HRT - Initial Consultation

The worrying publicity that accompanied previous studies, including the Women's Health Initiative (WHI) and the Million Women Study (MWS) has led to many women being concerned and anxious about the potential risks of hormone replacement therapy (HRT)\(^1,2\). It is very important to explore a woman's fears and understanding of the menopause and her expectations for HRT.

Data accumulated from studies over the period of a decade or so have shown that, in women under the age of 60 years with symptoms or other indications, starting HRT near the menopause should result in a favourable benefit:risk ratio for many women.

See also separate Menopause and its Management, Hormone Replacement Therapy (including Benefits and Risks), HRT - Follow-up Assessments and HRT-Topical articles.

The following outlines assessment and discussion points in an initial consultation about HRT.

Patient assessment

History
- Confirm the menopause if possible, as the diagnosis is usually clinical.
- Discuss the symptoms being experienced - consider whether they are likely to respond to HRT. Establish how much they are affecting the woman’s life.
- Bleeding - ask whether the woman is still having periods. If not, ask when her last period occurred. The majority of women notice irregularities in their cycle around the menopause: the cycle may lengthen to many months or shorten to 2-3 weeks; a slight increase in the amount of menstrual blood loss is common.
- Postmenopausal bleeding is vaginal bleeding occurring after 12 months of amenorrhoea and needs urgent investigation. Enquire about postcoital bleeding. Any abnormal bleeding pattern should be investigated before starting HRT.
- Age:
  - The average age of the menopause in the UK is 51 years.
  - To have a menopause up to five years younger or older than this is within the normal range.
  - Early menopause relates to those women aged <45 years.
  - Premature ovarian insufficiency occurs in women aged under 40 years.
- Uterus - cyclical progestogen must be added for those women who have not had a hysterectomy, to prevent endometrial cancer.
- Explore risk factors for osteoporosis, breast cancer and coronary heart disease (CHD).

Examination
- Blood pressure.
- Height and weight.
- Other examination as indicated by the history (routine vaginal/bimanual examination is not required).

Health promotion
There is some evidence that healthy lifestyle behaviours can improve vasomotor symptoms\(^3\). In addition, weight loss, mindfulness and cognitive behavioural therapy can have a mild-to-moderate effect on these symptoms\(^4\).

Discuss with women any modifiable risk factors for cardiovascular disease, such as alcohol, smoking, diabetes and hypertension control.

Take the opportunity for health promotion and offer lifestyle advice:
- Smoking and alcohol.
- Diet and exercise.
- Check cervical smear is up to date.
- Discuss breast self-examination and breast cancer screening.
Investigations

- The menopause is usually a clinical diagnosis.
- Laboratory tests are not required in the following otherwise healthy women aged over 45 years with menopausal symptoms:
  - Perimenopause based on vasomotor symptoms and irregular periods.
  - Menopause in women who have not had a period for at least 12 months and are not using hormonal contraception.
  - Menopause based on symptoms, in women without a uterus.
- There is no need for follicle-stimulating hormone (FSH) level to be undertaken routinely.
- FSH test could be considered to diagnose menopause in women aged 40-45 years with menopausal symptoms.
- FSH test should be undertaken in women aged under 40 years in whom menopause is suspected.
- Other tests, such as TFTs, glucose, cholesterol and pelvic scan, may be considered in some women.

See separate Menopause and its Management article for more information.

Counselling

Explain indications for HRT

For women with premature (age <40 years) or early (<45 years) menopause, current guidelines recommend HRT for women without contra-indications, until the age of 51 years for the treatment of vasomotor symptoms, and bone and cardiovascular protection.[5, 6]

Current indications for the use of HRT are:

- For the treatment of menopausal symptoms where the risk:benefit ratio is favourable, in fully informed women.
- For women with early menopause until the age of natural menopause (around 51 years).
- For those women under 60 years who are at risk of an osteoporotic fracture in whom non-oestrogen treatments are unsuitable.

Starting HRT in women over the age of 60 years is generally not recommended.

Discuss potential benefits

For most symptomatic women, use of HRT for five years or fewer is safe and effective. Benefits of HRT include:

- Vasomotor symptoms (including sleep or mood disturbance caused by these symptoms).
- Urogenital symptoms.
- Reduction of osteoporosis and also reduction in osteoporosis-related fractures.
- There is evidence that HRT reduces the risk of CHD, especially in women aged under 65 years.
- HRT may reduce palpitations, improve sleep and improve mood. However, it is not a treatment for clinical anxiety or depression.

Discuss potential risks

- Advise the woman that there is a small increased risk of:
  - Breast cancer - the risk is only with HRT containing oestrogen and progestogen.
  - Venous thromboembolism (VTE), pulmonary embolism and stroke with taking oral HRT (combined oestrogen and progestogen, and oestrogen-only) increases the risk of these.
  - However, the increased occurrence of these events (VTE, pulmonary embolism and stroke) can be prevented by the use of the transdermal route of estradiol administration.
  - CHD - for women who have started combined therapy more than 10 years after menopause.

Document that you discussed benefits and risks in your consultation notes.

For more detailed information see separate Menopause and its Management article.

