Information for Pharmacists to support patients with menopause and post menopause for the IIOP Webinar 2026

Deirdre Lundy
Clinical lead, Complex Menopause Clinic
NMH, Holles St. Dublin

Declarations

I am a regular speaker for:

Besins, Bayer, Consilient Health & other Pharma sponsored meetings.

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

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

FYI

- I often use the term ‘menopause’ meaning the biological, physiological and psychological stages of perimenopause, menopause and post menopause; natural, surgical and iatrogenic. Historically the term ‘menopause’ only describes menstrual status.

- I often use the word ‘lady’ or ‘woman’ in my slides. Much of this information will also be relevant to trans men, non-binary people assigned female at birth and some intersex people) with menopause-associated symptoms.

What all HCP should know about Menopause

Menopause and Perimenopause are typically normal, transitional life phases wherein ovarian function starts to splutter and then decline - much like puberty (but in reverse)

Occasionally decline and loss of ovarian function happens too young or abruptly – often as a result of medical therapies or in people with specific comorbidities; in those cases, specialist input might be needed

Sometimes, people are profoundly impacted they should have access to accurate information, advice and timely management in Primary Care

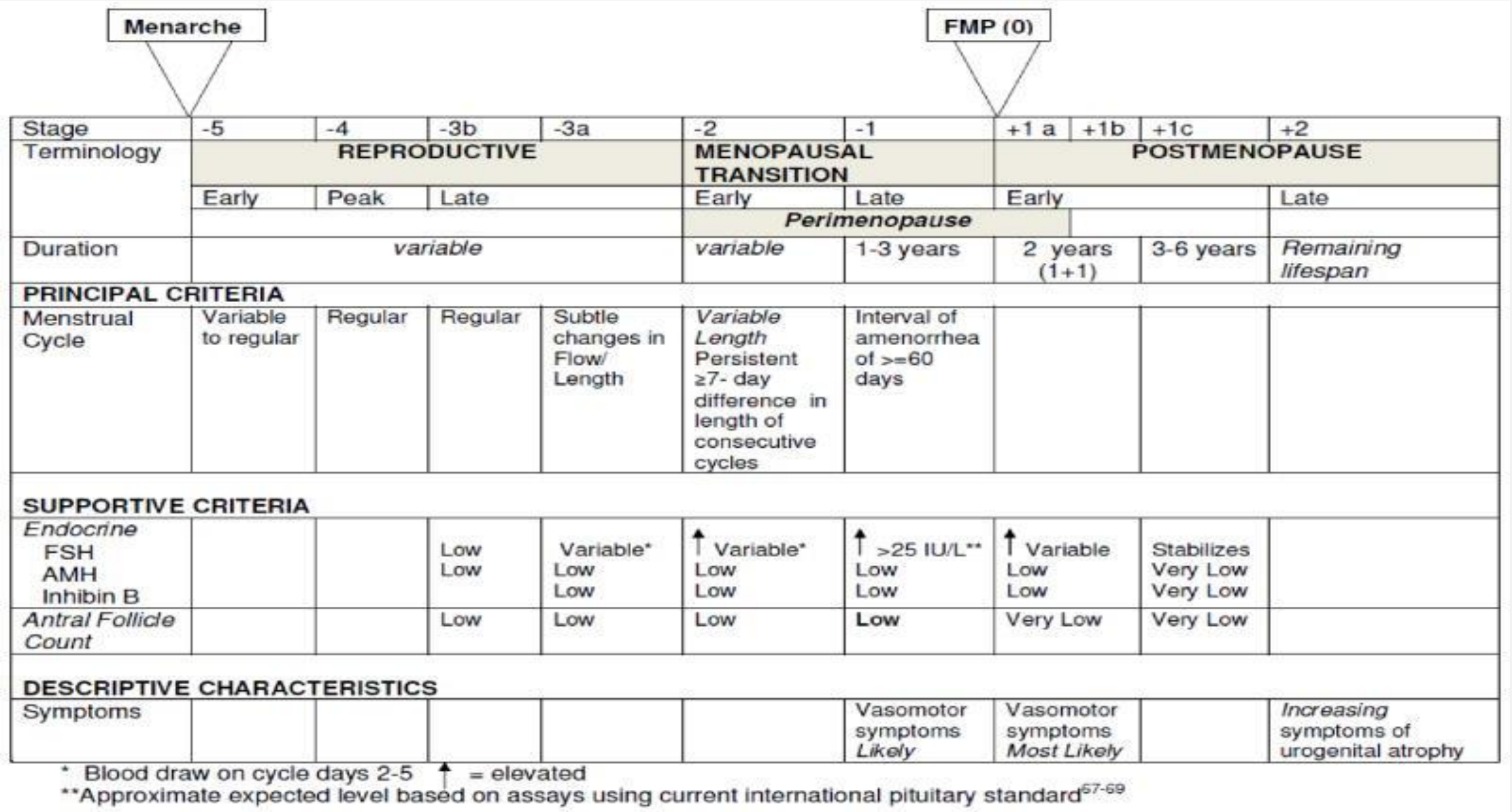
The use of Modern Menopausal Hormone Therapy (MHT- aka HRT or Hormone Replacement Therapy) is usually completely safe and exposes the user to FAR LESS 'RISK' than ESTROGEN CONTAINING CONTRACEPTIVES (which I think most of us routinely prescribe)

BMS https://thebms.org.uk, IMS, EMAS, NAMS

Physiology

- **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 when**
- **Levels of AMH & Inhibin B et al 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**

BMS Handbook, IMS, EMAS, Menopause.org (USA)



Harlow SD, Gass M, et al STRAW 10 Collaborative Group. Executive summary of the Stages of Reproductive Aging Workshop + 10: addressing the unfinished agenda of staging reproductive aging. Menopause. 2012 Apr;19(4):387-95. doi: 10.1097/gme.0b013e31824d8f40. PMID: 22343510; PMCID: PMC3340903.

