UK CPD courses. Publishes the journal "Post Reproductive Health".

2. **Menopause Matters**
   Website: www.menopausematters.co.uk
   Website about the menopause run by the previous chair of the BMS (Dr Heather Currie) with information for health professionals and patients. Publishes a menopause magazine for patients.

3. **International Menopause Society (IMS)**
   Website: www.imsociety.org/
   Professional website with useful guidelines, recommendations and position statements – check out their "IMPART" educational online tool for basic and more advanced menopause care https://www.imsimpart.com/

4. **Faculty of Sexual & Reproductive Healthcare (FSRH)**
   Website: www.fsrh.org
   Relevant information with regards to contraception in the perimenopause, including the recently updated "Contraception in women over 40" guideline

5. **Royal College of Obstetricians and Gynaecologists**
   Website: www.RCOG.org.uk
   Relevant professional information (Green Top Guidelines about PMS or ovarian cysts in postmenopausal women for example) and for patients (like the PIL "Treatment for Symptoms of the Menopause" (02/18) or the page "Menopause Hub"

6. **Manage My Menopause**
   Website: www.managemymenopause.co.uk
   Manage My Menopause is a new website developed by the Norfolk and Norwich University Hospital (NNUH) and supported by the BMS provides free tailored menopausal advice for women, provided by experts, which then be discussed with their GP.

7. **The Menopause Exchange**
   Website: www.menopause-exchange.co.uk/index.htm
   Another UK based website about the menopause directed at patients run by health care professionals

8. **National Osteoporosis Society**
   Website: www.nos.org.uk
   Useful information about bone health

9. **Women's Health Concern**
   Website: www.womens-health-concern.org
   Patient arm of the British Menopause Society (BMS) with a wide range of downloadable patient information leaflets

10. **The Daisy Network**
    Website: www.daisynetwork.org.uk
    Premature Ovarian Insufficiency (Menopause) Support Group

11. **Sexual Advice Association**
    Website: www.sexualadviceassociation.co.uk
    Professional site with downloadable fact sheets, SMART app etc.

12. **Association of Reproductive Health Professionals**
    Website: www.arhp.org/sexlife/
    Includes a female sexuality self-assessment tool

Books for clinicians:

Management of the Menopause (6th edition) by T. Hillard et al. The essential handbook about menopause care, published by the British Menopause Society 2017.

Managing the Menopause: 21st Century Solutions (1rst edition) by N. Panay et al. Useful additional handbook written by UK experts. Cambridge University Press 2015.

TSRHS Patient Information Leaflets:

Check out the NHS Tayside Staffnet for our information leaflets "Menopause and HRT"(LN1255), "Premature Ovarian Insufficiency and Early Menopause" (LN0680) and "Testosterone Treatment in Women" (LN0863).

17 References

Among the references we used were the two books mentioned above and the following publications:

Baber, R, Panay, N, Fenton, A.: IMS Recommendations on women's midlife health and menopause hormone therapy. Climacteric 2016; 19: 109–150

British Menopause Society: The 2013 British Menopause Society & Women's Health Concern Recommendations on Hormone Replacement Therapy. Menopause International 19(2) 59–68.

British Menopause Society: HRT Guide Post NICE Guidance for Healthcare Professionals 2016 https://thebms.org.uk/_wprs/wp-content/uploads/2016/04/HRT-Guide-160516.pdf

British Menopause Society: Prescribable Alternatives to HRT 2017 https://thebms.org.uk/_wprs/wp-content/uploads/2018/03/Prescribable-alternatives-to-HRT-01EE.pdf

De Villiers, TJ, Hall, JE, Pinkerton, JV: Revised global consensus statement on menopausal hormone therapy. Climacteric 2016; 19: 313–315

Hamoda H et al.: The British Menopause Society and Women's Health Concern 2016 recommendations on hormone replacement therapy in menopausal women. Post Reproductive Health. Vol 22,4. 165-183

Hickey, M, Szabo, RA, Hunter, MS: Non-hormonal treatments for menopausal symptoms BMJ 2017; 359 :j5101

Jane, FM, Davis, SR: A practitioner's toolkit for managing the menopause. Climacteric. 2014 Oct;17(5):564-79 https://www.tandfonline.com/doi/full/10.3109/13697137.2014.929651

