Menopausal hormone therapy (MHT) for the management of menopausal symptoms

Position statement

Key messages:

1. **Menopausal hormone therapy is the most effective treatment for vasomotor symptoms (hot flushes and sweats) and urogenital symptoms around the time of menopause**
2. **MHT is not suitable for all women. A thorough medical history to assess individual benefits and risks should be taken before MHT is prescribed, with risks reassessed annually**
3. **As well as appropriate management of symptoms, maintenance of health for women around and after menopause includes lifestyle factors such as good nutrition, being physically active, not smoking and limiting alcohol.**

Audience: Government, health organisations, women's organisations, health professionals

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Background

Menopause occurs when a woman's ovaries lose their reproductive function, resulting in periods ceasing. Usually, this occurs between the ages of 45 and 55. In Australia the average age of menopause is 51.

The resulting drop in the hormone oestrogen causes symptoms for up to 85% of women, with one in four postmenopausal women reporting moderate-severe symptoms.[1] The main symptoms are vasomotor (hot flushes and night sweats) and urogenital atrophy symptoms (including vaginal dryness and painful sexual intercourse). However, a range of other symptoms can occur and impact a woman's quality of life. [2]

Menopausal hormone therapy or MHT (formerly known as hormone replacement therapy, or HRT) is the most effective treatment for the management of the vasomotor and genito-urinary symptoms of menopause.[3, 4,5] MHT became popular in the 1960s and by 2001 in Australia, 21% of women aged 50 years or older reported using MHT. [6]

In 2002 research from a large-scale randomised study called the Women's Health Initiative (WHI) was published, highlighting the risks and benefits of MHT for women between the ages of 50-79 years[7]. A 50% reduction in the prescription of MHT from 2001-2005 occurred because the study reported that MHT caused an increased risk in coronary heart disease (CHD) and breast cancer. [7,8,9] In the following years, reanalysis of the initial WHI data was performed and the results were stratified according to age, with adjustment for risk factors. The subsequent results suggested that short-term use of MHT in healthy women 50-60 years of age, (ie around the age of menopause) was appropriate for management of symptoms. [10,11,]

Managing menopause continues to be an important area of healthcare for women, GPs and other health professionals. Evidence regarding the risks and benefits of MHT has improved markedly over the past 30 years and this is helping to provide clarity and assistance in clinical decision-making. Although there are still differing opinions on the use of MHT, there is agreement on a number of important aspects of its use. These are outlined in this paper.

In providing high-quality content and resources for a range of audiences, Jean Hailes ensures that any published information is based on the latest and most relevant peer-reviewed literature and evidence, such as clinical guidelines and management pathways.

Jean Hailes acknowledges that there are a number of comprehensive MHT statements published by expert societies and health organisations (including the North American Menopause Society, the International Menopause Society, US Endocrine Society, Australasian Menopause Society, National Institute for Health and Care Excellence (NICE)) that have extensively evaluated the research evidence. The Jean Hailes position statement focuses on the evidence of benefits and risks associated with MHT, to support women in their health decision-making and the work of health professionals.

The Jean Hailes position

JH notes the following evidence

1. MHT (in the form of a pill, patch or gel) is the most effective treatment for the management of the vasomotor symptoms (hot flushes and sweats). Vaginal oestrogen (MHT applied locally as a cream, pessary or tablet) is the most appropriate for genito-urinary symptoms (vaginal dryness, urinary problems) of menopause.[3,4,5,13]
2. MHT is not suitable for all women. A thorough medical history to assess individual benefits and risks should be taken before MHT is prescribed [15,16].
3. MHT is effective for reducing postmenopausal bone density loss and protects against fracture, but is not recommended as first-line treatment for low bone density.[14]
4. Women with a history of hormone-dependent cancer (eg breast cancer) should not be prescribed MHT [15,16]
5. Women with early menopause (onset before 45 years) or premature menopause (onset before 40 years) are recommended to have some form of oestrogen / progestogen treatment (MHT or alternative, such as combined hormonal contraceptive preparations), unless contraindicated, until the age of expected menopause. [17]
6. The risks of MHT differ, depending on the type, dose, duration of use and delivery method (eg tablet, patch, pessary, cream), when it is started (in relation to the woman's age and time of menopause) and whether a progestogen is used. [16]