Why is it important for you as a Pharmacist to be comfortable with diagnosis and management of (Peri) menopause?

Menopause is not considered a 'disease' unless occurring at a very early age (<40 usually)

It is a 'natural transition' from reproductive capability to post reproductive life - but for many it can be a struggle and not all of the symptoms are obvious

All body systems can be impacted so it stands to reason that symptoms are best managed by well trained Primary Care medics

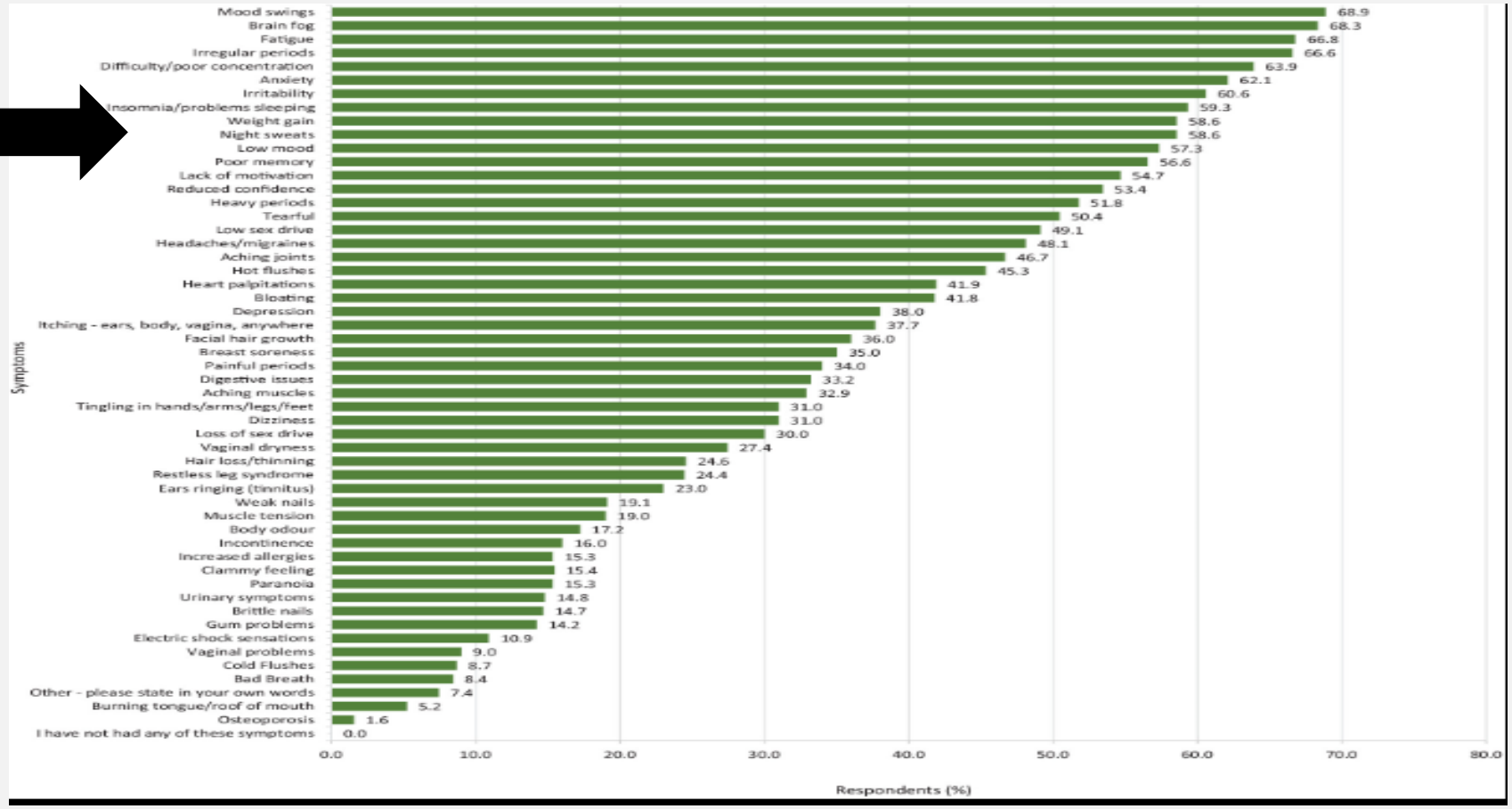
Additionally, prescription medication(s) are a common component of management – both on and off label !

So if you are a GP/Nurse/ Pharmacist and females are among your patient population, you need to know about menopause and perimenopause as more than half the population will experience it If they are lucky enough to live into their mid life

thebms.org.uk/wp-content/uploads/2023/08/17-BMS-TfC-What-is-the-menopause-AUGUST2023-A.pdf
thebms.org.uk/wp-content/uploads/2025/09/02-BMS-ConsensusStatement-BMS-WHC-2020-Recommendations-on-HRT-in-menopausal-women-SEPT2025-A.pdf

Symptoms are many and varied & its not always Flushes and Sweats ; Symptoms vary by region and race also[1]

The BMS say "VMS" are the most common Meno sx- but are they?



