The specialist authority for menopause & post reproductive health

British Menopause Society

Menopause Practice Standards

Produced by:

British Menopause Society (BMS)
Royal College of Obstetricians and Gynaecologists (RCOG)
Society for Endocrinology (SfE)
College of Sexual and Reproductive Healthcare (CoSRH)
Faculty of Pharmaceutical Medicine (FPM)
Royal Pharmaceutical Society (RPS)

The Menopause Practice Standards provide evidence-based recommendations and guidance on best practice menopause care. The standards support healthcare professionals to deliver menopause care in line with current national and international guidelines and recommendations.

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Standard 1:

In women aged 45 years and over presenting with menopausal symptoms, the diagnosis of perimenopause or menopause should be considered based on their symptoms alone, without confirmatory blood tests unless uncertainty about the diagnosis.

- The diagnosis should be based on symptoms experienced and there is no indication for laboratory testing (FSH, estradiol) to confirm unless uncertainty about the diagnosis or suspicion of other pathology.
- The average age of the menopause in the UK is 51 with a normal range of 45-55.
- The menopause transition can have a significant impact on many women, with more than 75% experiencing menopausal symptoms, a quarter describing severe symptoms and a third experiencing long-term symptoms.
- A significant proportion of women may experience troublesome menopausal symptoms while still perimenopausal (the phase proceeding the menopause where women experience menstrual cycle irregularities +/- menopausal symptoms) and the latter should be considered when assessing women.
- A wide range of menopausal symptoms have been reported. Commonly experienced menopausal symptoms include the following:
  Vasomotor symptoms - including hot flushes/night sweats
  Cognitive symptoms and mood disorders - low mood, labile mood, anxiety, irritability, loss of confidence, low self-esteem, difficulties with short-term concentration and memory/'brain fog' and difficulties in multi-tasking
  Menopause and perimenopause should be considered in women with mood disorders experienced de-novo during the menopause transition in the absence of pre-existing depression/anxiety
  Sleep disturbance - insomnia and disturbed sleep
  Fatigue, tiredness and low energy levels
  Loss of sexual desire and libido
  Joint and muscle pain
  Headaches
  Genitourinary symptoms - vaginal dryness, irritation, discomfort, burning, itching, dyspareunia. This may also include urinary symptoms such as urinary frequency urgency, dysuria and recurrent lower urinary tract infections
  Genitourinary symptoms may present a number of years after the menopause and should be considered in women who experience the above symptoms.
  Reduced quality of life - as a result of the symptoms above, as well as the detrimental effect on relationships and women's working life.

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Structure:

1. Follow national recommendations or implement local guidance that women aged 45 years and over presenting with menopausal symptoms are diagnosed as being perimenopausal or menopausal based on their symptoms alone, without confirmatory blood tests.

2. Follow national recommendations or implement local guidance that there is no indication for laboratory testing (FSH, estradiol) to confirm the diagnosis unless uncertainty about the diagnosis.

Outcome:

Proportion of women aged 45 years and over presenting with menopausal symptoms are diagnosed as being perimenopausal or menopausal based on their symptoms alone, without confirmatory blood tests.

Standard 2:

Women presenting with menopausal symptoms should be made aware of resources available for guidance and should be encouraged to seek help for managing their menopausal symptoms.

- All women should be able to access accurate advice on how to optimise their menopause transition and the years beyond.
- Women should be made aware of resources available for guidance. Links for such information are included below:
  https://thebms.org.uk/
  https://thebms.org.uk/publications/videos/bms-tv/
  https://www.nice.org.uk/guidance/ng23/resources/menopause-pdf-718895758021
  https://www.womens-health-concern.org/
  https://www.rcog.org.uk/en/patients/menopause/
  https://www.yourhormones.info/
  https://www.pcwhs.co.uk
  https://rockmymenopause.com/
  https://www.rcn.org.uk/clinical-topics/womens-health/menopause
  https://www.menopausematters.co.uk/
  https://www.daisynetwork.org/
  https://journals.sagepub.com/doi/pdf/10.1177/2053369120957514
  https://thebms.org.uk/find-a-menopause-specialist/

Structure:

Follow national recommendations or implement local guidance that women presenting with menopausal symptoms are made aware of resources available for guidance and offered access to such information.