Discuss potential side-effects

- Oestrogen: breast tenderness, leg cramps, bloating, nausea, headaches.
- Progestogen: premenstrual syndrome-like symptoms, breast tenderness, backache, depression, pelvic pain.
- Bleeding: monthly sequential preparations should produce regular, predictable and acceptable bleeds starting towards the end of, or soon after, the progestogen phase. Breakthrough bleeding is common in the first 3-6 months of continuous combined and long-cycle HRT regimens.
- There is a discussion of how to manage these side-effects in the separate HRT - Follow-up Assessments article.

Discuss contraception

- HRT is not a contraceptive and a woman is considered potentially fertile for two years after her last menstrual period if she is aged under 50 years and for one year if she is aged over 50 years.
- For women with a uterus, oestrogen HRT and an intrauterine system (IUS) may be an optimal combination.
- Alternatively, the progestogen-only pill can be given to women who are taking cyclical combined HRT.
Women aged 50 years and over should not be prescribed the combined oral contraceptive pill. See separate Contraception from 40 to the Menopause article.

Discuss alternatives to HRT
See the paragraph at the bottom of the separate Menopause and its Management article.

Which HRT should I prescribe?
It is important that an individualised approach be undertaken at all stages of diagnosis, investigation and management of menopause[5].

The dose, regimen and duration of HRT need to be considered for each individual. There is no maximum duration of time for women to take HRT; for the women who continue to have symptoms, the benefits from HRT usually outweigh any risks. Systemic HRT should not be arbitrarily stopped at age 65 years; treatment duration should be individualised based on a woman's risk profile and personal preference[7].

Use the lowest effective dose of HRT for the minimum duration to control symptoms. The dosage and type of HRT should be tailored to symptoms and possible side-effects. Start with a low-dose oestrogen and consider gradually increasing the dose after four to six weeks if vasomotor symptoms persist.

Micronised progesterone is a natural, 'body-identical' progestogen, devoid of any androgenic as well as glucocorticoid activities but being slightly hypotensive due to anti-mineralocorticoid activity. It may be the optimal progestogen in terms of cardiovascular effects, blood pressure, VTE, probably stroke and even breast cancer although this evidence is only from observational studies and they may carry a higher risk of endometrial hyperplasia[8]. There is currently only one available to prescribe in the UK. This can be prescribed with oral or transdermal oestrogen. It is commonly prescribed at a dose of 200 micrograms a day for two weeks followed by a two-week break for those women who are still having periods. For a continuous combined use, it should be prescribed as 100 micrograms daily. It is usually taken at night.

As transdermal oestrogen is associated with fewer risks than oral HRT, a transdermal route may be preferable for many women. This route is also advantageous for women with diabetes, for women with a history of VTE and also for women with thyroid disorders. Transdermal oestrogen should also be given to those women with a BMI over 30 kg/m². In addition, transdermal HRT is preferable to those women with a history of migraine or gallbladder problems.

Testosterone is not licensed for use in women in the UK. However, it does have a role for those women who have low libido despite receiving HRT. Testosterone has been shown in many studies to improve mood, energy and libido in menopausal women[9].

Systemic or local; cyclical or continuous?
- Women should be prescribed a sequential combined HRT if:
  - Their last menstrual period was less than one year previously.

- Women can be prescribed a continuous combined HRT if:
  - They have received sequential combined HRT for at least one year; or
  - It has been at least one year since their last menstrual period; or
  - It has been at least two years since their last menstrual period if they had a premature menopause.

- Topical (vaginal) oestrogen is advisable as first-line for women with vaginal atrophy.
- However, around 10-25% of women still have symptoms with topical oestrogen so will require HRT in addition.

Which delivery route?
This depends partly on patient preference but there are also other advantages to certain delivery routes.

- By avoiding the first pass metabolism through the liver, non-oral preparations (ie patches or gels):
  - Have less effect on clotting factors.
  - Reduce triglycerides.
  - Are are often more suitable for:
    - Women who experience side-effects such as nausea with oral preparations.
    - Women with liver disease or gallstones.
    - Women with a history of malabsorption.
    - Women who are at risk of thrombosis.
    - Women with diabetes.
    - Women taking enzyme-inducing drugs.
    - Those women with a history of migraines (the bolus effects of oral medication can trigger migraines in some women).

- Low-dose vaginal oestrogen (tablet, cream, pessary, or vaginal ring) may be preferred if symptoms are primarily urogenital.
- The levonorgestrel-releasing intrauterine system plus oestrogen component may be used if:
  - Progestogen side-effects are experienced with other progestogen preparations and delivery routes.
  - Contraception is still needed.
  - There is persistent heavy bleeding on cyclical combined HRT and normal investigations.
Tibolone

- Tibolone is a selective oestrogen receptor modulator (SERM) which combines oestrogenic and progestogenic activity with weak androgenic activity.
- It can be used in women with an intact uterus who have had no bleeding for more than one year, without the need for cyclical progestogen.
- Randomised controlled trials suggest it may be helpful in improving sexual function and vasomotor symptoms \[10\].
- There may be a small increased risk of stroke, and endometrial and breast cancer (including breast cancer recurrence) with tibolone.
- Tibolone is less effective than combined HRT in alleviating menopausal symptoms.

Further reading & references


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