‘Ask an Expert’: Dr Sonia Davison, menopause management

The answers provided in this document are for your knowledge and education only, they are not intended to provide specific medical advice. You will need to take into consideration each patient and their own presentation when providing medical management.

Question	Answer
Does premature menopause = premature ovarian failure?	No! Premature menopause could be due to surgical removal. POI usually means menopause due to auto-immune or other causes.
When you say higher doses in premature menopause - can you please give us an example of dose	Average reproductive level of oestradiol is 400, patches generally 150-200. Want the equivalent of a 50+ oestradiol patch, wouldn’t want to be lower than 50, ideally higher. Will depend on tolerance.
Is there a bone preserving dose of MHT?	Studies report that even very low doses of oestrogen can protect bones. One approach is to do a bone density scan at start of therapy and a year after starting therapy and see if there’s been a change. If they’re losing bone density, perhaps they’re not on enough MHT to see the protective effect
How is CVD risk a contraindication for MRT?	There is a CVD risk benefit to MHT, but it can depend on the MHT type and when they started it – e.g. higher risk if 65+, or existing CVD, but if they’re 50 there will likely be a benefit! It will depend also on general CVD risk factors and family history of CVD etc.
What about focal migraines? Is oral HRT/MHT contraindicated? Can we use oestrogen patch?	The pill is a really high dose of hormone, but MHT is a much lower dose and can be used when there’s a history of migraine or current migraine. Consider transdermal as first line. Refer to this AMS information sheet for more: Link: https://www.menopause.org.au/hp/information-sheets/560-migraine-headaches-menopause-and-mht-hrt
When do you change from cyclical MHT to continuous MHT if starting a perimenopause patient?	Depends if bleeding and if it lightens up on sequential – indicates they’re closer to menopause and good indication to try continuous. Some will stop bleeding anyway.

How do you decide which women with endometriosis need progesterone?	After hysterectomy, if there has been extensive endometriosis associated with bothersome symptoms there is a theoretical potential for oestrogen only treatment to stimulate the growth of any remaining endometriosis deposits, hence addition of a progestogen may protect against this.
How long would you leave the Mirena in for the purpose of treating menopausal symptoms? 5+/-2 yrs ?	If the Mirena is in and oestrogen is being used, you can keep the Mirena in for 5 years. If they stop the oestrogen, it can stay in for 7 years but we're not relying on it for endometrial protection for more than 5 years.
For perimenopause - can you use ocp + MHT?	If women are younger than 50 years, without risk factors and generally healthy the COCP can be used to control bothersome perimenopausal symptoms, but low dose preparations should be used. Or MHT, but the choice will depend on bleeding, symptoms, general health, the need for contraception and other risk factors.
Perimenopausal woman with menorrhagia and menopausal symptoms - is her menorrhagia likely to be helped by MHT or should they try OCP eg zoely first.?	Either low dose COCP or Mirena plus oestrogen.
How do you deal with bleeding side effects of MHT?	If women are perimenopausal with erratic periods, then a sequential regimen of MHT should ensure that they have a regular scheduled withdrawal bleed. Reassure women that any bothersome bleeding after initiation of MHT should settle in the first few months. If bleeding is still bothersome at this point then if on continuous MHT a trial of sequential MHT may be necessary, or investigation via transvaginal ultrasound to see if any pathology is evident e.g. a polyp. Some progestogens are better at controlling bleeding compared with others. Mirena may be a good option.
Is Kyleena IUD suitable for MHT?	No study data on this, so not able to recommend this.
Is there a maximal time of using MHT	There is no maximal duration. The guidelines suggest treating with the lowest dose for symptom control for the shortest duration. Some women will have long-term symptoms and require long-term use. Some women in their 80s are still on MHT, and with long-term use and older age low dose and transdermal MHT would generally be recommended. The North American Menopause Society has a useful and brief position statement on MHT (HRT) use after the age of 65 years.
Managing mood changes around menopause	Consider that mood may be due to hormonal changes, some people will be offended if you offer antidepressants. Many will do well with hormone treatment, but SSRIs or other antidepressants might be useful or needed.