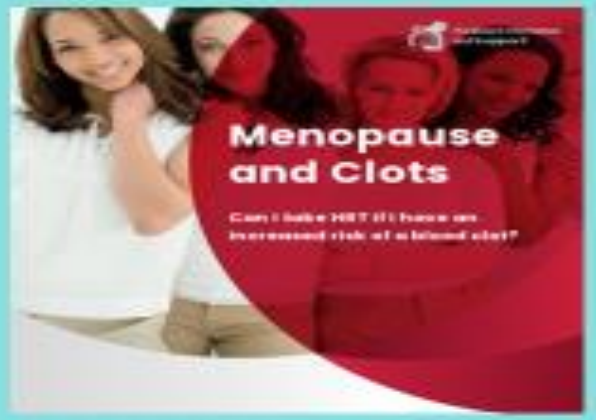
2022 Online survey from UK journal "Women's Health"

Harper JC, Phillips S, Biswakarma R, et al. An online survey of perimenopausal women to determine their attitudes and knowledge of the menopause. *Women's Health*. 2022;18. doi:10.1177/17455057221106890

1. Rossella E. Nappi, et al Prevalence and quality-of-life burden of vasomotor symptoms associated with menopause: A European cross-sectional survey, Maturitas, volume 167,2023,Pages 66-74,ISSN 0378-5122,https://doi.org/10.1016/j.maturitas.2022.09.006.(https://www.sciencedirect.com/science/article/pii/S0378512222002018)

Managing Menopause Symptoms – when the situation is more "Complex"

Know when to REFER; CLOTS, CORONARIES AND *Some* CANCERS



https://www.bhf.org.uk/informationsupport/support/women-with-a-heart-condition/menopause-and-heart-disease

Table 1: Summary of recommendations for use of systemic HRT and vaginal estrogen following treatment of gynaecological cancer

Primary Cancer	Subtype or Risk Group	Systemic HRT	Vaginal Estrogen
Ovarian Fallopian tube Primary peritoneal	High grade serous		
	Low grade serous stage 1		
	Low grade serous stage 2+		
	Endometrioid stage 1		
	Endometrioid stage 2+		
	Clear cell		
	Mucinous		
	Granulosa cell stage 1		
	Granulosa cell stage 2+		
	Germ Cell		
	Borderline tumour: No residual disease		
	Borderline tumour: Peritoneal implants, microinvasive disease, residual disease, recurrence		
Endometrial	Low and intermediate risk		
	High-intermediate risk		
	High risk: ER/PR negative		
	High risk: ER/PR positive		
	Advanced and metastatic		
Cervical	All		
Vulval	All		
Vaginal	All		
Uterine sarcoma	Leiomyosarcoma		
	Endometrial stromal sarcoma		

	Benefits usually outweigh risks. Suitable for non-specialist use.
	Refer to text of BGCS BMS guidelines. Discuss benefits and risks for the individual patient. Consider specialist advice.
	Not recommended. Refer for specialist advice if non-hormonal approaches are not effective.

Health Promotion & Lifestyle Support help improve well being around the Menopause

Nutrition (diet) www.womens-health-concern.org/wp-content/uploads/2023/07/28-WHC-FACTSHEET-Nutrition-in-Menopause-JULY2023-A.pdf

Movement www.womens-health-concern.org/wp-content/uploads/2023/06/29-WHC-FACTSHEET-Exercise-in-menopause-JUNE2023-A.pdf

Weight management www.womens-health-concern.org/wp-content/uploads/2023/06/31-WHC-FACTSHEET-Weight-Gain-and-menopause-JUNE2023-A.pdf

Reduce Alcohol, Smoking & Vaping www.imsociety.org/2009/02/02/smoking-and-hot-flushes, quit.ie, www.womens-health-concern.org/wp-content/uploads/2025/07/34-NEW-WHC-FACTSHEET-Alcohol-and-Menopause-JULY2025-A.pdf

Talk to Friends and Colleagues and Family https://www.arccancersupport.ie, www.hse.ie/eng/services/list/4/mental-health-services/mental-health-engagement-and-recovery/resources-information-and-publications/menopause-mental-health-report.pdf

Breathing & Thinking differently – see CBT for menopause BMS thebms.org.uk/wp-content/uploads/2025/11/01-NEW-BMS-TfC-CBT-NOV2025-C.pdf

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 principal Ovarian hormones :**
- **Estrogen**
- **Progestagen**
- **Testosterone**

thebms.org.uk/wp-content/uploads/2026/01/17-NEW-BMS-TfC-What-is-the-menopause-JAN2026-A.pdf

