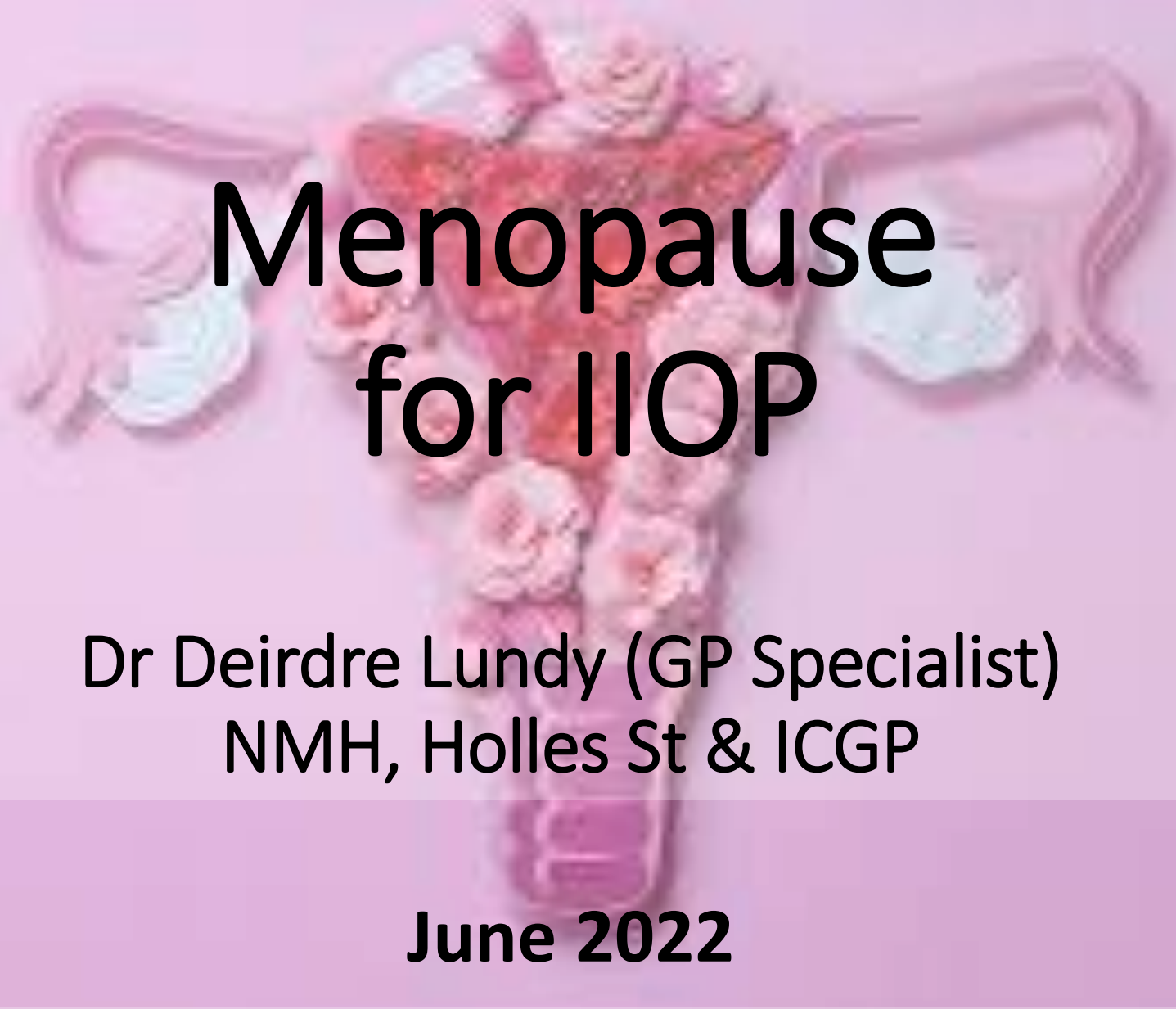

Menopause for IIOP

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NMH, Holles St & ICGP

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Declaration of
Financial Interests or Relationships

I have the following financial interest or relationships to disclose with regard to the subject matter of this presentation:

I am a regular speaker for:

Besins, Bayer, Consilient Health, MSD, AZ & many other Pharma sponsored meetings.

I have attended numerous meetings in Ireland and abroad thanks to educational grants from Bayer, Consilient, Besins & other pharmaceutical companies.

The information in these slides comes from peer reviewed sources and not the pharmaceutical industry.

What is happening at the Menopause? Or is it Perimenopause ?

The word **'menopause'** means end of menstruation- it usually occurs by 51 yoa and marks the end of reproductive ability BUT.....

