NICE: Menopause, Diagnosis and Management – from Guideline to Practice

Guideline Summary

Why?

It is very clear that women live many years after their ovaries stop producing estrogen and the lack of estrogen can have significant short and long term effects. In the past there has been much confusion about the menopause and treatment options: clarity was needed and has now been provided.

Aim

To provide advice for healthcare professionals and women regarding the menopause and the way symptom relief can be achieved.

Ten key messages

1 Individualisation

All women are different and respond differently both to estrogen deficiency and in their response to treatments. Decisions have to be made on an individual basis, taking into account symptoms, past history, family history, diet and lifestyle and individual preferences and concerns.

2 Diagnosis

Blood tests are rarely required to diagnose perimenopause or menopause in women aged over 45 and should not be taken. While measurement of FSH has often been used in the past to diagnose perimenopause or menopause, the level fluctuates significantly and bears no correlation with severity or duration of symptoms or to requirement for treatment. Reducing inappropriate use of testing FSH levels will produce savings in terms of cost of test, time for further consultation to discuss the results and will reduce delay in commencing agreed management.

3 Provision of information

Emphasis is made on the importance of explaining to women about the stages and many consequences of the menopause, which extends beyond flushes and sweats and includes psychological symptoms, musculo-skeletal, vaginal, bladder and sexual effects, as well as long term effects on bone and cardiovascular health. Note is also made of the need for contraception during the perimenopause and the importance of providing appropriate information for women who are about to undergo treatment which may lead to menopause. Much work is needed to provide this information in many formats such as websites, leaflets, magazines, as well as traditional face to face consultations.

4 Management

Diet and lifestyle advice should be considered, particularly smoking cessation, weight loss, alcohol reduction and increasing exercise to help general health and well-being and all treatment types should be discussed.

For vasomotor symptoms such as flushes and sweats, HRT should be offered after full consideration of benefits and risk, since it was shown to be the most effective treatment with minimal risks. The type will be determined by whether or not the woman has had a hysterectomy, whether perimenopausal or postmenopausal, past medical and family history, other medication and individual preferences. Clonidine or antidepressants should not routinely be offered. Of the non-hormonal therapies, isoflavones or black cohosh have been shown to be helpful but consideration should be given to the fact that not all preparations contain the same amount or quality of product.

For low mood due to menopause, HRT should be considered rather than antidepressants, and Cognitive Behavioural Therapy can be helpful.

For low sexual desire, testosterone can be considered if HRT alone is not sufficient.

5 Management of symptoms after breast cancer

Women who have had breast cancer or who are thought to be at high risk of breast cancer and who have menopausal symptoms should be offered a discussion about all treatment options. Of the non-hormonal options, St John's Wort may be used but it should be noted that it may interact with other medications. The antidepressants Fluoxetine and Paroxitene, which have been often used in the past for vasomotor symptoms, should not be

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used in women also taking Tamoxifen since interactions can occur, reducing the effectiveness of Tamoxifen. Women who are at risk of breast cancer should receive care from a healthcare professional with expertise in menopause care.

6 Urogenital atrophy

It is well recognised that estrogen deficiency can cause significant vaginal and bladder problems yet is hugely under-recognised and under-treated. It is recommended that vaginal estrogen should be offered and used long term with no concerns about risks, since absorption around the body is extremely low. For some women taking HRT, vaginal estrogen may be required in addition and can also be considered in women who may have medical problems for which there would be concern about using HRT. Vaginal lubricants and moisturisers can also be used along with vaginal estrogen.

7 Review and referral

Review should be arranged with a healthcare professional three months after commencing HRT and, once settled on treatment, annually thereafter. Referral to a healthcare professional with expertise in menopause should be considered for women who have a complex medical history when it is uncertain if HRT can be used, if persistent side effects on treatment occur or if there is poor symptom control.