Kim, H-K, Kang, S-Y, Chung, Y-J, Kim, J-H, Kim, M-R: The Recent Review of the Genitourinary Syndrome of Menopause. Journal of Menopausal Medicine. 2015;21(2):65-71

Lal, V, Mamoojee, YH, Quinton R: Non-menopausal endocrine and non-endocrine causes of flushing and sweating. Post Reprod Health. 2017 Dec;23(4):177-182

National Institute of Health and Care Excellence (NICE) Guideline: Menopause (NG 23) https://www.nice.org.uk/guidance/ng23

North American Menopause Society: Nonhormonal management of menopause-associated vasomotor symptoms: 2015 position statement of the North American Menopause Society. Menopause 2015 ;359: 1155-72

North American Menopause Society: The 2017 hormone therapy position statement of The North American Menopause Society. Menopause. 2017 Jul;24(7):728-753

Stuenkel, CA, Davis, SR, Gompel, A: Treatment of symptoms of the menopause: an endocrine society clinical practice guideline. J Clin Endocrinol Metab 2015; 100: 3975–4011

18 Appendix

18.1. Menopause Symptoms Chart

TSRHS Menopausal Symptoms Questionnaire

Name: **Date:**

Sticker or CHI number:

Current hormonal and/or non- hormonal treatment for menopausal symptoms:

Please mark a box with a tick (✓) to show if and how much you have been troubled by any of these symptoms over the past four weeks:

Symptoms	Not at all	A little	Quite a bit	A lot
Vasomotor symptoms				
1. Hot flushes during the day				
2. Sweating at night				
Emotional symptoms				
3. Feeling tired or lacking in energy				
4. Loss of interest in most things				
5. Feeling unhappy or depressed				
6. Crying spells				
7. Feeling tense or nervous				
8. Irritability				
9. Panic attacks				
10. Difficulty in concentrating				
11. Difficulty in sleeping not relating to sweats				
Local and sexual symptoms				
12. Dryness or soreness of vulva and/or vagina				
13. Discomfort on passing urine				
14. Discomfort during sexual intercourse				
15. Loss of interest in sex (libido)				
Other symptoms				
16. Headaches				
17. Pressure or tightness in head or body				
18. Parts of body feel numb or tingling				
19. Muscle and joint pains				

Thank you very much for filling out this form!

18.2. Sexual Health Toolbox

Sex, women and the menopause:
a sex advice tool box for Tayside Sexual & Reproductive Health Service patients

Websites (adult sex education and sex advice):

- **"Sexual Advice Association"**: http://sexualadviceassociation.co.uk/factsheets/ . See the easy-to-read fact sheets and patient booklets covering many different male and female sexual health problems written by UK professionals. They also publish a useful app.
- **"Jo Devine**": www.jodevine.com. Online UK-based luxury sex toy shop, co-founded by a nurse. There are lots of articles on the "sexual health" tabs for women and men on how painful sex, sexual problems, sex when having medical problems, sex after the menopause etc.
- **"Association of Reproductive Health Professionals"**: www.arhp.org/topics/sex-and-sexuality and www.arhp.org/topics/menopause. Check out the "Patient resources" pages, including the subscription to the "Sex and the healthier you" website and e-newsletter, the "Size up your sex life" self-assessment tool and other patient resources.
- **"Sexuality.about.com"**: www.sexuality.about.com. Check out the informed, informative and very open website of the psychologist, sex therapist and sex educator Cory Silverberg.
- **"Menopause Matters":** www.menopausematters.co.uk. Evidence-based information and a magazine published by Dr. Heather Currie, a Scottish menopause specialist, about menopause including vaginal health.
- **"North American Menopause Society: Sexual problems at midlife"**: www.menopause.org/for-women/sexual-health-menopause-online. Comprehensive website with lots of easy-to-read information about sexual health in the menopause.