a) **Cardiovascular disease risk –** MHT does not increase coronary heart disease risk when started in women aged under 60 years old. [17]

b) **Breast cancer risk**

- Women who are currently using combined oestrogen-progestogen MHT have an increased risk of breast cancer compared with women who have never used it. [18]
    - The level of increased breast cancer risk with MHT use varies, according to which data is analysed. It is not possible to estimate an overall absolute risk of breast cancer by combining and examining all the available MHT research. Research studies may look at different types of MHT, different doses, different ages of women, different age of treatment initiation, different duration of use of MHT. All these factors may influence the risk.
- The risk of breast cancer increases the longer a woman uses combined MHT, but decreases with time after treatment is stopped.[15] Some studies suggest that the risk may remain elevated for up to 10 years after treatment has stopped. [21]
- In women using oestrogen-only MHT, the increased risk of breast cancer is smaller. [20,21]

c) **Venous thromboembolism (VTE) risk**

- The risk of venous thromboembolism (VTE) – including blood clots affecting the legs and the lungs – in women taking MHT is increased by oral MHT, while the risk associated with transdermal MHT, given at standard therapeutic doses, is no greater than baseline population risk.[22]

Key points

1. The impact of menopause symptoms on a woman's quality of life is an important consideration in clinical decision-making relating to menopause management.
2. MHT is a suitable short-term treatment for the management of menopause symptoms and should be used for the shortest duration and lowest dose consistent with treatment goals and the risks of the individual woman.
3. If a woman is prescribed MHT, annual assessments should be made by a GP or specialist to assess continued need for therapy and/or any change in risk factors.
4. MHT is not recommended as first-line treatment for prevention of disease.
5. Because women experiencing early (<45 years) or premature menopause (<40 years) are at higher risk of cardiovascular disease, cognitive decline, osteoporosis and early mortality, the use of combined oestrogen and progestogen (when appropriate) hormone therapy is recommended until the average time of menopause.
6. Custom-compounded (bioidentical) hormone therapy is not recommended as a management option for menopausal symptoms because of a lack of regulation (Therapeutic Goods Administration), safety and quality standards and evidence-based research to support its use.
7. New research in the area of menopause management is conducted all the time. It is important that GPs and other healthcare professionals remain informed and up to date with the latest evidence.

Informed decision-making

Consumers have a right to easy-to-understand and up-to-date information about their healthcare and conditions, including treatment options, expected outcomes, risks, possible side effects and costs. This will help them make informed decisions about their care.

1. A health professional consultation for the management of menopause symptoms should include a discussion with the woman about available and appropriate treatment options. If MHT is indicated, the benefits and risks of MHT for the individual should be discussed.
2. Information about benefits and risks of MHT should be provided to the woman in a format that is easy for her to understand, take away and consider following the consultation.
3. A healthcare provider should give consumers every opportunity to ask questions as part of the shared decision-making process. They should also ensure that a woman has understood the information that has been discussed and/or provided.
4. Women should be provided with the best available, evidence-based information to assist their health decision-making.
5. A woman should be given adequate time to consider, ask questions about and discuss the menopause treatment options available to her.

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Resources

Jean Hailes for Women's Health
jeanhailes.org.au/health-a-z/menopause

Australasian Menopause Society
https://www.menopause.org.au/health-info/fact-sheets

https://www.menopause.org.au/health-info/fact-sheets/what-is-menopausal-hormone-therapy-mht-and-is-it-safe

https://www.menopause.org.au/health-info/fact-sheets/9-myths-and-misunderstandings-about-mht

Cancer Australia
https://breastcancerriskfactors.gov.au/

Cancer Council NSW
https://www.cancercouncil.com.au/754/cancer-information/general-information-cancer-information/fact-sheets-and-position-statements/cancer-council-new-south-wales-combined-hormone-replacement-therapy-and-cancerfact-sheet/

Cancer Research UK
https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/hormones-and-cancer