- Ovarian function becomes less predictable as we pass 35yoa &
- **Levels of AMH & Inhibin B** start to decline which will impair follicle maturation & ovulation as a result
- The Hypothalamic-Pituitary-Ovarian hormone cascade may be disrupted at times (but at other times it may be functioning typically) and symptoms may start to arise well before the final menstrual bleed - this is **Perimenopause**

Perimenopause

MIDDLE-AGED BARBIE

- Symptoms often precede the Final Menstrual Bleed by Years but typically, start in mid 40's- amen & elev FSH under 40 is POI and <u>needs</u> urgent management
- Average duration of PM symptoms is 7 years, but 30% patients have longer episodes of significant symptoms - some are symptomatic into their late 60's. *(Avis 2015)*
- HCPs can't out rule menopause just because patient still has periods = therefore, there are <u>NO RELIABLE BLOOD TESTS TO DIAGNOSE MENOPAUSE TRANSITION (perimenopause)</u>
- Patient often juggling Contraception needs and Menopause symptoms
- Use of HRT is almost <u>NEVER contraindicated</u> and can usually be offered- you put a patient in far more 'danger' with the COCP than you could ever do with HRT

Diagnosis is Clinical- rarely need blood tests

- **NIGHT SWEATS &**
- **HOT FLUSHES**
- **MENSTRUAL CHANGES:**
- **MENORRHAGIA, IRREGULARITY**
- **DECREASE IN METABOLISM**
- **LOSS OF VAGINAL ELASTICITY & LUBRICATION "GUSM"**
- **INCREASE INCIDENCE OF METABOLIC SYNDROME**
- **HAIR & SKIN CHANGES**
- **JOINT ACHES & PAINS**
- **BLADDER COMPLAINTS**

- **DEPRESSION,**
- **MOOD SWINGS**
- **IRRITABILITY, RAGE**
- **ANXIETY**
- **CHRONIC FATIGUE**
- **MEMORY LOSS, CONCENTRATION ISSUES &**
- **BRAIN FOG**
- **LOSS OF LIBIDO**
- **PMS-TYPE SYMPTOMS**

GREENE SYMPTOM CHECKER

	Score before MHT	3 months after starting MHT	6 months after starting MHT
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

MANAGEMENT OF THE MENOPAUSE without Hormones & Optimising Mid Life Health for Women

Menopause is “natural”, does it need to be medicated??

Health Promotion: Diet

- Encourage oily fish, low GI fruits & veg, whole grains, soya, legumes
- Discourage excess red meat & simple sugars

- Vitamin D intake of at least 400mIU (10 microg) /day or use monthly bolus Vit D products
- Calcium 700-1200mg /day ideally via diet but should supplement if diet is restricted

Health Promotion: Be as ACTIVE as you can

Regular Activity :

- Decreases premature death, CVD, DM, HTN, CA colon & Obesity.
- Has a beneficial effect on Bone, Muscle & can reduce the risk of falling by improving strength, flexibility & balance.
- Improves psychological symptoms
- Decreases LDLs, &
- Increases HDLs

The WHO recommends:

- 75 min vigorous or 150 min moderate aerobic activity / week

Health Promotion: Weight management

Menopause can bring weight gain

- Metabolic slow down
- Shift from Gluteo- femoral to Central adipose deposition
- Tiredness & Low Mood promote increased calorie intake

Health Promotion: Reducing Alcohol

- Moderate alcohol intake (< 2 units/day) is linked to lower mortality than abstinence – although the link is unclear
- **Breast Cancer risk however is higher in women who consume even low levels of alcohol (compared to abstinent women)**
- Heavy alcohol consumption is linked to increased rates of breast cancer, low bone density, falls & fractures and much more

Health Promotion: Smoking cessation

- 12 mos after smoking cessation, the risk of CVD death is reduced by 50% (INTERHEART study)

Smoking cessation is shown to be more likely when:

- the GP intervenes
- Nicotine replacement is used

See ICGP Smoking Cessation in eLearning modules & ”quit.ie”

Alternatives & Options in Symptom Care

REASONS FOR CHOOSING NON HORMONAL SYMPTOM THERAPIES

- Perception of symptom severity is minimal
- Not wishing to medicalise mid life transition
- Worries that hormone use is “against nature”
- Lack of understanding or Poor knowledge/information- fear of breast cancer and HRT being the main one
- MEDICAL CONTRAINDICATIONS

Non Rx remedies for Meno Symptoms

- **PHYTO-OESTROGENS**

  ISOFLAVONES – soya beans/chickpeas/legumes/red clover
  LIGNANS – oil seeds/flax/whole cereals/legumes/fruit

  - SOME EVIDENCE THAT THEY MAY ATTENUATE FLUSHES
  - GOOD SAFETY PROFILE but minimal scientific studies to show Sx control over placebo

BLACK COHOSH

- Isoflavones- like effect but
- May also stimulate oestrogen receptors

- 2012 Cochrane review – insufficient evidence to support use in the menopause.
- Quality of products may vary
- Long term effects unknown
- C/I in liver disease &
- May interfere with conventional breast cancer treatments inc radiation

Ginseng:

no robust data on sx control over placebo

Oil of evening primrose & Multi Vitamins:

no better than placebo

Dong Quai Chinese herb:

no better than placebo & MAY INTERACT WITH WARFARIN

Gingko Biloba:

may improve cognition and concentration but no long term studies.