Books and DVDs (adult sex education):

- General information- books and DVDs:

- **"Naked at our age- speaking out loud about senior sex"** by Joan Price. Seal Press, 2011. Excellent, sex-positive read about enjoying a healthy sex life after the age of 50. Also available as audiobook.
- **"Sex: A Lover's Guide: The Ultimate Guide to Physical Attraction, Love-Making Techniques and Sexual Relationships with Over 1000 Photographs"** (Southwater, 2015) by N.Lacroix and J. Bastyra. Very visual guide written by a sex therapist.
- **"Sexual Intelligence- What we really want from sex and how to get it"** by Dr. Marty Klein. HarperOne, 2013. Essential read to review your concept of sex and sexuality and how to lead a happy sex life. Also available as audiobook.
- **"Getting It on"** by P.Joannides (Goofy Foot Press, 2017). Comprehensive sex guide written by a recognised sex educator/psychoanalyst which has a light- hearted approach and uses cartoon-style illustrations.
- **The Sex Book"** by S. Godson and M.Agace. Cassell Illustrated, 2006. Beautifully illustrated in pop art style and well researched book full of information about sex and with lots of personal quotes from the UK.

- **"The Good Vibrations Guide to Sex"** by C.Winks et P.Gloeckner, 2002. Informative sex guide embracing, among others, sexual diversity.
- **"Massage Secret for Lovers- the ultimate guide to intimate arousal"** by Dr. Andrew Stanway (Quadrille, 2002). Well illustrated guide about of sex, intimacy and connection beyond intercourse. Another similar guide (still using picture from its first edition in the seventies though) is **"Art of Sensual Massage"** by G.Inkeles (Arcata Arts, 2011) which is also available as DVD.
- **"The Lover's Guide- Interactive"** (Sony Picture Home Entertainment, 2008). Adult sex education DVD with real couples.
- **"Sinclair Institute"** website: www.sinclairinstitute.com. Check out under "Instructional" for their informative adult sex education DVDs (e.g. the "Better Sex" series) and extensive library (from the US, international shipping available).
- **"Ageless Erotica"** by Joan Price (editor). Seal Press, 2013. Anthology of erotic stories and memoir essays written for a "mature audience".

- Self-help books:

- **"Becoming orgasmic- a sexual and personal growth programme for women**" by J.R.Heiman and J.LoPiccolo. Piatkus, 2009. Excellent book about much more than becoming orgasmic.
- **"Rekindling desire"** (2.ed., Routledge, 2014), **"Sexual Awareness- your guide to healthy couple sexuality"** (Routledge, 2012) and **"Discovering your couple sexual style: sharing desire, pleasure and satisfaction"** (Routledge, 2009) by Dr. Barry and Emily McCarthy. Highly regarded guides to help couples to improve or rediscover their sexuality.
- **"Relate Guide to Sex in Loving Relationships" (Relate Series)** by S. Litvinoff. Vermilion, 2001. Readable guide which includes practical exercises.

Online shopping for sex toys and vaginal dilators (trainers):

- **"Jo Devine**": www.jodevine.com. Online UK-based luxury sex toy shop, co-founded by a nurse, selling a range of beautiful sex toys for women and men and also graded vaginal dilators made of soft, silky material. Also includes lots of sexual health information (see above).
- **"FPA Pleasure":** www.fpapleasure.co.uk/. Professionally-run, low-key sex shop which also includes useful articles and supports the charity FPA (Family Planning Association).
- **"Sh!"-** women-only sex shop (and online shop) situated in London. Sell sets of vibrating silicone vaginal dilators/trainers. Also organises erotic classes. http://www.sh-womenstore.com/
- **"Coco de mer"**: www.coco-de-mer.com/ . Luxury sex shop for special occasions. Offers also lingerie and erotic fiction.
- **Soul Source silicone vaginal dilators:** more comfortable than the Amielle plastic dilators available on the NHS. Can be warmed up, available in 8 sizes. Sold single or as sets at: www.pelvicrelief.co.uk/product/soul-source-silicone-small-set/

Tayside Sexual & Reproductive Health Service offers psychosexual therapy for sexual problems of men and women referred by their GP

18.3. HRT Prescription Charts

Hormone Replacement Therapy: pharmacological content

(NHS Tayside Formulary "first choice" HRT in each category is in dark green, other Formulary HRT preparations are in yellow)