SPECIAL PRECAUTIONS for HRT use

- **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>

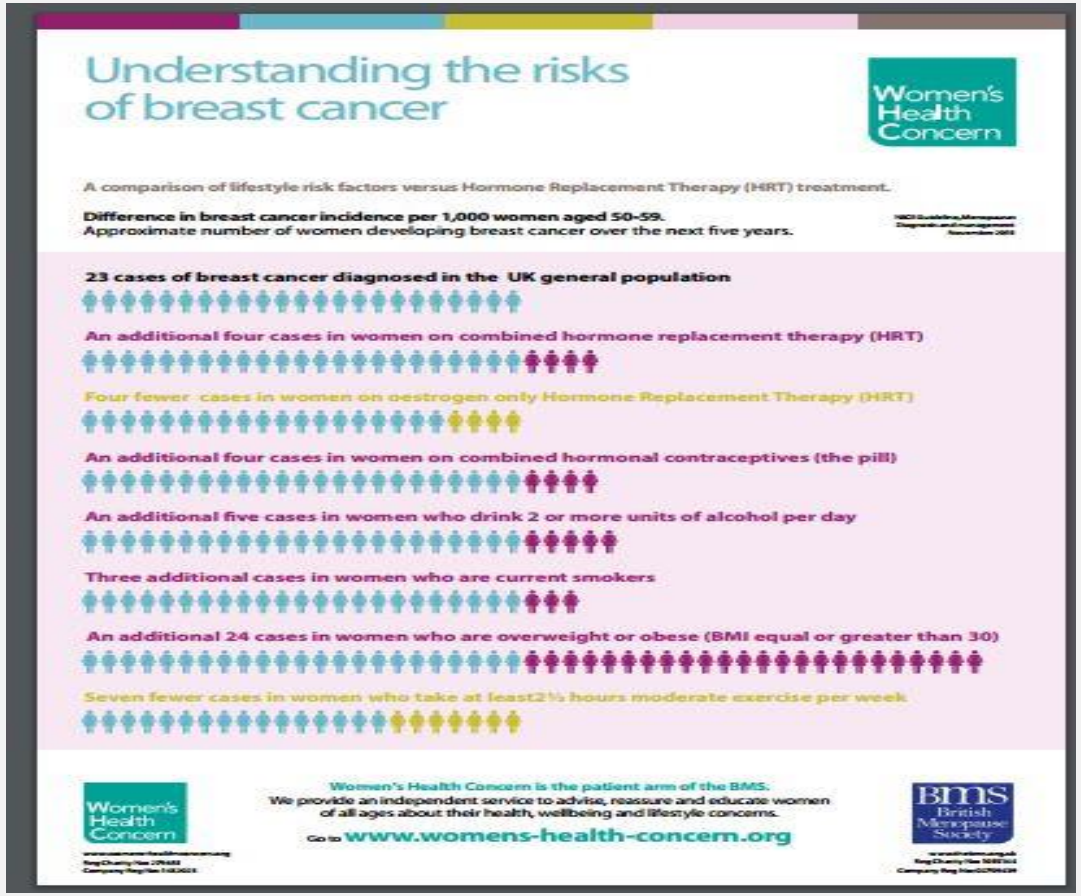
- **Thromboembolic disorders; avoid oral E2, pick a good Prog, start low- COUNSELING**
- **Undiagnosed, irreg bleeding (? investigate ALL Post Meno Bleeds, examine, scan, refer)**
- **Hx of Endometriosis/ Fibroids/ Endometrial cancer/ Hypertriglyceridemia. (Rx wisely & monitor more often)**

Managing patient worries by Managing YOUR worries first

What about the serious risks of HRT? Does HRT *cause* Breast Cancer ?

- **HRT is not a "carcinogen" it is thought of as a promoter; linked to small increase in risk over time (like we see with obesity, alcohol, smoking, lack of physical movement, etc.)**

- **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! It is Poorly understood & grossly under researched**



thebms.org.uk/wp-content/uploads/2025/09/12-NEW-BMS-ToolsforClinicians-Fast-Facts-HRT-and-Beast-Cancer-Risk-SEPT2025-B.pdf

What about serious risks of HRT? Cardiovascular Disease

- **The number one cause of death in females is CVD – we also experience more CVD morbidity when compared with males with CVD[1]**
- **Cardiovascular disease & sex hormones have a complicated relationship but we know Estrogen has major benefits for arterial health improving vascular function and reducing atheroma formation**
- **but the 'Women's Health Initiative' study (2002) raised questions about that- with some MI events linked to oral CEE use- Could this have been related to their exclusive use of an oral Equine Estrogen+MPA cocktail ? Could it have been related to the fact that most of the participants were older (mean age 63) and already suffering symptomatic CVD?[2]**
- **Newer studies have led to the development of the "The "Timing Hypothesis" which suggest that initiating HRT within 10 years of the Final menstrual Period provides protective CVD benefit[3]**

1. Salpeter SR, Buckley NS, Liu H, et al. The cost-effectiveness of hormone therapy in younger and older postmenopausal women. Am J Med 2009

2. thebms.org.uk/publications/consensus-statements/primary-prevention-of-coronary-heart-disease-in-women/

3. thebms.org.uk/2024/03/new-bms-tool-for-clinicians-hrt-after-myocardial-infarction/

Bottom line for menopausal patients with CVD & CVD Risk factors ?

- **People with existing CVD (Angina, MI, etc) should get the OK from cardiology before we Rx HRT - and use only TD, low dose Estradiol and benign Progestagen e.g. Utrogestan if possible**
- **Women over 60 AND >10 years past their LMP can try HRT <u>but more caution is needed & they should be advised the CVD protection window has closed for them</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**

HRT & Thrombosis

- **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**

Hicks A, Robson D, Tellis B, Smith S, Dunkley S, Baber R. Safety of menopause hormone therapy in postmenopausal women at higher risk of venous thromboembolism: a systematic review. Climacteric. 2025 Oct;28(5):497-509. doi: 10.1080/13697137.2025.2503874. Epub 2025 Jun 9. PMID: 40488293.