NO EFFECT ON FLUSHES

Sage:

no robust data

Yam- based plant progestogen /used in creams:

no data to support use

St John's Wort/Valerian/Agnus Castus:

no data to support use & POTENTIAL FOR DRUG INTERACTION

OK, well what has been proven to help?

VAGINAL PREPARATIONS

- MOISTURISERS – REGELLE/REPLENS
- LUBRICANTS – YES/SYLK
- Usually will RELIEVE SYMPTOMS; CAN & SHOULD BE USED TOGETHER
- NO DATA TO SHOW EFFECTS ON VAGINAL ATROPHY

For Flushes & Sweats: CBT & Mindfulness

- Cognitive Behavioural Therapy has been found beneficial over placebo in several aspects of Peri menopausal management including VMS relief* with up to 50% reduction

- Mindful Meditation Practice is recommended by NICE for help with low mood & anxiety

* (MENOS 2)

Flushes & Sweats: Alpha Agonists have a license for VMS but are not very effective

CLONIDINE HCl 50-75 microg BD

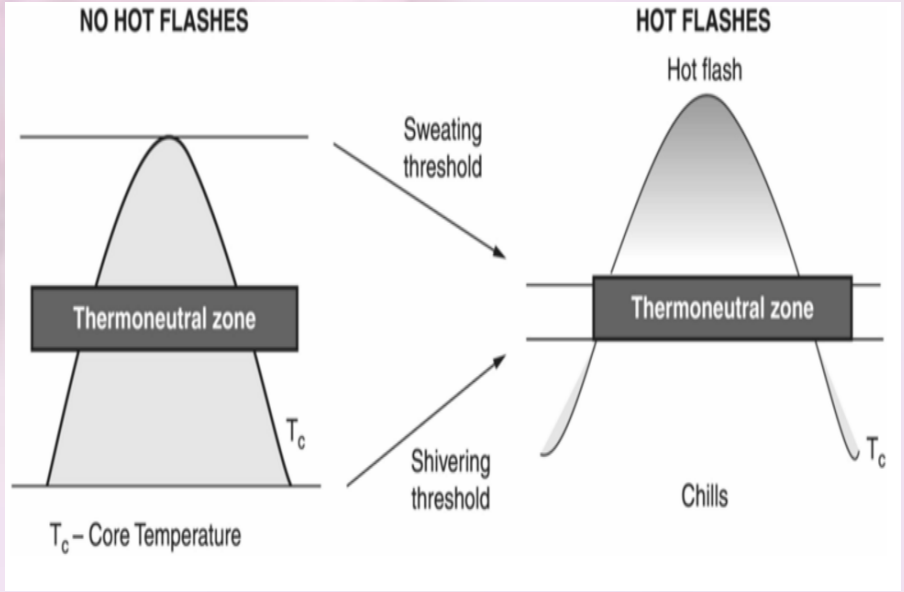
Alpha adrenergic agonist

Licensed for Migraine & VSM symptoms of the Menopause

(can be used for HTN but at much higher doses)

It widens the “thermo-regulatory zone “

Can cause insomnia, dry mouth, drowsiness



Alternative Therapies: The Pill for POI

- COC; Combined Oral/TD/TV Contraception
- Much larger quantities of more potent Estrogen & Progestins
- Should provide some VMS relief & is CONTRACEPTIVE
- Consider Cat 3 & 4 risks though
- May prefer Qlaira/ Zoely

Alternative Therapies: Flushes & Sweats: SSRIs & SNRIs

- Selective Serotonin/Noradrenaline Reuptake Inhibitors
- Avoid paroxetine and fluoxetine in women taking tamoxifen; 75mg venlafaxine prob best/safest
- Obviously may help with low mood in higher doses
- Often used for women with personal history of Breast CA

[1] Nelson HD, Vesco KK, Haney E, et.al. Nonhormonal therapies for menopausal hot flashes: systematic review & meta- analysis. JAMA 2006; 295:2057-71

Alternative Therapies: Flushes & Sweats: Gabapentin

- NICE says 900mg daily of GabaP has been shown to reduce VMS by approx 50% & may help sleep disruption

OXYBUTYNIN

- Anti cholinergic OAB medicine
- **Has been shown to reduce severity & frequency of flushes/sweats almost as effectively as HRT**
- 5mg BD/TID is best (85% reduction in VMS),
- 2.5mg BD gives 65% reduction
- **No license for this as yet but being trialled in Breast Cancer survivors**

Ref: Roberto A. Leon-Ferre, MD, of the Mayo Clinic, Rochester, Minn., reported at the San Antonio Breast Cancer Symposium Nov 2018

Neurokinin antagonists are on their way !

