The specialist authority for menopause & post reproductive health

British Menopause Society

HRT – Practical prescribing

Types of HRT

Estrogen

Estradiol	• 0.5mg (combined only)/ 1mg / 2mg oral • 25mcg / 30mcg and 40mcg combined only / 50mcg / 75mcg / 100mcg patches • 0.06% Oestrogel 0.75mg • 500mcg / 1mg Sandrena gel • 1-3 sprays Lenzetto • 10mcg vaginal tablets • 7.5mcg vaginal ring
Estriol	• 0.1% / 0.01% vaginal creams, vaginal pessary, 50mcg/g vaginal gel
Conjugated estrogens	• 0.3mg / 0.625mg / 1.25mg

Non-estrogens

Gonadomimetic Tibolone	• 2.5mg oral tablet (for systemic symptoms)
DHEA Prasterone	• 6.5mg pessary (for genitourinary symptoms)
SERM Ospemifene	• 60mg oral tablet (for genitourinary symptoms)

Progestogens

Micronised progesterone	• Combined and stand alone
Dydrogesterone	• Combined and stand alone
Norethisterone	• Combined only (stand alone off licence)
Levonorgestrel	• Combined and IUD
Medroxyprogesterone acetate	• Combined and stand alone
Drospirenone	• Combined only (stand alone off licence)

Testosterone

Implants (off licence, limited availability)
Gel (off licence)
Cream (not approved for NHS use)

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Routes of therapy

Oral	• Tablets (estrogen only, progestogen only, or combined), SERM (for urogenital atrophy)
Transdermal	• Patches (estrogen only or combined) / gels (estrogen only) / spray (estrogen only)
Sub-cutaneous	• Implants (estrogen only, testosterone only, off licence, limited availability)
Vaginal	• Ring/tablets/creams/pessary/ gel (all estrogen only), DHEA
Intrauterine	• IUD (progestogen only)

Regimens

Estrogen only	• Hysterectomised patients
Estrogen and progestogen • Sequential/cyclical preparations • Continuous combined	• If uterus is present • Perimenopausal women • Post menopausal women
Tibolone	

Approximate equivalent doses of estradiol products for those of average menopause age with symptoms (45-55 yrs)

Product	Low	Medium	High†
Oestrogel (gel pump)	1 pump	2-3 pumps	4 pumps
Sandrena (gel sachet)	0.5 mg	1 mg 2 mg*	2.5-3 mg* *See note 2*
Lenzetto (spray)	1-2 sprays	3 sprays 4 sprays*	5-6 sprays* *See note 3*
Patch	25/30/37.5 mcg	40/50/75 mcg	100 mcg
Oral estradiol	0.5 mg	1-2 mg	3 mg* *See note 4*

** Outside of Summary of Product Characteristic licensing.*

† High doses and doses outside of product license should only be considered in exceptional individualised cases and after full discussion about the relative lack of evidence of additional benefit and risks with these doses. If response has not been assessed with other options, consider offering a change of estrogen preparation before increasing the dose above license.

Notes

1. The table has been drawn up as a practical guide based on a combination of pharmacokinetics, clinical trials and clinical experience. The dose equivalents are subject to significant individual variations in absorption and metabolism, so cannot be precise.
2. **Sandrena**: high doses have been extrapolated from other gel preparations.
3. **Lenzetto** has a unique mode of action so data cannot be extrapolated: the excipient pushes estradiol through the skin into a reservoir from which it slowly releases. If going above 3 sprays, advise applying these additional sprays to the contralateral side.
4. **Oral estradiol**: high doses are rarely used in this age group.
5. Doses for those with premature ovarian insufficiency (POI) are not included in this table.

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Stand-alone progestogen dose per licensed estrogen dose in the baseline population

Estrogen dose	Micronised progesterone *Continuous*	Micronised progesterone *Sequential*	Medoxyprogesterone *Continuous*	Medoxyprogesterone *Sequential*	Norethisterone *Continuous*	Norethisterone *Sequential*	Dydrogesterone *Continuous*	Dydrogesterone *Sequential*	LNG-IUD, 52 mg
Low	100 mg	200 mg	2.5-5 mg	10 mg	5 mg*	5 mg*	10 mg‡	10 mg	for up to 5 years of use
Medium	100 mg	200 mg	5 mg	10 mg	5 mg	5 mg	10 mg‡	10 mg	
High	200 mg	300 mg	10 mg†	20 mg†	5 mg	5 mg	10 mg	20 mg	

* *1 mg provides endometrial protection for low to medium dose estrogen but the lowest stand-alone dose currently available in the UK is 5 mg (off license use of three Noriday POP, i.e. 1.05 mg, could be considered if 5 mg is not tolerated).*

† *There is limited evidence in relation to optimal MPA dose with high dose estrogen; the advised dose is based on studies reporting 10 mg providing protection with up to medium dose estrogen.*

‡ *2.5 mg provides endometrial protection for low dose estrogen and 5 mg for medium dose estrogen but the lowest stand-alone dose currently available in the UK is 10 mg.*

Notes

Drospirenone (DRSP): RCT data suggests 0.5 mg daily DRSP provides endometrial protection with 1 mg oral estradiol over 12 months of use. Extrapolation suggests 4 mg of DRSP should provide protection for up to high dose estrogen (but no dose specific studies have been completed). Dosages of 2 mg DRSP per 1 mg estradiol have been shown to provide better bleed control. Whilst no direct evidence, efficacy has been demonstrated with a dose of 3 mg DRSP when combined with 30 mcg of ethinyl estradiol which is equivalent to high dose estradiol. DRSP 4 mg (Slynd) is licensed in the UK as a progestogen only contraceptive. It can be used off license as the progestogen component of HRT by taking one active hormone tablet 4 mg daily on a continuous basis (omitting the 4 hormone free pills in the pack).

Desogestrel: earlier studies have reported that desogestrel 150 mcg is effective as the progestogen component of HRT with no increase in the risk of endometrial hyperplasia. There is lack of evidence on the use of desogestrel 75 mcg as the progestogen component of HRT. If desogestrel 75 mcg is used as contraception in women receiving HRT, it would be recommended to add further progestogen (e.g. micronised progesterone 100 mg daily or 200 mg for 12 days a month) to provide adequate endometrial protection.

Dienogest: 2 mg can be considered as an option (off license) if other measures have been ineffective.
(see the BMS *Tool for Clinicians on Progestogens and endometrial protection*).

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Common side effects	Dealing with side effects
Estrogen • Fluid retention • Breast tenderness • Bloating • Nausea / dyspepsia • Headaches **Progestogens** • Fluid retention • Breast tenderness • Headaches • Mood swings • PMT-like symptoms	**Estrogen** • Reduce dose • Change route • Change type • Which hormone is causing the side effect? **Progestogens** • Change type • Reduce dose if available • Change route • Alter duration

REVIEWED: MAY 2026
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This BMS Tool for Clinicians has been developed by the medical advisory council of the British Menopause Society. It will be updated when guidance changes and/or new data becomes available.

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Women's Health Concern

British Menopause Society