8 Starting and stopping HRT

HRT can be commenced for vasomotor symptoms or low mood or anxiety that is menopause related. Since we cannot predict how long symptoms will last, there should be no arbitrary limits for duration of use of HRT and previously held views that HRT should be stopped after 2 to 5 years or at the age of 60 are not backed up. When women do decide to have a trial cessation of HRT to see if it is still required for symptom control, either stopping suddenly or gradually makes no difference to whether or not symptoms will return.

9 Long term benefits and risks of HRT

While for many women HRT used appropriately provides more benefits than risks, it is important to understand benefits and risks, which will vary from woman to woman, being strongly influenced by her baseline risk which is affected by diet, lifestyle, past medical and family history.

Blood clot (Venous thromboembolism--VTE)—small increased risk with tablet but not transdermal (patch or gel) HRT. Transdermal should be offered to women at high risk for VTE, including those with Body Mass Index over 30.

Cardiovascular disease--no increased risk when started under age of 60. Appears to be a small increased risk of stroke with tablet but not transdermal HRT but baseline risk in women under age of 60 is very small. Studies have shown that starting HRT before the age of 60, or within 10 years of the menopause may reduce the risk of heart disease, but evidence so far is not strong enough to confirm this.

Diabetes—HRT does not affect risk of developing diabetes and is unlikely to affect glucose control.

Breast cancer—HRT does not affect risk of dying from breast cancer. HRT with estrogen alone is associated with little or no increased risk of breast cancer. HRT with estrogen and progestogen can be associated with a small increased risk of breast cancer which is related to duration of treatment and risk reduces after stopping HRT. The view is that HRT may promote the growth of breast cancer cells in some women which are already present, rather than cause cancer to develop. It is unclear whether or not different types of progestogen are associated with different risks. It should also be noted that being overweight and alcohol consumption (more than 14 units per week) is associated with greater risks than HRT.

Osteoporosis—HRT reduces the risk of osteoporotic fracture, the benefit being maintained while HRT is taken.

Dementia—the likelihood of HRT either reducing or increasing risk of dementia is unknown.

Sarcopenia—muscle mass and strength decrease with age and can affect risk of falling and daily living. There is a possibility that HRT may have a beneficial effect in improving muscle strength and mass but this is not certain.

10 Premature Ovarian Insufficiency

Women experiencing menopause under the age of 40 with menopausal symptoms and absent or infrequent periods should have diagnosis confirmed by 2 blood tests for FSH level taken 4 to 6 weeks apart. Hormone replacement in the form of HRT or the combined contraceptive pill should be offered and recommended to be continued at least until the average age of the menopause (51 years), unless there is a contraindication to the use of hormone therapy. Use up to the average age of the menopause is required for bone and cardiovascular health as well as for symptom control. Both HRT and combined contraceptive pill provide bone benefit, but HRT may have a better effect on blood pressure. HRT should not be relied upon for contraception.

BMS British Menopause Society

Ten key messages condensed

1. Provide evidence based information about menopause and treatment options and help women make informed, individual decisions about menopause management
2. Do not use blood tests to diagnose perimenopause or menopause in women over age 45
3. Offer HRT first line for menopause related vasomotor symptoms and low mood
4. Do not routinely offer clonidine or antidepressants
5. Do not use Fluoxetine or Paroxetine in women taking Tamoxifen
6. Offer long term vaginal estrogen for urogenital symptoms, even if taking HRT
7. Understand appropriate review and when to refer
8. Support women to choose when to stop HRT, do not choose arbitrary limits
9. Use pictorial charts to discuss long term risks and benefits of HRT
10. Do use blood tests to confirm diagnosis of POI and offer hormonal treatment up to average age of menopause at least

Resources

For healthcare professionals — www.thebms.org.uk
For women — www.womens-health-concern.org
www.menopausematters.co.uk
www.managemymenopause.co.uk

Women's Health Concern

For further details – please visit

www.thebms.org.uk or telephone **01628 890 199**

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