Neurokinin 1/3 receptor antagonists are entering Phase 3 clinical trials soon in Ireland !

‘Oasis 4’ is in the early development stage, with recruitment planned to include women with concomitant medical diagnoses such as **breast cancer**

See ***“Effects of NT-814, a dual neurokinin 1 and 3 receptor antagonist, on vasomotor symptoms in postmenopausal women: a placebo-controlled, randomized trial.”***

Coping with Menopause in GP

- **Have literature to hand or signpost to good websites**
- **NMH is TAKING REFERRALS for our "Complex Menopause Clinic"** thanks to funding from the Minister for Health & the National Women's & Infants Program

- it is a Proforma referral only by GP so need GP visit first to ascertain suitability

- **NMH catchment area to start**
- **NMH WEBSITE WILL HAVE LOTS OF PATIENT AND HCP INFO**
- **National Women's & Infants Program plan to expand to other parts of Ireland soon**

PATIENT SUPPORT & REASSURANCE

-**The British Menopause Society** has good publications; membership is required (£105 at www.bms.org.uk) - well worth it

-**Menopause Matters website,** run by Dr Heather Currie, has some great advice, recommendations; registration is free

see: www.menopausematters.co.uk

-**Primary Care Women's Health Forum** Is a UK charity that works with the NHS on aspects of health promotion offering free publications & factsheets on Menopause & HRT see www.pcwf.co.uk

MYTH	FACT
HRT only delays the inevitable	HRT effectively manages the symptoms of the menopause and lower doses of HRT continue to work when women are older.[4]
HRT carries the same risks as the pill	They contain similar hormones but those in HRT are less potent and in lower doses, and may be delivered in different ways so the effects are not the same.[4]
Natural methods to treat menopausal symptoms are safer than HRT	Just because it is natural, doesn't mean it is safe – the studies haven't been done.[4]
Women stop having sex after the menopause	Some do, but don't need to. Local oestrogen treatments reverse the vaginal changes and restore comfort.[4]
Women need examinations to make sure they can take or need HRT	This usually isn't necessary but a woman's blood pressure needs checking.[4]
You can only have HRT for 5 years, whatever age you are	HRT may be taken for as long as necessary at the lowest effective dose. This is particularly important for younger women, who should not stop before 50 years of age.[4]

Now, let's talk about HRT !

- **Most effective treatment option for Peri Menopause and Menopause Symptoms**
- **Public & some Healthcare perception has been quite negative and ill- informed since 2002 WHI trial publications**
- **2015 UK NICE guidelines started to reverse that trend**
- **Recent media coverage has caused huge escalation in HRT interest**
- **Demand increase has created endless stock problems**

What is HRT?

- Hormone Replacement Therapy or HRT refers to the various products that contain one or more of the 3 pronciapl Ovarian hormones :
- Estrogen
- Progestagen
- Testosterone

ABSOLUTE CONTRAINDICATIONS TO HRT

NONE

there are SPECIAL PRECAUTIONS

- **Breast cancer (individualise care)- get Meno expert/ Oncology opinion)**
- **Porphyria (individualise care- get Meno expert/Haematology opinion)**
- **Severe Active Liver Disease (individualise care- get Meno expert/Hepatology opinion)**

<u>Special Cases</u>

- **Thromboembolic disorders; avoid oral E2, pick a good Prog, start low- COUNSELING**
- **Undiagnosed, irreg bleeding (? investigate ALL Post Meno Bleeds, examine, scan, refer)**
- **Hx of Endometriosis/ Fibroids/ Endometrial cancer/ Hypertriglyceridemia. (Rx wisely & monitor more often)**

Consult essentials

- **History - all the basics with attention to prev pregnancies and contraceptive use (has she 'survived' estrogen in the past ?)**
- **Family Hx- <u>no C/I to HRT w any FHx of anything</u>**
- **Medicines - LEI meds will interact**
- **Smoking & Alcohol, what contraception are you using?**
- **BP is necessary when Rx ORAL estrogen- not TD**
- **HRT pro's & con's + Trial Rx**
- **Signpost to support literature/ websites/ podcasts**

Managing patient worries by Managing YOUR worries first !

know the facts about HRT

HORMONES AND BREASTS: these are the FACTS

- **HRT is not a "carcinogen"**
- **There is no direct evidence that HRT transforms benign breast cells into high risk, premalignant conditions**

but... some Hormones may have a stimulatory effect on pre-existing, quiescent premalignant lesions (or not- this is Poorly understood)

- **It takes at least 10 years for breast cells to change from the pre-malignant state to being a clinically detectable cancer.**

- **Malignant changes cannot be reversed by stopping hormones.**

Understanding the risks of breast cancer

Women's Health Concern

A comparison of lifestyle risk factors versus Hormone Replacement Therapy (HRT) treatment.