Outcome:

Proportion of women presenting with menopausal symptoms made aware of resources available for guidance and offered access to such information.

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Standard 3:

Women aged 45 years and over who seek help for managing their menopausal symptoms should be offered treatment after information and support to make an informed decision about their management options.

- There should be a holistic and individualised approach in assessing and advising women, with particular reference to lifestyle advice and dietary modification including optimising weight, stopping smoking, exercising, healthy diet and reducing alcohol consumption. It should also include advice on risk factors for cardiovascular disease (including raised blood pressure, raised cholesterol and obesity), advice on bone health and osteoporosis as well as cancer risk reduction, in addition to management options including HRT or non-hormonal and alternative therapies.
- Women who wish to have HRT should be offered treatment (if not contraindicated) after counselling about the benefits and risks of HRT. Women should be provided information and given sufficient time to make an informed decision.
- Women should be informed that HRT compared with placebo has been consistently shown to improve menopausal symptoms and overall quality of life and remains the most effective treatment for menopausal symptoms for most women.
- The decision whether to take HRT, the dose of HRT used, regimen and the duration of its use should be made on an individualised basis after discussing the benefits and risks with each patient and supplying the patient information leaflet for the product selected. This should be considered in the context of the overall benefits obtained from using HRT including symptom control and improving quality of life as well as considering the bone and potential cardiovascular benefits associated with HRT use.
- Transdermal administration of estradiol is unlikely to increase the risk of venous thrombosis or stroke above the risk in non-users and is associated with a lower risk compared with oral administration of estradiol. The transdermal route should therefore be considered as the first-choice route of estradiol administration in women with related risk factors.
- Alternative treatments and non-hormonal options should be discussed with women who are unable to take or do not wish to take HRT.

Structure:

1. Follow national recommendations or implement local guidance that women aged 45 years and over who seek help for managing their menopausal symptoms are offered treatment after information and support to make an informed decision about their management options.

2. Follow national recommendations or implement local guidance that women who seek help for managing their menopausal symptoms should be offered advice regarding lifestyle and dietary modification, advice on risk factors for cardiovascular disease, advice on bone health and osteoporosis, advice on reducing cancer risk, in addition to management options including HRT or non-hormonal and alternative therapies.

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3. Follow national recommendations or implement local guidance that women aged 45 years and over who seek help for managing their menopausal symptoms and who wish to have HRT should be offered treatment (if not contraindicated) after counselling about the benefits and risks of HRT. Women should be provided information and given sufficient time to make an informed decision. Alternative treatments and non-hormonal options should be discussed with women who are unable to take or do not wish to take HRT.

4. Follow national recommendations or implement local guidance to indicate that the transdermal route of estradiol administration should be considered as the first-choice route of estradiol administration in women with increased risk of thrombosis including women with raised BMI who wish to take HRT.

Outcome:

1. Proportion of women aged 45 years and over who seek help for managing their menopausal symptoms offered treatment after information and support to make an informed decision about their management options.

2. Proportion of women who seek help for managing their menopausal symptoms offered advice regarding lifestyle, dietary modification, advice on risk factors for cardiovascular disease, bone health and osteoporosis, cancer risk reduction, in addition to management options including HRT or non-hormonal and alternative therapies.

3. Proportion of women aged 45 years and over who seek help for managing their menopausal symptoms who wish to have HRT, are being offered HRT (if not contraindicated).

4. Proportion of women with increased risk of thrombosis who wish to take HRT are being offered transdermal estradiol.

Standard 4:

Women with genitourinary symptoms of the menopause should be offered vaginal estrogen treatment and this can be continued long term as required to relieve symptoms.

Genitourinary symptoms of the menopause have been reported to be experienced by approximately 50% of postmenopausal women. Topical vaginal estrogen treatment has been shown to be effective in improving symptoms related to vaginal atrophy, such as vaginal dryness and superficial dyspareunia.

Low-dose vaginal estrogen preparations can be used by symptomatic women and continued for as long as required. All topical estrogen preparations have been shown to be effective in this context.

