

Putting the new NICE menopause guideline into practice

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BACKGROUND

The first National Institute for Health and Care Excellence (NICE) Guideline on *Menopause: Diagnosis and Management* was published in November 2015.¹ It was eagerly awaited by clinicians around the UK as a source of accurate information following years of sensationalist headlines and confusion around hormone replacement therapy (HRT), and will be a particularly important resource for primary care where most symptomatic women present and where most HRT prescribing takes place.

INDIVIDUALISATION AND INFORMATION

The document starts by advocating an individualised approach at all stages of the diagnosis, investigation and management of menopause, a life transition which varies widely between women. As many as 80% of women going through menopause experience symptoms, typically lasting for around 4 years after their last period, but in about 10% of cases symptoms can last for up to 12 years. The average age for menopause, currently 51 years in the UK, varies between ethnic groups, with Indian, Hispanic and African women having an earlier menopause and Japanese women tending to have a later menopause compared to Caucasian women.² Premature menopause, also known as premature ovarian insufficiency, affects 1 in 100 women aged under 40 years.³

The importance of information for women and their family members or carers is emphasised, and this should include an explanation of the stages of the menopause, common symptoms and diagnosis, and the need for contraception when necessary along with treatment options. The benefits and risk of treatments should be explained in the context of the individual woman's personal risk factors, ideas, concerns and expectations.

The consultation ideally will also discuss lifestyle changes and interventions that could improve general health and well-being. In some women menopausal symptoms may severely affect a woman's health and quality of life.

AVOID ROUTINE USE OF AN FSH LEVEL TO DIAGNOSE MENOPAUSE

A key change is the recommendation against biochemical confirmation of menopause via follicle-stimulating hormone (FSH) testing to diagnosis menopause in women aged over 45 years with menopausal symptoms and irregular periods, women who have been amenorrhoeic for at least 12 months and are not on hormonal contraception, or women without a uterus. FSH tests should be reserved for women aged 40–45 years with menopausal symptoms, including a change in their menstrual cycle, and women aged under 40 years. An FSH test cannot be interpreted if the woman is taking estrogens or high-dose progestogens and should not be undertaken.

HRT IS A FIRST-LINE OPTION FOR MOST WOMEN

HRT can be offered as first-line treatment for managing short-term perimenopausal symptoms, as the benefits of perimenopausal use before age 60 years outweighs the risks in most women. Women with a uterus must be offered estrogen and progestogen, while women without a uterus may be offered estrogen-only therapy. Initial treatment should be reviewed at 3 months and then the risks and benefits reassessed annually thereafter. For women with or at high risk of breast cancer, NICE refers to the guidelines on *Early and Locally Advanced Breast Cancer*⁴ and *Familial Breast Cancer*⁵ with sections on advice for the treatment of menopausal symptoms. These women require information on all available treatment options from a menopause



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specialist, and paroxetine and fluoxetine should not be offered to women with breast cancer taking tamoxifen.

HRT IS EFFECTIVE FOR LOW MOOD

Selective serotonin reuptake inhibitors (SSRIs), serotonin, and noradrenaline reuptake inhibitors (SNRIs) and clonidine are no longer recommended as first-line treatment for vasomotor symptoms alone; and SSRIs and SNRIs should not automatically be started in women with mild depression either. Mild depression that affects quality of life is usually short-lived and is associated with hormonal fluctuations during the menopause transition. NICE states that there is no clear evidence for SSRIs or SNRIs to ease low mood in menopausal women who have not been diagnosed with depression, and that HRT and cognitive behaviour therapy should be considered first.

HRT AND SEXUAL FUNCTION

Vaginal symptoms are effectively relieved by topical estrogens, and NICE is clear that treatment may be continued for as long as it is needed because atrophic symptoms often recur when treatment is stopped. Adverse effects are rare and routine endometrial monitoring is not required but any unscheduled bleeding should be reported. We are reassured that vaginal estrogen is usually appropriate for women in whom systemic HRT is contraindicated, although advice from a menopause specialist is recommended.