Type	Route	Estrogen	Progestogen	PV Bleed	Brand	Comment
Sequential Combined Therapy	**Patches**	Estradiol 50 mcg/d	Norethisterone 170 mcg/d	Monthly	**Evorel Sequi®**	Twice weekly change, 14 d E + 14 d E & P
		Estradiol 50 mcg/d	Levonorgestrel 10 mcg/d	Monthly	**FemSeven Sequi®**	Weekly change, 14 d E + 14 d E & P
	Tablets	Estradiol 1 mg	Norethisterone 1mg	Monthly	**Elleste-Duet® 1 mg**	16 d E + 12 d E & P
					Climagest® 1 mg	16 d E + 12 d E & P
					Novofem®	16 d E + 12 d E & P
		Estradiol 1 mg	Dydrogesterone 10mg	Monthly	**Femoston® 1/10**	14 d E + 14 d E & P
		Estradiol 2 mg	Norethisterone 1mg	Monthly	**Elleste-Duet® 2 mg**	16 d E +12 d E & P
					Climagest® 2 mg	16 d E + 12 d E & P
					Clinorette®	16 d E + 12 d E & P
		Estradiol 2mg	Norgestrel 500 mcg	Monthly	Cyclo-progynova®	11 d E + 10 + 7 d pill-free interval
		Estradiol 2 mg	Dydrogesterone 10 mg	Monthly	**Femoston® 2/10**	14 d E + 14 d E & P
		Estradiol 2 mg	Medroxyprogestrone 20 mg	Quarterly	Tridestra®	70 d E + 14 d E & P + 7 d placebo tablets
		Estradiol 2/2/1 mg	Norethisterone 1 mg	Monthly	Trisequens®	12 d E + 10 d E & P + 6 d E
		Conj. oestrogens 625 mcg	Norgestrel 150 mcg	Monthly	Prempak-C® 0.625	28 d CE + 12 d CE & P
		Conj. oestrogens 1.25 mcg	Norgestrel 150 mcg	Monthly	Prempak-C® 1.25	28 d CE + 12 d CE & P
Continuous Combined Therapy	**Patches**	Estradiol 50 mcg/d	Norethisterone 170 mcg/d	None	**Evorel Conti®**	Twice weekly change
		Estradiol 50 mcg/d	Levonorgestrel 7 mcg/d	None	FemSeven Conti®	Weekly change
	Tablets	Estradiol 0.5 mg	Dydrogesterone 2.5 mg	None	**Femoston conti® 0,5/2,5**	Lowest dose oral estrogen on the market
		Estradiol 1 mg	Dydrogesterone 5 mg	None	**Femoston conti® 1/5**	
		Estradiol 1 mg	Drospirenone 2 mg	None	Angeliq®	Possible ↑K
		Estradiol 1 mg	Norethisterone 0.5mg	None	Kliovance®	
		Estradiol 1 mg	Medroxyprogesterone 2.5 mg	None	Indivina® 1 mg/2.5 mg	Licensed to start 3 years of menopause.
		Estradiol 1 mg	Medroxyprogesterone 5 mg	None	Indivina® 1 mg/5 mg	Licensed to start 3 years of menopause.
		Estradiol 2 mg	Norethisterone 1mg	None	**Elleste Duet Conti®**	
					Kliofem®	
					Nuvelle Continuous®	
		Estradiol 2 mg	Medroxyprogesterone 5 mg	None	Indivina® 2 mg/5 mg	Licensed to start 3 years of menopause.
		Conjungated oestrogens 300 mcg	Medroxyprogesterone 1.5 mg	None	Premique low dose®	"Normal dose" Premique® (625 mcg/ MDPA 5 mg) has been discontinued
Gonado-mimetics	**Tablets**		**Tibolone** (2.5 mg)	None	**Livial®**	Induce bleeding if on other HRT before starting. Higher CVD risk for women >60.

Hormone Replacement Therapy: pharmacological content (cont.)

(NHS Tayside Formulary "first choice" HRT in each category is in dark green, other Formulary HRT preparations are in yellow)