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There is no requirement to combine vaginal estrogens with systemic progestogen treatment for endometrial protection, as low-dose vaginal estrogen preparations do not result in significant systemic absorption or endometrial hyperplasia.

Women with genitourinary symptoms of the menopause can use moisturisers and lubricants alone or in addition to vaginal estrogen.

Structure:
Follow national recommendations or implement local guidance that women with genitourinary symptoms of the menopause should be offered vaginal estrogen treatment and this can be continued long term as required to relieve symptoms.

Outcome:
Proportion of women with genitourinary symptoms of the menopause offered vaginal estrogen treatment.

Standard 5:

Women having treatment for menopausal symptoms should ideally have a review 3 months after starting treatment and should continue to be reviewed at least annually after that.

- The objective of the review would include assessment of the following:
  – Symptom management
  – Side effects (such as nausea, breast discomfort and bloating)
  – Basic health checks including measuring weight and blood pressure
  – Changes to dosage or preparation can be considered, if required
  – Discussion of routine cervical and breast screening in accordance with NHS Screening Programme guidance
- Once optimal replacement is achieved, further interval reviews should be considered at least once a year.
- More frequent reviews may be needed depending on the woman's response to treatment and her medical background and the option of patient initiated follow-up appointments should be offered where feasible.

Structure:
Follow national recommendations or implement local guidance that women having treatment for menopausal symptoms should ideally have a review 3 months after starting treatment and should continue to be reviewed at least annually after that.

Outcome:
1. Proportion of women having treatment for menopausal symptoms reviewed 3 months after starting treatment.

2. Proportion of women having ongoing treatment for menopausal symptoms being reviewed at least annually.

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Standard 6:

Duration of treatment should be individualised. No arbitrary limits should be placed on the dose of HRT, duration of usage or age of women taking treatment.

Cochrane analysis suggests that HRT (estrogen with or without progestogen) started before the age of 60 or within 10 years of the menopause is associated with a reduction in atherosclerosis progression, coronary heart disease and death from cardiovascular causes as well as all-cause mortality.

Evidence from the Cochrane data-analysis as well as the long-term follow-up data from the WHI showed no increase in cardiovascular events, cardiovascular mortality or all-cause mortality in women who initiated HRT more than 10 years after the menopause.

This decision should be made on an individualised basis after discussing the benefits and risks with each patient and should be considered in the context of the overall benefits obtained from using HRT.

The median duration of menopausal symptoms is over 7 years and it estimated that approximately 20% of women experience symptoms up to 15 years. This decision regarding the duration of HRT intake should be made on an individualised basis taking into consideration the benefits and risks for the individual woman.

Advise women who continue HRT intake over the age of 60 to have estradiol administered transdermally.

Women should continue routine cervical and breast screening in accordance with NHS Screening Programme guidance.

Women taking HRT should continue basic health checks including measuring weight and blood pressure on an annual basis.

Structure:

Follow national recommendations or implement local guidance that duration of treatment should be individualised. No arbitrary limits should be placed on the dose of HRT, duration of usage or age of women taking treatment.

Outcome:

1. Reasons for discontinuation of HRT.

2. Assessment of average durations of HRT intake.

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Standard 7:

If HRT with adequate estrogen intake has not been effective, testosterone supplementation can be considered in menopausal women with low sexual desire.

- There are no testosterone products for female use licensed in the UK. The previous license for female testosterone patches and implants were both withdrawn for commercial (not medical) reasons and there is good evidence to support the efficacy and safety of testosterone replacement.
- Given the lack of availability of licensed preparations, it is now common practice to use testosterone preparations licensed for use in men out with their product license to provide testosterone in female replacement doses. This is backed by national guidance and meets the criteria proposed by the GMC and MHRA on prescribing an unlicensed medicine or using a medicine off-label (i.e. no suitably licensed products available; be satisfied there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy; make a clear record of reasons for prescribing an unlicensed medicine; give patients, or those authorising treatment on their behalf, sufficient information about the proposed treatment).
- Assessment of serum androgen levels is unlikely to be beneficial in making the diagnosis of hormone dependent low sexual desire, as there is poor correlation between circulating androgen levels and clinical symptoms.
- However, best practice as recommended by the Global Consensus Position Statement on the Use of Testosterone Therapy for Women is that testosterone levels should be checked to exclude high baseline levels and to prevent subsequent supraphysiological replacement.
- Assessment of total testosterone level should be kept within the female physiological threshold.