Difference in breast cancer incidence per 1,000 women aged 50-59.
Approximate number of women developing breast cancer over the next five years.

23 cases of breast cancer diagnosed in the UK general population

An additional four cases in women on combined hormone replacement therapy (HRT)

Four fewer cases in women on oestrogen only Hormone Replacement Therapy (HRT)

An additional four cases in women on combined hormonal contraceptives (the pill)

An additional five cases in women who drink 2 or more units of alcohol per day

Three additional cases in women who are current smokers

An additional 24 cases in women who are overweight or obese (BMI equal or greater than 30)

Seven fewer cases in women who take at least2½ hours moderate exercise per week

Women's Health Concern

Women's Health Concern is the patient arm of the BMS.
We provide an independent service to advise, reassure and educate women of all ages about their health, wellbeing and lifestyle concerns.

Go to www.womens-health-concern.org

BMS British Menopause Society

Breast Cancer & HRT according to NICE

- **Individual baseline risk should be considered**
- **E alone; little or no change**
- **E + P; can be associated with increased risk**
- **Related to treatment duration, reduces after stopping**
- **Think of HRT as a "promoter rather than initiator"**
- **And put into context by Comparing to Other Risk Factors, e.g., obesity, alcohol, smoking**

Heart disease & HRT; more facts for you

- Coronary heart disease is the leading cause of death in women overall - accounting for almost 20 % of all female deaths- at all ages
- CHD is uncommon in younger women but becomes the most common cause of death for women over 60 yoa
- Women are living longer and there are more older women around generally, so CHD will continue to be an important health issue
- Use of HRT started within 10 yrs. (ish) of LMP will be more benefit than risk

BMS | Consensus Statement

Primary prevention of coronary heart disease in women

The British Menopause Society (BMS) educates, informs and guides health professionals specialising in menopause care and post reproductive health. The Medical Advisory Council of the BMS produces a series of consensus statements which address key disorders and controversial topics. These are comprised of evidence-based medicine and informal consensus.

Summary

Coronary heart disease (CHD) is a leading cause of death in women. Observational studies have consistently shown oestrogen to help prevent CHD in postmenopausal women. The large randomized controlled Women's Health Initiative (WHI) trial initially did not confirm these observational findings. However, further analyses of the WHI study as well as meta-analyses of randomised clinical trials of

“Timing Hypothesis”

- “Elite” Study (Hovis 2016 ‘Vascular Effects of Early versus Late Postmenopausal Treatment with Estradiol’)
- Results showed us that early intervention with HRT in women <10 yrs after their LMP was cardio protective
- Intervention after that time did not increase IHD rate -but just did not help prevent

Bottom line for menopausal patients with possible CVD ?

- **People with existing CVD (Angina, MI, etc) should get the OK from cardiology before we Rx HRT - and ideally use only TD Estrogen and benign Progestagen e.g. Utrogestan**
- **Women over 60 AND >10 years past their LMP can try HRT <u>but more caution is needed</u>**
- **Women <60 with a very strong Family Hx of CVD (e.g.. First degree premenopausal female relative) should consider CV screening in the peri- Menopausal years anyway but HRT may certainly be offered (Q-Risk, BP monitoring, ECG, fasting Lipids, Glucose, etc.) as it may confer protection**