Type	Route	Oestrogen	Brand	Comment
Unopposed Oestrogen*	**Tablets**	Estradiol 1 mg	**Elleste- Solo® 1 mg** Climaval® 1 mg Progynova® 1 mg Zumenon® 1 mg	
		Estradiol 2 mg	**Elleste- Solo® 2 mg** Bedol® Climaval® 2 mg Progynova® 2 mg Zumenon® 2 mg	
		Conj. oestrogen 300 mcg Conj. oestrogen 625 mcg Conj. oestrogen 1.25 mg	Premarin® 300 mcg Premarin® 625 mcg Premarin® 1.25 mcg	
	Patches**	Estradiol 25 mcg	**Evorel®** Estraderm MX® Estradot®	Twice weekly change Twice weekly change Twice weekly change
		Estradiol 37.5 mcg	Estradot®	Twice weekly change
		Estradiol 40 mcg	Elleste Solo MX®	Twice weekly change
		Estradiol 50 mcg	**Evorel®** **FemSeven®** Estraderm MX® Estradot® Progynova TS®	Twice weekly change Weekly change Twice weekly change Twice weekly change Weekly change
		Estradiol 75 mcg	**Evorel®** **FemSeven®** Estraderm MX® Estradot®	Twice weekly change Weekly change Twice weekly change Twice weekly change
		Estradiol 80 mcg	Elleste Solo MX®	Twice weekly change
		Estradiol 100 mcg	**Evorel®** **FemSeven®** Estraderm MX® Estradot® Progynova TS®	Twice weekly change Weekly change Twice weekly change Twice weekly change Weekly change
	Gel***	Estradiol (0.06%) Estradiol 500 mcg Estradiol 1 mg	**Oestrogel®** Sandrena® Sandrena®	Pump: 1-4 pumps/day (0.75mg- 3mg) Sachets: 0.5-1.5 mg/day Sachets: 0.5- 1.5 mg/day

* Women with a uterus require cyclical progesterone 12-14 days per 28 day cycle or continuous progesterone, depending on their menopausal status.

** All patches (except the weekly FemSeven® and ProgynovaTS® patches) should be used continuously, changed twice weekly and started within five days of period (or any time if cycle has ceased or periods infrequent). Recommended application sites are on clean, dry, healthy, intact skin and each application should be made to a slightly different area of skin on the trunk below waistline (abdomen, hip or buttock).

*** Apply to intact dry skin (lower trunk, tights, arms, shoulders) over an area of 1-2 times size of hand. Avoid breast and vulval area. Let dry for 5 min before covering with clothing. No washing, use of other skin products or skin contact to another person for over an hour afterwards. Wash hands.

Hormone Replacement Therapy- adjunctive progestogens: pharmacological content

(NHS Tayside Formulary "first choice" HRT in each category is in dark green)

Type	Route	Progestogen	Brand	Comment
Adjunctive progestogens	**Tablets or capsules**	Progesterone (micronized)	Utrogestan® 100 mg Utrogestan® 200 mg	Take capsules at bedtime on empty stomach. 200 mg nocte day 15-26 of 28 day cycle 100 mg/d nocte 1-25 of 28 day cycle or, preferably, 100mg nocte continuously (unlicensed). Can be used vaginally (unlicensed)- ?less SE. CVD and breast friendly progestogen. Progestogen- only HRT: 300 mg nocte (unlicensed) Not recommended by SMC as slightly more expensive than MPA (£15/year)
		Medroxyprogesterone Acetate (MPA)	***Provera® 2.5 mg*** ***Provera® 5 mg*** ***Provera® 10 mg*** Climanor® 5 mg	Sequential HRT: 5- 10 mg/d day 15-28 of each 28-day cycle for endometrial protection (14 days) (licenced) Continuous HRT: 2.5mg OD (with 1mg of estradiol po or 25 mcg/d patch) or 5 mg OD (with 2 mg estradiol po or ≥ 50 mcg/d patch) for endometrial protection (unlicensed) Progesterone only HRT for vasomotor symptoms: 10- 20 mg/d (unlicensed)
	IUS (intrauterine system)	Levonorgestrel (LNG) (20 mcg/ 24h)	***Mirena®***	Licensed for 4 years, unlicensed use for 5 years endorsed by the FSRH. Jadess®, Kyleena® and Levosert® are not licensed for endometrial protections and not recommended for use as part of HRT.

18.4. Menstrual Chart

Menstrual Record Chart

Patient:

CHI No:

Year:

Month	1	2	3	5	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															
Jul																															
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															

Type of vaginal bleeding: **X Normal** **+ Light** **■ Heavy (clots/ flooding)** **★ Spotting** **✓ Bleeding after sex**

Severity of pelvic pain: **1-5: From 1 for mild pain to 5 for severe pelvic pain**

Please don't forget to take this chart with you when you visit your doctor or nurse.