Structure:

1. Follow national recommendations or implement local guidance that if HRT with adequate estrogen intake has not been effective, testosterone supplementation can be considered in menopausal women with low sexual desire.

2. Follow national recommendations or implement local guidance that serum testosterone levels are assessed to exclude high baseline levels.

3. Follow national recommendations or implement local guidance that serum testosterone levels are assessed ideally within 3-4 months of starting treatment to ensure levels are kept within the female physiological threshold.

Outcome:

1. Proportion of women on HRT with adequate estrogen intake with low sexual desire receiving testosterone supplementation.

2. Proportion of women having their baseline serum testosterone levels assessed prior to starting testosterone supplementation.

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3. Proportion of women receiving testosterone supplementation having their serum testosterone levels assessed within 3-4 months of starting treatment.

Standard 8:

Women under the age of 40 presenting with a picture suggestive of premature ovarian insufficiency (POI) should have their levels of follicle stimulating hormone (FSH) measured.

Diagnosis of POI should be based on a combination of oligomenorrhoea/amenorrhoea of more than 3 months' duration associated with elevated gonadotropins. FSH levels above 25iu/l can be used to confirm the diagnosis and a further FSH at least four to six weeks later can be carried out if there is diagnostic uncertainty.

If the diagnosis of POI is inconclusive, consider referral to (or seek advice from) a specialist menopause service. Consider assessment for other causes if there is suspicion of other pathology.

Structure:

1. Follow national recommendations or implement local guidance that women under the age of 40 presenting with a picture suggestive of POI should have assessment of their FSH serum levels on at least two occasions measured four to six weeks apart.

2. Follow national recommendations or implement local guidance that if the diagnosis of POI is inconclusive referral to (or seeking advice from) a specialist menopause service should be considered.

Outcome:

1. Proportion of women under the age of 40 presenting with a picture suggestive of POI having their FSH serum levels assessed.

2. Proportion of women with suspected POI being referred to a specialist menopause service and indications for referral.

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Standard 9:

Women with POI should be advised to take hormone replacement and continue to do so at least until the natural age of the menopause (unless contraindicated).

POI can result in a number of short-term and long-term sequelae related to the hypo-estrogenic status associated with the condition.

Women with POI are at increased risk of cardiovascular disease, osteoporosis and cognitive impairment.

Women with POI should be advised to take hormone replacement and continue to do so at least until the natural age of the menopause in the absence of a contraindication. Hormone replacement is likely to lower the long-term risk of cardiovascular disease in women with POI, prevent osteoporosis and have a beneficial effect on cognitive function.

The aim of hormone replacement in women with POI should be to achieve physiological levels of estradiol.

Women with POI who do not experience menopausal symptoms would still be advised to consider hormone replacement for the prevention of the long-term sequelae of the condition.

HRT and the combined contraceptive pill containing ethinyl estradiol, estetrol or estradiol are suitable options for hormone replacement. However, HRT may be more beneficial in improving bone health and blood pressure and may be associated with lower cardiovascular risk when compared to the combined oral contraceptive pill.

Structure:
Follow national recommendations or implement local guidance that women diagnosed with POI should be advised to take hormone replacement and continue to do so at least until the natural age of the menopause (unless there is a contraindication).

Outcome:
Proportion of women diagnosed with POI advised to take hormone replacement and to continue to do so at least until the natural age of the menopause.

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Standard 10:

Women with early menopause (women aged 40-45 years) should be offered information and support in a similar way to women with POI and advised to take hormone replacement at least until the natural age of the menopause.

Diagnosis of early menopause should be based on a combination of menopausal symptoms and or oligomenorrhoea/amenorrhoea of more than 3 months' duration associated with elevated gonadotropins (FSH > 25 IU/l). FSH assessment can be repeated after 4-6 weeks if there is diagnostic uncertainty.