HRT PRESCRIBING

- **The 3 main ovarian hormones are the 3 estrogens, progesterone and the 4 principal androgens**
- **Estrogen is the key 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**

thebms.org.uk/wp-content/uploads/2022/12/03-BMS-TfC-HRT-Practical-Prescribing-NOV2022-A.pdf

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?**

HRT Estrogens as per BMS

ESTROGENS	Ultra Low dose	Low dose	Typical dose	Moderate dose	High dose
***Oestrogel* pump**	½ a pump daily	1 pump daily	2 pumps daily	3 pumps daily	4 pumps daily
***Divigel* sachet**	¼ sachet daily	½ sachet daily	1 sachet daily	1.5 sachets daily	2 sachets daily
Patches	12.5mcg 2x/week	25mcg 2x/week	50mcg 2x/ week	75mcg 2x/ week	100mcg 2x/ week
***Lenzetto* spray**	1 spray daily	2 sprays daily	3 sprays daily	4-5 sprays daily	6 sprays daily
Oral estradiol	.5mg daily	1mg daily	2mg daily	3mg daily	4mg daily

thebms.org.uk/wp-content/uploads/2022/12/03-BMS-TfC-HRT-Practical-Prescribing-NOV2022-A.pdf

HRT Progestagens as per BMS

PROGESTAGENS	Ultralow & Low E Doses		Typical E Dose		Moderate E dose		High E dose	
	CONTIN	CYCLICAL	**CONTIN**	**CYCLICAL**	CONTIN	CYCLICAL	CONTIN	CYCLICAL
MP/ *Utrogestan*	100mg nocte	200mg x 14 days/ month	**100mg nocte**	**200mg x 14 days/ month**	200mg nocte	300mg x 14 days/ month	200mg nocte	300mg x 14 days/ month
Dydrog/ *Duphaston**	10mg daily	10mg x 14 days/ month	**10mg daily**	**10mg x 14days/ month**	20mg daily	30mg x 14 days/ month	20mg daily	30mg x 14 days / month
MPA/ *Provera*	2.5mg daily	10mg x 14 days/ month	**2.5-5mg daily**	**10mg x 14 days/ month**	5mg daily	10mg x 14 days/ month	10mg daily	20mg x 14 days/ month
NET/ *Primolut* **	5mg daily	5mg x 14 days/ month	5mg daily	5mg x 14 days/ month	5mg daily	5mg x 14 days/ month	5mg daily	5mg x 14 days/ month
MIRENA								

And most recently …. SLYND 2mg Drospirenone

thebms.org.uk/wp-content/uploads/2022/12/03-BMS-TfC-HRT-Practical-Prescribing-NOV2022-A.pdf

Bleeding Control is a common issue

The BMS says: Progestagen administration is REQUIRED to oppose Estrogens & provide Endometrial Protection while using HRT

40% of HRT users experience unexpected / unscheduled PV bleeding[1]
Many HRT users had HMB before they started HRT

The underlying cause is almost never malignancy (as opposed to post-menstrual bleeding in people not on HRT where the underlying cause is often malignancy)[1]

The P should be delivered for at least the same duration as the luteal phase of an average menstrual cycle (12-14 days per month) for a menstruating patient – the P should be delivered every day for people who are no longer menstruating[1]

Getting the E:P dosing right in GP should minimise the chances of UB and reduce the number of unnecessary referrals to Ultrasound scanning, Gyne OPD, etc. - not to mention worry and disruption for the patients

Yes Mirena might make things simpler but not everyone needs or wants one

1. Buchanan C, Robinson M, Macdonald MC. Endometrial cancer rate in Hormone replacement therapy users with postmenopausal bleeding: Retrospective cohort study. Post Reprod Health. 2022 Sep;28(3):143-148. doi: 10.1177/20533691221116171. Epub 2022 Aug 17. PMID: 35976770.

What is the ‘correct’ dose of Progestagen ? That is a long story !

We pick the progestagen and its dose based on the DOSE of the estrogen

In the BMS’ 2023 Tools for Clinicians slide, this is how they classed the different dose of estrogen with >75 mcg being identified as HIGH DOSE

Estradiol – equivalent doses*

	Ultra low	Low	Medium	High
Oral	0.5mg	1mg	2mg	3-4mg
Patch	Half 25	25	50	75-100
Gel-pump	½ pump	1 pump	2 pumps	3-4 pumps
Gel-sachet	½ x 0.5mg sachet - 0.25mg	0.5mg	1-1.5mg	2-3mg
Spray	1 spray	2 sprays	3 sprays	—

* 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.

thebms.org.uk/wp-content/uploads/2022/12/03-BMS-TfC-HRT-Practical-Prescribing-NOV2022-A.pdf

But .. In the 2024 BMS Joint Statement on the Management of unscheduled bleeding on HRT they include this table which calls 75mcg estrogen as MODERATE DOSE and only > 100mcg as HIGH dose

Table 2: Prescribed estrogen dose for ultra-low, low, standard, moderate and high dose regimens

	Ultra-low dose	Low Dose	Standard dose	Moderate dose	High dose
Oestrogel	½ pump	1 pump	2 pumps	3 pumps	4 pumps
Sandrena	0.25 mg	0.5 mg	1 mg	1.5-2 mg	3 mg*
Lenzetto spray	1 spray	2 sprays	3 sprays	4-5 sprays*	6 sprays*
Patch	12.5 µg	25 µg	50 µg	75 µg	100 µg
Oral estradiol	0.5 mg	1 mg	2 mg	3 mg^	4 mg^