Altered sexual function is listed under short-term symptoms and there is a recommendation to consider testosterone supplementation for menopausal women with low desire if HRT alone is not effective. This can be a challenging situation when clinicians have to resort to off-label prescribing of a testosterone preparation; there are no licensed testosterone preparations for women available in the UK. Satisfactory 'peripheral' estrogenisation is necessary before adding testosterone therapy, which acts 'centrally' on the brain, and any psychosexual issues should be addressed.

ALTERNATIVES TO HRT

The section on complementary therapies and unregulated preparations is a welcome inclusion as many women try herbal or alternative therapies instead of HRT and request advice from clinicians on the optimal dose or regime.⁶ There is some evidence that isoflavones and black cohosh may relieve vasomotor symptoms but different preparations may vary in strength and effectiveness and their long-term safety is not certain. Again NICE is clear in stating that the quality, purity and constituents of complementary therapies may vary, and the efficacy and safety of unregulated compounded bioidentical hormones are unknown.

Box 1 Information about hormone replacement therapy for patients*

Blood clots (venous thromboembolism)

- ▶ HRT tablets (but not patches or gels) are linked with a higher risk of developing a blood clot.
- ▶ If you are at higher risk of developing blood clots (e.g. being obese) and you are considering HRT, you may be offered patches or gel rather than tablets.
- ▶ If you have a strong family history of blood clots you may be referred to a haematologist before considering HRT.

Heart disease and stroke (cardiovascular risk)

- ▶ If you start HRT before age 60 years it does not increase your risk of CVD.
- ▶ HRT does not affect your risk of dying from CVD.
- ▶ HRT tablets (but not patches or gels) slightly raise the risk of stroke. However, it is important to remember that the risk of stroke in women aged under 60 years is very low.
- ▶ If you are already at higher risk of CVD (e.g. with hypertension) it may still be possible to take HRT.

Breast cancer

- ▶ Estrogen-only HRT cause little or no change in the risk of breast cancer.
- ▶ HRT that contains estrogen and progestogen may increase breast cancer risk. This risk may be higher if you take HRT for longer but falls again when you stop taking it.

Type 2 diabetes

- ▶ HRT does not increase your risk of developing type 2 diabetes.
- ▶ If you already have type 2 diabetes, HRT is unlikely to have a negative effect on your blood sugar control.

Osteoporosis

- ▶ You should be given advice about bone health and osteoporosis at your first appointment and when reviewing your treatment. HRT reduces the risk of osteoporosis while it is being taken but the benefit only lasts while you are taking HRT, unless you have taken HRT for a long time.

Loss of muscle strength

- ▶ HRT may improve muscle strength; however, it is also important to carry on with daily activities and exercise.

Dementia

- ▶ It is currently unknown whether HRT affects the risk of developing dementia.

*Taken from the National Institute for Health and Care Excellence (NICE) summary: advice for patients on the risks and benefits of HRT.⁷

CVD, cardiovascular disease; HRT, hormone replacement therapy.

LONG-TERM RISKS AND BENEFITS OF HRT

The long-term benefits and risks of HRT are detailed in the guideline document in comprehensive tables covering venous thromboembolism (VTE), cardiovascular disease (CVD), type 2 diabetes, breast cancer, osteoporosis, dementia and muscle mass and strength. **Box 1** provides a brief summary of key information for patients. We can now reassure women that transdermal preparations of HRT given at standard doses are not associated with an increased risk of VTE, but oral HRT is associated with a small increased risk for VTE and stroke. Women at high risk of VTE, such as those with a strong family history or hereditary thrombophilia, may benefit from a haematology assessment before considering HRT. Cardiovascular risk factors do not in themselves contraindicate HRT, as long as they are optimally managed. We are reminded that HRT does not increase CVD risk when started in women below the age of 60 years and does not affect the risk of dying from CVD. Estrogen-only HRT is in fact associated with no, or reduced, risk of coronary heart disease. Neither oral or transdermal HRT increase the risk of developing type 2 diabetes, nor does HRT usually affect blood glucose control.