Would you use MHT if the woman only has significant mood disturbances with no vasomotor symptoms/hot flushes/sweats?	The decision will be up to the woman, once informed of the likely hormonal link with her mood symptoms, and the benefits and risks of MHT vs. other options – e.g. antidepressants or counselling. But MHT may benefit mood disturbance around the time of perimenopause / menopause.
Please comment on MHT in prevention of dementia	There are marked cognitive changes around perimenopause, these symptoms tend to settle after menopause. Some women will benefit with MHT – especially in aiding symptoms of sleep disturbance, lethargy or 'brain fog'. There is no evidence to suggest that MHT will prevent cognitive decline; the exception here is premature menopause.
Can you recommence MHT when symptoms recur after several months post cessation?	If there are no other contraindications to MHT use.
With women with persistent symptoms after 5-years, how long can you keep patients on MHT.	See answer about duration above.
In women that cannot have the COCP but have started MHT, and also need contraception - how do we manage the oral progesterone. (If Mirena is not used). Can POP be the progesterone component?	There are no data to support the use of progesterone only pills (POP) in combination with MHT oestrogen. Hence other contraceptive measures should be used (tubal ligation / vasectomy / barrier methods etc). The Australasian Menopause Society MHT equivalents webpage (link below) states as a disclaimer: Low dose progestogen-only contraceptive pills (Microlut (30mcg levonorgestrel), and Noriday (350mcg norethisterone) are used by some clinicians in various doses but there is limited data for dosages of these pills required for endometrial protection. 1 mg norethisterone was considered the minimum dose (cyclical or continuous) for adequate endometrial protection in the Cochrane Review (Cochrane Database Syst Rev. 2009 Apr 15;(2):CS000402). https://www.menopause.org.au/hp/information-sheets/426-ams-guide-to-equivalent-mht-hrt-doses
To follow on from my previous question (above line). If a woman on combined MHT also needs contraception can she use POP or implanon on top of the progesterone in the MHT?	Similarly, there is no data to support the use of implanon as the progestogen in MHT, and there is no need to use 2 progestogens together. The choices are either COCP if perimenopausal and otherwise appropriate for this option, or MHT containing oestrogen and progestogen, plus non-hormonal contraceptive measures. The progestogen can however be Mirena, which will provide contraception.
If woman needs contraception because they are perimenopausal would the POP provide adequate protection?? If on combined MHT and needs contraception, then can they have POP too?	See answers above.

Can vaginal oestrogen be added to oral MHT if vaginal atrophy symptoms are not controlled well by oral MHT?	Yes, it may be necessary to initiate both together but in some women the vaginal oestrogen may be able to be stopped at some point when the systemic MHT is controlling the genito-urinary symptoms.
Would you consider a factor v Leiden heterozygote to be at increased risk not to start MHT?	This will depend on their personal and family history of VTE, their general health and other VTE risk factors, and whether they have gone through pregnancies and COCP use without VTE events previously. My preference is for these women to see a haematologist who has expertise in advising women about MHT use. If MHT is the best option for bothersome symptoms, then generally transdermal MHT at the lowest dose to control symptoms would be favoured.
If a woman starts a sequential MHT in the perimenopause, is it essential to switch to continuous combined therapy? Can she stay on the sequential treatment? Does this reduce breast cancer risk as she's exposed to less progesterone?	The studies suggest that there is a lower risk of breast cancer associated with sequential MHT use, hence it is a matter of preference for the woman. If she prefers to be bleed-free then continuous oestrogen and progestogen will be more likely to achieve this goal, however some will be able to use sequential MHT and have minimal or no bleeding, some years after menopause.
When reducing MHT and using gel on alternate nights do you also reduce Prometrium? (if combined MHT)	If a woman is using a low dose of transdermal gel alternate nightly then the Prometrium can also be used alternate nightly. If there are bleeding issues with this strategy the Prometrium may need to be nightly.

Other resources:

Jean Hailes - Menopause Health Professional tool link

Monash University - A Practitioner's Toolkit for the Management of the Menopause' link

Australasian Menopause Society – equivalent MHT/HRT doses (Australia only) link