* Off-license use ^ Off-license use – rarely required to achieve symptom control
mg = milligrams µg = micrograms

Table 3: Progestogen dose per licensed estrogen dose in the baseline population

Estrogen dose	Micronised Progesterone		Medroxy progesterone		Norethisterone		LNG-IUD (52mg)
	continuous	sequential	continuous	sequential	continuous	sequential	
Ultra/Low	100 mg	200 mg	2.5 mg	10 mg	5 mg*	5 mg*	One – for up to 5 years of use
Standard	100 mg	200 mg	2.5-5 mg	10 mg	5 mg*	5 mg*	
Moderate	100 mg	200 mg	5 mg	10 mg	5 mg	5 mg	
High	200 mg	300 mg	10 mg^	20 mg^	5 mg	5 mg	

* 1 mg provides endometrial protection for ultra-low to standard 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

thebms.org.uk/wp-content/uploads/2024/12/01-BMS-GUIDELINE-Management-of-unscheduled-bleeding-HRT-NOVEMBER2024-A.pdf

Amalgamated HRT Prescribing Table

ESTROGENS	Ultra Low dose	Low dose	Typical dose	Moderate dose	High dose
***Oestrogel* pump**	½ a pump daily	1 pump daily	2 pumps daily	3 pumps daily	4 pumps daily
***Divigel* sachet**	¼ sachet daily	½ sachet daily	1 sachet daily	1.5 sachets daily	2 sachets daily
Patches	12.5mcg 2x/week	25mcg 2x/week	50mcg 2x/ week	75mcg 2x/ week	100mcg 2x/ week
***Lenzetto* spray**	1 spray daily	2 sprays daily	3 sprays daily	4-5 sprays daily	6 sprays daily
Oral estradiol	.5mg daily	1mg daily	2mg daily	3mg daily	4mg daily

PROGESTAGENS	Ultralow & Low E Doses		Typical E Dose		Moderate E dose		High E dose	
	CONTIN	CYCLICAL	**CONTIN**	**CYCLICAL**	CONTIN	CYCLICAL	CONTIN	CYCLICAL
MP/ *Utrogestan*	100mg nocte	200mg x 14 days/ month	**100mg nocte**	**200mg x 14 days/ month**	200mg nocte	300mg x 14 days/ month	200mg nocte	300mg x 14 days/ month
Dydrog/ *Duphaston**	10mg daily	10mg x 14 days/ month	**10mg daily**	**10mg x 14days/ month**	20mg daily	30mg x 14 days/ month	20mg daily	30mg x 14 days / month
MPA/ *Provera*	2.5mg daily	10mg x 14 days/ month	**2.5-5mg daily**	**10mg x 14 days/ month**	5mg daily	10mg x 14 days/ month	10mg daily	20mg x 14 days/ month
NET/ *Primolut***	5mg daily	5mg x 14 days/ month	5mg daily	5mg x 14 days/ month	5mg daily	5mg x 14 days/ month	5mg daily	5mg x 14 days/ month
MIRENA								

** They don't make anything less than a 10mg Duphaston*

*** They don't make anything less than a 5 mg Primolut*

Testosterone ? Why not?

- **Sx of low libido or HSDD is an indication for a trial of testosterone – usually WITH the standard estrogen + progestagen HRT (management of brain fog is currently NOT an indication)**
- **Blood levels do not equal tissue levels or action- so do not use se TT as a diagnostic measure - but Prescribers Should do a baseline total testosterone (TT) before initiating and then after 3mos & then every 12 mos thereafter to ensure patient is not being over medicated**
- **Ask for Total Testosterone (FAI no longer recommended)**
- **Timing of blood draw; between 8 and 10am & not within 2-3 days of off label application of Testogel**
- **Aim for total testosterone in normal physiological range < 2/2.4**

thebms.org.uk/wp-content/uploads/2022/12/08-BMS-TfC-Testosterone-replacement-in-menopause-DEC2022-A.pdf

CONTRACEPTION & HRT

- **Standard HRT is not strong enough to afford Contraception usually**
- **Mirena & Estrogen will obviously give both HRT & Contraception but once the Mirena is in place for > 5 yrs, additional progestagen will be needed**
- **The Combined Hormonal Contraceptives (CHC) such as the combined pill (COCP) or ring or patch are permitted until 50 yoa and it might also help reduce Meno Sx to a degree + provide contraception- but may/may not be suitable for all patients - check the UKMEC for category 3 or 4 risks**
- **You cannot Rx the CHC and HRT at the same time**
- **You can Rx HRT alongside any non-CHC contraceptive**
- **Discuss and figure out what suits best- it could just be a condom**

www.nhs.uk/medicines/hormone-replacement-therapy-hrt/when-to-take-hormone-replacement-therapy-hrt/

Local Estrogen Options for GSM

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

BLISSEL – <u>Estriol</u> .05mg per applicator of gel

OVESTIN – <u>Estriol</u> .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

thebms.org.uk/wp-content/uploads/2025/11/09-NEW-BMS-ConsensusStatement-Genitourinary-Syndrome-of-Menopause-GSM-NOV2025-B.pdf