SUPPORTED & REPEATED BY NICE 2015

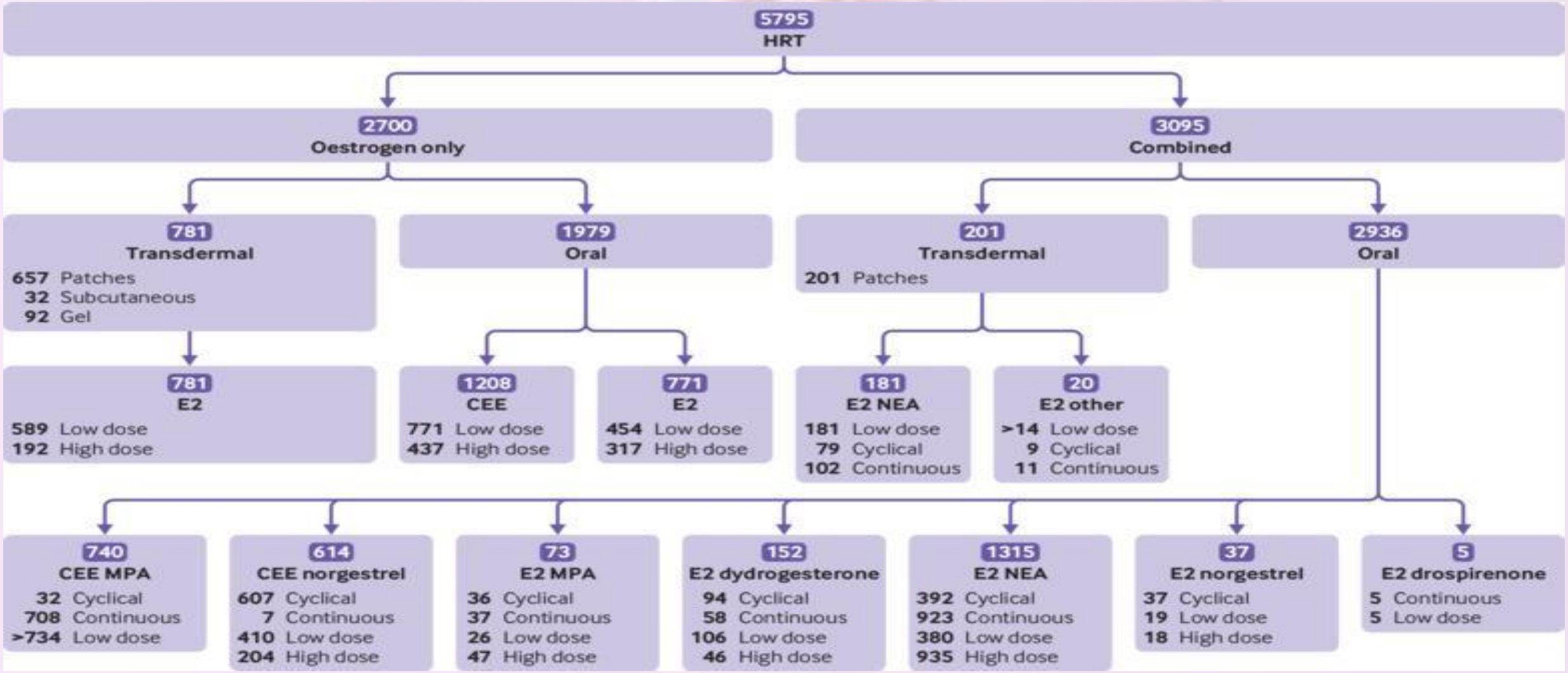
HRT & Thrombosis

HRT: Putting Benefits & Risks into Perspective M.Warren MD; Columbia Univ Med School

- **WHI did show ↑ risk in VTE within the first 2 years (although the absolute risk remained low) particularly for the E+ P group - oral equine Estrogen is particularly thrombogenic**
- **PE rates were NOT increased**
- **Multiple studies (observational) suggest that Transdermal HRT is neutral on VTE risk**
- **Is MPA progestin thrombogenic? Not sure – but best avoided anyway**
- **Favour micronised progesterone (Utrogestan) & Mirena**

Yana Vinogradova et al. BMJ 2019;364:bmj.k4810

Hormone replacement therapy (HRT) preparations available in the UK and number of women with venous thromboembolism exposed to HRT from QResearch and Clinical Practice Research Datalink (CPRD) databases.



HRT & risk of VTE: the bottom line

- In the first year or two from starting oral HRT the risk of getting a DVT is slightly elevated- but not for TD, low dose Estrogen (<75 microg)
- HRT can be offered- with caution- to people who have had VTE even if provoked by around pregnancy or while on the COCP- TD only, start low & slow
- Patients with a strong FHx of or multiple risk factors for DVT might benefit from Haematological review before Rx and then always safer on Transdermal products-
- healthy cocp use or pregnancies are a great reassurance

HRT PRESCRIBING

- The 3 main ovarian hormones are the 3 estrogens, progesterone and the 4principal androgens
- Estrogen is the principal hormone of HRT- it comes in many forms
- Non oral delivery of Estrogen avoids 1st pass and is considered ‘superior’ to other estrogens but patient preference, cost and convenience are all taken into account
- Progestogen is a requirement of HRT in a nonhysterectomised patient
- Testosterone is an optional extra but very popular

Cost of HRT

- Considerable variations from pharmacy to pharmacy
- Patients may struggle to afford their HRT
- They may struggle to find HRT at all
- New “yellow pack” pharmacy with competitive prices- Australian chain – no dispensing fees, no mark up
- NI pharmacies honour ROI scripts and post to 26 counties
- Some EU member countries dispense HRT as an OTC at minimal cost

Practical Prescribing

- Estrogen will alleviate most meno Sx but it will cause a certain amount of endometrial thickening
- Left unopposed for any more than 3-6 mos this can allow the development of dysplasia and in some cases, increase the risk of endometrial CA. **In almost all cases estrogen needs some progestagen to prevent the development of heavy, prolonged or unpredictable PV bleeding.**

But the selection of products in the MIMS is very limited so sometimes we Rx by combining an estrogen (usually 50mcg) with a progestogen but

- **which progestagen ?**
- **how much ?**
- **how often?**

Which Progestagen ?

