



## C-Gyn 9

# Management of the menopause

Given knowledge of the major changes which occur in the quality of life and the health of women in the years around the menopause, the College believes it is incumbent upon its fellows and members to ensure awareness of these changes amongst the medical profession and the wider general community.

1. All perimenopausal and post menopausal women should be offered counselling about the menopause, its consequences and management options.
2. All post menopausal women should be examined regularly. Such examinations should include general physical, breast and pelvic examinations. The performance and frequency of other tests such as blood lipid and bone density estimations should be determined by analysis of risk factors.
3. It is recommended that Pap smears should be performed according to national screening recommendations.
4. In Australia, it is recommended that mammography be performed every two years from 50-69 years, and in New Zealand it is recommended that mammography be performed every two years from 45 to 69 years.
5. Women seeking relief from menopausal symptoms should first be offered advice on life style factors including stress reduction, regular exercise, optimal weight management, appropriate diet and avoidance of smoking and excessive alcohol and caffeine intake.
6. Some evidence exists for relief of mild menopausal symptoms with gabapentin or venlafaxine.
7. The safety and efficacy of some alternative medicines such as black cohosh and phytoestrogens is unclear with conflicting evidence from various clinical trials.
8. Hormone therapy has been clearly shown to alleviate menopausal symptoms compared to placebo. Relief of menopausal symptoms remains the main indication for the use of hormone therapy.
9. Hormone therapy has also been shown to increase bone density and to reduce fracture risk.
10. In women at risk of osteoporosis and fracture, evidence based therapy options should be discussed and individualised. Options will include HT (particularly if associated with short term menopausal symptoms), bisphosphonates, strontium ranelate and raloxifene (a Selective Estrogen Receptor Modulator).
11. Hormone therapy should not be prescribed for the primary prevention of long term disease. With regard to cardiovascular disease; although observational studies, in vitro

and in vivo data all support a protective role for HT and ERT, recent randomised trials have not found any such benefit in the populations studied and thus HT is not currently advocated for the treatment or prevention of cardiovascular disease.

12. There is a link between continuous combined HT and breast cancer. Previous observational studies and a re analysis of the world literature showed an increase in relative risk from 1 to 1.35 after 10 years of hormone use. The Womens Health Initiative (WHI) study of continuous combined HT use showed a statistically non-significant increase in relative risk of 1.26 (RR 1.0-1.59) after 5 years. This increase is also consistent with a recent meta analysis of four randomised trials where the overall RR was 1.27 (CL 1.03-1.56) for combined HT. In absolute terms this quantifies to 3.2 extra cases per 1000 users over 5 years for women aged 50-59 and an extra 4 cases per 1000 users over 5 years for women aged 60-69. In contrast however, the only major randomised trial of oestrogen-only hormone therapy in hysterectomised women (WHI) showed no increase in risk of invasive breast cancer after 6.8 years.

Some studies have suggested a possible increase in ovarian cancer with HT. However, there is insufficient evidence from high quality studies to draw conclusions regarding the effects of HT on ovarian cancer. The age standardised incidence of ovarian cancer in Australia for women aged 50-59 years was 1-2 cases per 10,000 women per year.

13. Because of the risk of breast cancer with long term use it is reasonable to attempt to wean patients off continuous combined cyclical oestrogen –progestin therapy HT after 4-5 years treatment.
14. Women with persistent symptoms requiring further hormone therapy should be offered appropriate counselling on risks and benefits after which they may continue with the lowest effective dose of hormone therapy.
15. Oral HT use increases the risk of venous thromboembolism. RR 2.14 (1.64-2.81). Whether this applies to non oral HT remains inconclusive, although the available evidence indicates that the risk with non oral oestrogen is less.
16. There is no consensus on whether or not HT increases the risk of stroke. In the Women's Health Initiative Study, the use of HT by women aged range 60-79 years was associated with an increase in risk of stroke of approximately 8-12 events per 10,000 women per year. No increase in risk was seen for women aged 50 -59 years {JAMA 2007; 287: 1465}
17. Hormone therapy, if offered, should be individualised.
18. Oral therapy remains appropriate for most women, however women at increased risk of thrombosis should be prescribed nonoral oestrogen.
19. Oestrogen only therapy is appropriate for women who have had an hysterectomy.
20. Women who have not had an hysterectomy should be offered oestrogen and progestin therapy rather than oestrogen alone unless there are exceptional circumstances.
21. Tibolone, a synthetic steroid with oestrogenic, progestogenic and weak androgenic effects, provides an alternative to HT for hysterectomised and non-hysterectomised women more than 12 months postmenopause. In randomised controlled trials tibolone has not been found to be associated with any change in mammographic density or with any increase in risk of venous thrombosis, Early results of long term studies using Tibolone suggest breast cancer and stroke rates may be comparable to standard hormone treatment
22. Early follow up after commencement of therapy is advisable to adjust the regimen if

necessary. Further adjustments may be made by any practitioner from time to time however a full gynaecological examination is appropriate every 2 years.

## References

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3. National Breast Screening Programme (New Zealand). <http://www.moh.govt.nz/moh.nsf/7004be0c19a98f8a4c25692e007bf833/074b7c41e7d22f90cc256c4a0077915a?OpenDocument>
4. National Cervical Screening program (New Zealand). [http://www.nzgg.org.nz/library/gl\\_complete/gynae\\_cervical/index.cfm](http://www.nzgg.org.nz/library/gl_complete/gynae_cervical/index.cfm)
5. Loprinzi CL, Barton DL, Rhodes D. *Management of Hot Flushes in Breast Cancer Survivors* Lancet Oncology 2001;2:199-204.
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7. MacLennan A, Lester S, Moore V. *Oral estrogen replacement therapy versus placebo for hot flushes*. Cochrane data base of systematic reviews. Issue 3, 2002.
8. Beral V, Banks E Reeves G. *Evidence from randomised trials on the long term effects of hormone replacement therapy*. Lancet. 2002; 360:943-944.
9. Collaborative Group on Hormonal Factors in Breast Cancer. *Breast Cancer and Hormone Replacement Therapy: Collaborative Reanalysis of Data from 51 Epidemiological studies of 52,705 women with breast cancer and 108,411 women without breast cancer*. Lancet 1997;79:286-294.
10. Risks and Benefits of estrogen plus progestin in healthy post menopausal women. *Principal results from the Women's Health Initiative randomised controlled trial*. Writing Group for the women's health initiative. JAMA 2002; 288: 321-33.
11. Baber R, O'Hara J and Boyle F. *Hormone replacement therapy: to use or not to use?* MJA 2003 Vol 178; 12: 630-633.
12. Pandya KJ, Morrow GR, Roscoe JA, Zhao H, Hickok JT, Pajon E, Sweeney TJ, Banerjee TK and Flynn PJ. *Gabapentin for hot flashes in 420 women with breast cancer: a randomised double-blind placebo-controlled trial*. Lancet. 2005; 366:818-824.

## Links to other related College Statements

C-Gyn 15 [Management of the menopause after breast cancer](#)

C-Gen 2 [Guidelines for consent and the provision of information regarding proposed treatment](#)

## Other useful links

*The risk of breast cancer with HRT use* (Media release of the Australasian Menopause Society 2002). [http://www.menopause.org.au/public/media\\_detail.asp?ID=25](http://www.menopause.org.au/public/media_detail.asp?ID=25)

Advice to members of the Australasian Menopause Society: *Indications for Prescribing Oestrogens and Progestogens in Menopausal Women*, Update September 2003.

## **Patient Resources**

RANZCOG Patient information pamphlet "Menopause: A guide for women" (released 2003).

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