Ospemifene & Prasterone for GSM

- Ospemifene is an **oral** TSEC which acts as an agonist in the vaginal mucosa, lowering vaginal pH and improving the vaginal maturation index, reducing vaginal dryness and dyspareunia.
- There is an antagonist effect on the endometrium and breast tissue, and it can be used in women with a history of breast and endometrial cancer, who have completed treatment. It is an appropriate choice for women who are not eligible for vaginal estrogen therapy or who prefer oral treatment to any form of vaginal treatment
- It is marketed as ***Senshio***
- PO Ospemifene is licensed in the UK & USA
- PO Ospemifene is not licensed in the ROI and not covered by Free HRT scheme – we can rx them on the exempt medical product list

- Prasterone is a **vaginal gel** containing DHEA (dehydroepiandrosterone) which is a sex hormone precursor. Marketed as ***Intrarosa***
- PV DHEA is converted into estrogens and androgens by enzymes within the epithelial cells of the vagina resulting in maturation of the parabasal cells into superficial cells, with an associated increase in mucosal thickness and secretions.
- There is also an increase in collagen density in the lamina propria and stimulation of the muscle in the layer below.
- PV DHEA is licensed for GSM in the UK & USA
- It is not licensed in the ROI and not covered by the free HRT scheme – we can rx them on the exempt medical product list

thebms.org.uk/wp-content/uploads/2025/11/09-NEW-BMS-ConsensusStatement-Genitourinary-Syndrome-of-Menopause-GSM-NOV2025-B.pdf
https://www.hpra.ie/regulation/human-medicine/wholesalers-and-retailers/exempt-medicinal-products

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-]**
- **<u>Long term observational studies have reported no extra risk for those using HRT with a family history of breast cancer</u>**
- **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*

Latest chatter on Social media .....

Fezolinetant & Elinzanetant- the NKR inhibitors that improve VMS

The KNDy neurons (Kisspeptin, Neurokinin B & Dynorphin) which are located in the arcuate nucleus of the hypothalamus play a pivotal role in thermoregulation and gonadotropin hormone release (among other things). One Neuromodulator that is involved in KNDy activity is known as "Neurokinin B" (NKB).

NKB is believed to be a key upstream regulator of GnRH secretion and, consequently, a fundamental regulator of the HPO axis[1] via its effects on the NKB receptors (known as NK1, NK2 and NK3)

NK3 receptors (NK3R) are primarily found in the central nervous system and play a crucial role in the pathophysiology of Vasomotor Symptoms in menopause (VMS)- NK3R is also involved in anxiety modulation through its distribution in the limbic & brain stem regions[2] Two NK3 receptor antagonists (the NK3R antagonist Fezolinetant and the dual NK1R/NK3R antagonist Elinzanetant), have been developed with the hopes of helping people with menopausal VMS[3]

Veoza (fezolinetant) IS avail in the ROI (not on GMS or DPS) and Lynkuet (Elinzanetant) IS NOT

OASIS 4- the ongoing, multicentre, multicountry, double-blind, randomized, placebo-controlled, phase III study is evaluating the efficacy and safety of Elinzanetant in women aged 18 to70 years at high risk of developing or with a personal history of HR+ breast cancer receiving tamoxifen or aromatase inhibitors.

1. *Meczekalski B, et al A New Hope for Woman with Vasomotor Symptoms: Neurokinin B Antagonists. J Clin Med. 2025 Feb 21;14(5):1438. doi: 10.3390/jcm14051438. PMID: 40094924; PMCID: PMC11900985.*
2. *www.sciencedirect.com/topics/neuroscience/neurokinin-3-receptor*
3. *www.maturitas.org/article/S0378-5122(25)00590-0/pdf: Fezolinetant compared with Elinzanetant for the treatment of vasomotor symptoms associated with menopause: A matching-adjusted indirect comparison Petra Stute a , Marla Shapiro C.M. Bogdan Muresan f , Karla Martins b c , Antonia Morga , Yechu Hua g c , Ting-an Tai , Angela Zhao g d , Mayank Ajmera , Jingyi Liu Rossella E. Nappi*

"There is enough evidence to show that fezolinetant provides benefits and value for money, so it can be used routinely across the NHS in this population"
"Fezolinetant is not recommended for people who have breast cancer or other oestrogen-dependent cancers. For people who have had breast cancer or other oestrogen-dependent cancers and are no longer on any cancer treatments, an individual risk assessment is advised"

Endometriosis & HRT; no drama just be aware

- **There is a slight risk of Endometriosis reactivation with HRT estrogen use as well as an even more rare risk of malignant change[1] when we Rx HRT to someone w a b/g of Endometriosis**
- **Prescribers need to consider offering either a potent progestagen/ Mirena/ higher dose Utrogestan if the pt still has a womb**

1. *Zanello M, Borghese G, Manzara F, Degli Esposti E, Moro E, Raimondo D, Abdullahi LO, Arena A, Terzano P, Meriggiola MC, Seracchioli R. Hormonal Replacement Therapy in Menopausal Women with History of Endometriosis: A Review of Literature. Medicina (Kaunas). 2019 Aug 14;55(8):477. doi: 10.3390/medicina55080477. PMID: 31416164; PMCID: PMC6723930.*