- **UTROGESTAN: Oral Micronised Progesterone 100mg- 200mg (or even 300mg prn)** Micronised progesterone has a neutral effect on BP, BMI, Glucose & HbA1c
- **DUPHASTON : Oral Dydrogesterone 10mg- 20 mg (30mg prn)**
- **MIRENA: for 5 years – also contraceptive (no other IUS is OK for HRT progestagen)**
- **PROVERA: Oral medroxyprogesterone acetate 5mg- 10 mg**
- **NORIDAY: Oral norethisterone acetate 350 microg (3 tabs daily) -also contraceptive**

BLEED-PRODUCING HRT products in the MIMS

(the SmPC may be inaccurate and contradict guidelines)

FEMOSTON 2/10 -Sequential Oral 2mg Estradiol+/- 10mg.Dydrogesterone

Femoston 1/10- Sequential Oral 1mg Estradiol+/- 10mg.Dydrogesterone

NOVOFEM -Sequential Oral 1mg Estradiol+/- 1mg.Norethisterone

TRISEQUENS- Sequential Oral Estradiol 2 & 1mg +/- 1mg.Norethisterone

Or EVOREL SEQUI in NI
or "DIY" HRT cocktail……

DIY Cyclical Options

ESTROGENs

- Patches 25-100 mcg 2/week
- Estrogen 1-4 pumps daily
- Divigel 1-2 sachets daily
- Lenzetto 1-3 sprays daily

Or Oral Estradiol 1-2mg daily

PROGESTAGENs

- Mirena
- Utrogestan 100mg daily for 21 days/ month Utrogestan 200mg for 2 weeks/month
- Utrogestan 300mg for 2 weeks/ month
- Duphaston 10mg for 2 weeks/ month
- Duphaston 20mg for 2 weeks/ month

NON-BLEED-PRODUCING HRT in the MIMS

ACTIVELLE – Continuous Combined Oral
1mg. Estradiol + .5mg Norethisterone

ANGELIQ- Continuous Combined Oral
1mg.Estradiol + 2mg.Drospirenone

EVOREL CONTI -ContComb.Transdermal
50microg.Oestradiol + 170microg.Norethisterone 19.99

FEMOSTON-CONTI 1/5 -Cont. Comb. Oral
1mg Estradiol + 5mg.Dydrogesterone

FEMOSTON-CONTI 0.5/2.5-Cont. Comb. Oral
.5mg Estradiol + 2.5mg.Dydrogesterone

INDIVINA - Cont. Comb. Oral
1 mg. Oestradiol +
Medroxyprogesterone acetate(MPA);2.5 or 5mg

KLIOGEST- Cont. Comb. Oral
2mg.Oestradiol/ 1mg.Norethisterone

***LIVIAL- 2.5mg.** Tibolone a steroid Gonadomimmetic

OR ANY transdermal estrogen + progestagen every night …..

DIY Continuous Options

ESTROGENs

- Patches 25-100 mcg 2/week
- Estrogen 1-4 pumps daily
- Divigel 1-2 sachets daily
- Lenzetto 1-3 sprays daily

Or Oral Estradiol 1-2mg daily

PROGESTAGENs

- Mirena
- Utrogestan 100mg daily
- Utrogestan 200- 300mgdaily if bleeding
- Duphaston 10mg daily
- Duphaston 20-30mg daily if bleeding

Cutting Patches

- It may work fine
- It is not tested so not recommended but often the only way to access the correct dose
- Might try alternative E delivery system

ESTROGEN-ONLY products

some not in the MIMS
For use in: Hysterectomised people, Mirena wearers when Mirena in < 5 yrs. or with stand alone progestagen

Divigel-transdermal .1% estradiol gel, 1 sachet ~ 50mcg patch
Estrofem - oral 2mg.estradiol
Evorel -transdermal 50microg. Estradiol
Estradot-transdermal estradiol 37.5, 50. 75 & 100 microg.
Fematab -oral 1 & 2 mg. estradiol
Lenzetto spray- transdermal 1 spray ~ 25mcg patch
Oestrogel -transdermal .75 mg of estradiol per pump ~ 25mcg per pump- *is the new formula weaker ???*
Premarin - oral conj. equine oestrogen .625 & 1.25 mg.

When is it OK to just use Estrogen?

- Mirena in for < 5 years
- Hysterectomised
- Briefly (< 3 mos) to see if HRT side effects are progestagen related – if prog intolerant.
- “Long cycle” progestagen can be tried (2 weeks progestagen every 10 weeks only – but must keep eye on endometrial thickness)

Local Estrogen Options for GUSM

VAGIFEM - Intra Vaginal Estradiol 10 microg
Minimal systemic absorption tiny pills
28 individual applicators – also "VAGIRUX" less plastic

IMVAGGIS – Estriol .03mg per pessary

OVESTIN – Estriol .5 mg per applicator of cream

These are ideal for people with local symptoms-
They are unlikely to have any direct influence on Breast, CVD, etc. but we still use with caution but CAUTION IF ON AI'S

Offer IMVAGGIS/ VAGIFEM/ OVESTIN/ BLISSEL to all symptomatic patients

(the SmPC is inaccurate and contradicts guidelines)

Intra Vaginal Estradiol 10microg permits Minimal systemic absorption so is ideal for patients with local symptoms and is highly unlikely to have direct influence on Breast, CVD, etc..