Combined HRT is associated with an increase in the risk of breast cancer which is related to the duration of treatment and reduces after stopping HRT, but breast cancer risk also varies according to personal risk factors and estrogen-only HRT carries negligible increased risk. There are estimated to be five more cases of breast cancer in current users of combined HRT per 1000 women aged 50–59 years over 7.5 years compared to estrogen-only HRT, which is associated with little or no change in risk. Bone density increases while on HRT so the risk of fragility fracture is reduced, and there is limited evidence that HRT may improve muscle mass and strength. It is unknown whether HRT affects the risk of dementia in the future.

The NICE guidance recommends referring women to a healthcare professional with expertise in menopause if treatment does not improve their menopausal symptoms or they have ongoing troublesome side effects (**table 1**).

CONCLUDING REMARKS

This NICE guideline contains useful evidence for many areas of menopause care; however, it lacks prescribing guidance and information on what constitutes an annual review, and may generate an increase in clinical queries to primary and secondary care at a time when the National Health Service is under pressure. A prescribing algorithm would have been helpful plus information on contraception for perimenopausal women. There are some suggestions about improving knowledge amongst health professionals but in many

Table 1 When to refer to a menopause specialist

Indication	What to include in your letter
Abnormal bleeding	USS with endometrial thickness ±cervical smear report, consider fast-track cancer referral
Multiple treatment failure (3+)	List types and detail problems
VTE (confirmed)	Detail confirmation (e.g. circumstances, anticoagulation, thrombophilia screen, USS, venogram, V/Q scan)
Premature menopause	Reason for ovarian failure, FSH, TFTs, BMD, auto-antibody screen
Osteoporosis	BMD confirmed by DEXA if possible with T and Z scores, detail any non-traumatic fracture
Previous or high risk of hormone-dependent cancer	Details of disease, stage, treatment, family history

BMD, bone mineral density; DEXA, dual-energy X-ray absorptiometry; FSH, follicle-stimulating hormone; TFT, thyroid function test; V/Q, ventilation/perfusion; VTE, venous thromboembolism; USS, ultrasound scan.

areas there is no menopause service or lead clinician to do this, and the definition of who can be a menopause specialist is not clear. The effectiveness of the implementation of this NICE guideline may be in jeopardy if demand increases and clinical commissioning groups are unable to respond, with more women being referred to gynaecology.

Competing interests None declared.

Provenance and peer review Commissioned; externally peer reviewed.

REFERENCES

- 1 National Institute for Health and Care Excellence (NICE). *Menopause: Diagnosis and Management* (NICE Guideline No. 23). 2015. <https://www.nice.org.uk/guidance/ng23> [accessed 12 February 2016].
- 2 Gold EB, Bromberger J, Crawford S, *et al.* Factors associated with age at natural menopause in a multiethnic sample of midlife women. *Am J Epidemiol* 2001;153:895–874.
- 3 Edwards H, Currie E. Are we ready for NICE? *Post Reprod Health* 2015;21:81.
- 4 National Institute for Health and Care Excellence (NICE). *Early and Locally Advanced Breast Cancer: Diagnosis and Treatment* (NICE Guideline CG80). 2009. <https://www.nice.org.uk/guidance/cg80> [accessed 12 February 2016].
- 5 National Institute for Health and Care Excellence (NICE). *Familial Breast Cancer: Classification, Care and Managing Breast Cancer and Related Risks in People with a Family History of Breast Cancer* (NICE Guideline CG164). 2015. <https://www.nice.org.uk/guidance/cg164> [accessed 12 February 2016].
- 6 Pitkin J. Alternative and complementary therapies for the menopause. *Menopause Int* 2012;18:20–27.
- 7 Sarri G, Davies M, Lumsden MA, on behalf of the Guideline Development Group. Diagnosis and management of menopause: summary of NICE guidance. *BMJ* 2015;351:h5746.