Endometriosis & HRT – in the hysterectomised patient

- **If HRT is offered after hysterectomy for endometriosis, we still add a progestagen (esp. with a b/g of moderate to severe disease, when we know there was lots of residual Endo tissue left in at resection or if there is an Endometriotic symptom flare after we start the HRT**
- **If HRT is offered after BSO for Endometriosis , the BM[1] says: 'The estrogen threshold theory suggests that add-back HRT therapy or HRT after removal of the ovaries contains a low enough dose of estrogen for maintenance of bone density and relief of hypo estrogenic and vasomotor symptoms but not enough to reactivate endometriosis'[1]**
- **So, yes we can and often SHOULD in some cases (e.g. < 45yo) Rx HRT after TAH/BSO for endometriosis but we must add in a progestagen to avoid the risk of endometriotic flare (about 2% risk)[2] or malignant transformation**
- **BMS suggest we offer a continuous Progestagen regime for at least for the first year TAH, then can try E only[2]**
- **Pt must be informed good data is lacking and we both have to watch out for pain, pressure, haematuria, etc.**

1, https://thebms.org.uk/wp-content/uploads/2022/12/10-BMS-TfC-Induced-Menopause-in-women-with-endometriosis-NOV2022-A.pdf
2. Gemmell LC, Webster KE, Kirtley S, Vincent K, Zondervan KT, Becker CM. The management of menopause in women with a history of endometriosis: a systematic review. Hum Reprod Update. 2017 Jul 1;23(4):481-500. doi: 10.1093/humupd/dmx011. PMID: 28498913; PMCID: PMC5850813.

Menopause, HRT, Grey Matter & Dementia

A 2026 study in *Psychological Medicine*, found that using HRT does not appear to help certain aspects of menopause such as reductions in grey matter volume, increased levels of anxiety/depression & difficulties with sleep. Looking at 125 000 women from the UK Biobank, authors noted an increase in anxiety and depression around menopause as well as cognitive impairment
They then tried to evaluate the experiences of people using HRT vs those not using HRT but failed to find mitigation[1]

Prof Pauline Maki's paper on Brain Fog in Menopause[2] reminds us that:

- **Women lose grey matter volume with Aging & NOT BECAUSE OF MENOPAUSE**
- **Cognitive changes at (peri) menopause are usually short term and resolve with time – middle aged males experience this too ! This should not be confused with dementia; dementia before age 64 years is thankfully rare**
- **HRT use has not been shown to convey any direct benefit on cognition – unless the cognitive issues were exacerbated by VMS and poor sleep – HRT can help mitigate both of these issues**

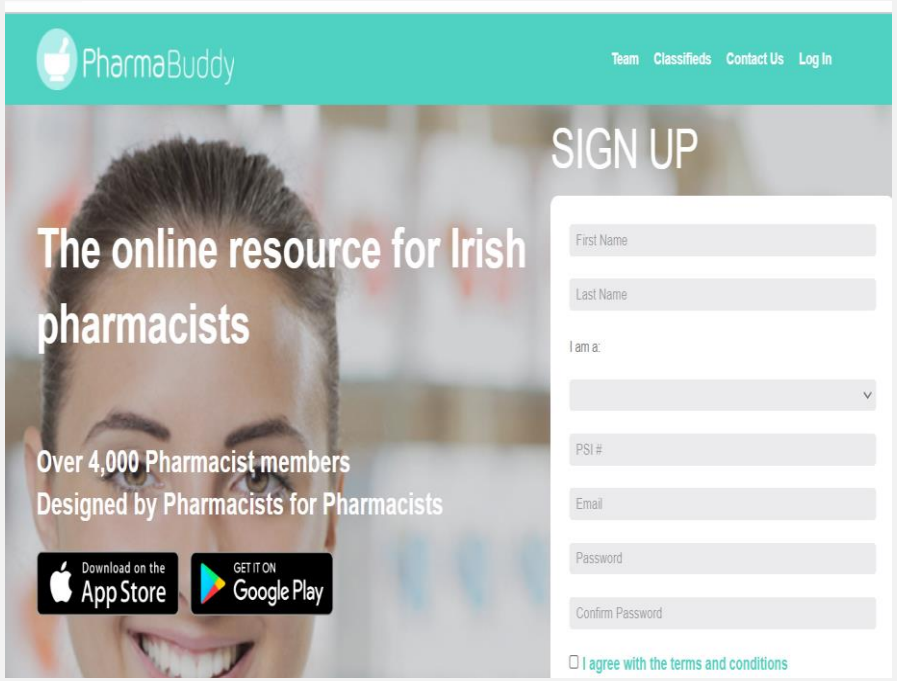
Zuhlsdorff K, Langley C, Bethlehem R, Warrier V, Romero Garcia R, Sahakian BJ. Emotional and cognitive effects of menopause and hormone replacement therapy. Psychological Medicine. 2026;56:e24. doi:10.1017/S0033291725102845

thebms.org.uk/wp-content/uploads/2025/11/24-NEW-BMS-ToolsforClinicians-Measurement-of-serum-estradiol-JULY2025-C.pdf
2. P. M. Maki & N. G. Jaff (2022): Brain fog in menopause: a health-care professional's guide for decision-making and counseling on cognition, Climacteric, DOI: 10.1080/13697137.2022.2122792

Keep up to date and share cases

www.menopausesocietyireland.ie/

www.consilienthealth.ie/healthcare-professionals/menopause/menopause-patient-management-guide/



Menopause Society
OF IRELAND

Menopause Society
OF IRELAND

Save the Date

Menopause Society of Ireland
Annual Conference

Saturday, 12 September 2026

Royal Dublin Convention Centre

Thank you & Questions?