If the diagnosis is inconclusive, consider referral to (or seek advice from) a specialist menopause service.

Early menopause between the age 40 and 45 affects 5% of women and can result in a number of short-term and long-term sequelae related to the hypo-estrogenic status associated with the condition.

Women with early menopause are at increased risk of cardiovascular disease, osteoporosis and cognitive impairment.

Women with early menopause should be offered information and support in a similar way to women with POI and advised to take hormone replacement and continue to do so at least until the natural age of the menopause in the absence of a contra-indication.

Hormone replacement is likely to lower the long-term risk of cardiovascular disease in women with early menopause, prevent osteoporosis and have a beneficial effect on cognitive function.

Structure:

1. Follow national recommendations or implement local guidance that women with early menopause (women aged 40-45 years) should be offered information and support in a similar way to women with POI and advised to take hormone replacement at least until the natural age of the menopause (unless contraindicated).

2. Follow national recommendations or implement local guidance that diagnosis of early menopause should be based on a combination of menopausal symptoms and / or oligomenorrhoea/ amenorrhoea of more than 3 months' duration associated with elevated gonadotropins (FSH > 25 IU/l). FSH assessment can be repeated after 4-6 weeks if there is diagnostic uncertainty.

3. Follow national recommendations or implement local guidance that if the diagnosis is inconclusive, referral to (or seeking advice from) a specialist menopause service should be considered.

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Outcome:

1. Proportion of women with early menopause (women aged 40-45 years) having their FSH serum levels assessed.

2. Proportion of women with early menopause (women aged 40-45 years) receiving HRT.

3. Proportion of women with early menopause (women aged 40-45 years) referred to a specialist menopause service where the diagnosis is inconclusive, or specialist advice is needed.

Standard 11:

Referral to (or seeking advice from) a specialist menopause service should be considered where menopause specialist input is required.

Healthcare professionals (HCPs) in primary care should manage women and offer menopause advice and care within their clinical expertise and seek further specialist menopause advice (by phone, email or direct referral) as appropriate. Criteria for referral (or seeking further advice) may include the following:

- Women who may experience difficulty obtaining satisfactory symptom control despite adjustments of their HRT intake.
- Women experiencing ongoing unscheduled bleeding more than 6 months after starting HRT despite adjustments to their progestogen intake as per national guidelines: https://thebms.org.uk/publications/bms-guidelines/management-of-unscheduled-bleeding-on-hormone-replacement-therapy-hrt/
- Women where the diagnosis of POI or early menopause is inconclusive.
- Women with complex medical backgrounds (such as women with breast cancer, personal history of venous thrombosis or personal history of stroke).
- Women with genitourinary symptoms of the menopause who do not obtain satisfactory symptom relief despite use of topical vaginal estrogens.
- Other related issues where it is felt that specialist input is required.

Structure:

Follow national recommendations or implement local guidance that referral to (or seeking advice from) a specialist menopause service should be considered where menopause specialist input is required. This may include the following:

- Women who may experience difficulty obtaining satisfactory symptom control despite adjustments of their HRT intake.
- Women experiencing ongoing unscheduled bleeding more than 4-6 months after starting HRT despite adjustments to their progestogen intake.
- Women where the diagnosis of POI or early menopause is inconclusive.

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- Women with complex medical backgrounds (such as women with breast cancer, personal history of venous thrombosis or personal history of stroke).
- Women with genitourinary symptoms of the menopause who do not obtain satisfactory symptom relief despite intake of topical vaginal estrogens.

Outcome:
Proportion of women being referred to a specialist menopause service and indications for referral.

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The Menopause Practice Standards have been developed by the medical advisory council of the British Menopause Society, in collaboration with the Royal College of Obstetricians & Gynaecologists, Society for Endocrinology, College of Sexual and Reproductive Healthcare, Faculty of Pharmaceutical Medicine and the Royal Pharmaceutical Society. They will be updated when guidance changes and/or new data becomes available.

Royal College of Obstetricians & Gynaecologists

Society for Endocrinology

COSRH The College of Sexual & Reproductive Healthcare

Faculty of Pharmaceutical Medicine

ROYAL PHARMACEUTICAL SOCIETY

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