SHOULD BE OFFERED TO ALL patients AT WHATEVER DOSE (max 5/ day) or INTERVAL THEY REQUIRE - WITH NO RESTRICTION TO DURATION OF USE

Twice weekly applications will, in one year (104 pessaries), result in less systemic exposure than a single PO HRT tablet

Ospemifene

- Known as “Senshio”, this is an **oral** TSEC which significantly improves VV atrophy

- Ospemifene can be prescribed for patients five years post-breast cancer diagnosis, once treatment has been completed

Testosterone ? why not?

- **Licensed and approved for Rx in hypoactive sexual disorder- low libido (? brain fog, muscle and joint health)**
- **Blood levels do not equal tissue levels or action but**
- **Should offer free T blood tests 3-6 mos after Rx given to ensure they not over medicated**
- **Ask for Total Testosterone or Free Androgen Index blood assay**
- **Timing—between 8 and 10am**
- **Aim for total testosterone in normal physiological range <5 %**

What to Rx ?: aim for 5mg daily dose

- **Tibolone- may benefit libido in suitable women**

Licensed testosterone for women only one approved product which is

- **"Androfem1" cream 0.5ml per day not on GMS**

Unlicensed equivalents include: (offer leaflet on UULP)

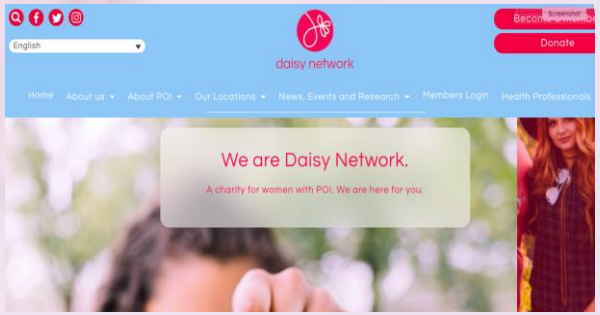
- **Testogel: 50mg sachet once every 7-10 days (or ½ a sachet twice a week)**
- **Testogel pump: 1 pump delivers 25mg so 1 single pump every 7-10 days should do**
- **Tostran: 1 pump delivers 10mg so a pump every other day should do**
- **Apply to lower abdomen / upper, inner thigh - not on genitals - it's in alcohol ☹**
- **Might take 8-12 weeks before benefit is maximal**

CONTRACEPTION & HRT

- **Standard HRT is not strong enough to afford Contraception**
- **Mirena & Estrogen will obviously give both HRT & Contraception but once the Mirena is in place for > 5 yrs, additional progestagen will be needed**
- **The COCP (or ring or patch) is permitted until 50 yoa and it should also help with Meno Sx + provide contraception but may/may not be suitable (check for UKMEC 3 or 4 risks) - discuss and figure out what suits**

What about POI

Premature Ovarian Failure is a health crisis that demands hormone Rx



- **Symptoms usually worse and hormone requirement higher than standard meno patient – E doses of 150-175mcg not uncommon**
- **Fertility preservation key**
- **Assessment for possible Underlying disorder ideally**
- **Testosterone more relevant here too**
- **HRT or COCP until 50 minimum but may opt to continue**

What about women at high risk of breast cancer & HRT ?

- Family history has no additive impact on breast cancer risk with HRT use[1,2] although women with gene mutations are at vastly increased lifetime risk of breast cancer
- HRT use and family history had independent and non interacting risk factors for breast cancer in WHI[3-]
- Long term observational studies have reported no extra risk for those using HRT with a family history of breast cancer
- HRT following risk reduction surgery , HRT use appears not to increase risk[4,5]
- HRT in such women should use minimal progestogen and ideally MICRONISED progesterone or dydrogesterone

1. Rippy L Marsden J Climacteric 2006;9:404-15
2. Sellars T et al Ann Intern Med 1997;127:973-80
3. Gramling R et al Epidemiology 2009;20:752-6
4. Rebeck T et al J Clin Oncol 2005;23:7804-10
5. Eisen J et al J Nat Cancer Inst. 2008;100:1361-67

What about people who can’t/won’t use HRT ?

Alternatives to HRT in Menopause Symptom Care

MACC: Life After cancer clinic

- **Irish Cancer Society has supported a survivor's clinic - Prof Donal Brennan in MMH taking referrals now**
- **What does the pt want? What is their idea of a successful outcome ?**
- **They not offering HRT – CBT, Gaba, Citalopram**

Thank you & Questions?