Menopause

This briefing focuses on treatments for menopausal symptoms. Medicines optimisation projects in this area focus on selecting the most cost-effective, appropriate products and discontinuing them at an appropriate point for the individual.

Key recommendations

- For vasomotor symptoms:
  - Offer hormone replacement therapy (HRT) first line after a discussion of short term (up to five years) and longer-term benefits and risks.[1]
  - Do not routinely offer selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) or clonidine as first-line treatment for vasomotor symptoms alone.[1]
  - Clonidine is the only non-oestrogen based preparation that is licensed for menopausal flushing in the UK, but its use is limited by moderate efficacy and relatively high rate of adverse effects.[3]
- Consider HRT for menopausal low mood, or cognitive behavioural therapy for menopausal low mood or anxiety. There is no clear evidence that SSRIs/SNRIs ease low mood in menopausal women without a diagnosis of depression.[1]
- For urogenital atrophy, offer vaginal oestrogen (including to those on systemic HRT) and continue for as long as needed to relieve symptoms.[1]
- The lowest effective dose of HRT should be used for the shortest possible time.[4] Review treatment at three months to assess efficacy and tolerability. Review therapy and discuss an individual's risk:benefit ratio for continuing HRT at least annually.[1] Regular attempts to discontinue treatment should be made. For vasomotor symptoms, most women require two to five years of HRT, but some women may need longer.[5]
- The risk of venous thromboembolism (VTE) is increased by oral HRT but not transdermal HRT, compared with baseline population risk. NICE recommend discussing this difference in risk with the patient and considering transdermal rather than oral HRT for women at increased risk of VTE, including those with a BMI over 30kg/m^2. Refer those at high risk (for example, those with a strong family history of VTE or a hereditary thrombophilia) to a haematologist for assessment before considering HRT.[1]
- Do not offer the SSRIs paroxetine and fluoxetine to women with breast cancer who are taking tamoxifen, as they may inhibit the metabolism of tamoxifen to an active metabolite.[1]
- Refer to a specialist if symptoms do not improve, if ongoing adverse effects are a problem, or if uncertain about the most suitable treatment.[1]

Clinical evidence

Strong evidence supports the use of HRT in relieving menopausal vasomotor symptoms. More limited evidence supports its use in relieving menopausal low mood.[1]

The risk of venous thromboembolism is increased by oral HRT but not transdermal HRT, compared with baseline population risk.[1]

HRT does not increase risk of cardiovascular disease when started in women aged less than 60 years.[1]

Oral (but not transdermal) oestrogen is associated with a small increase in the risk of stroke, but the baseline population risk of stroke in women aged under 60 years is very low.[1]

Around the age of natural menopause, oestrogen alone is associated with little or no change in the risk of breast cancer. Combined oestrogen and progestogen can be associated with an increase in the risk of breast cancer. Any increase in the risk is related to HRT duration and reduces after stopping.[1]

NICE did not discuss ovarian cancer risk with HRT. A 2015 meta-analysis of 52 epidemiological studies found an increased risk in current HRT users compared to women who have never used HRT. The excess absolute risk was small, estimated at about one additional case per 1000 users with five years of HRT use starting at around 50 years old.[7]

Costs and savings

In England and Wales £57.2 million* is spent annually on HRT and local oestrogen preparations for urogenital atrophy (this includes £4 million on ethinyloestradiol used for other indications) (ePACT Nov 16 to Jan 17). Using cost-effective, appropriate products at the lowest effective dose for the shortest possible time has the potential to release cost savings.

A 10% reduction in prescribing could result in potential annual savings of £5.7 million (£9,351 per 100,000 patients).

If 80% of estriol 0.01% cream prescribing was for Ovestin 0.1% cream instead, there would be potential for an annual saving of approximately £5.3 million (£8,610 per 100,000 patients).

References

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Additional resources available: https://www.prescqipp.info/category/365-menopause

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