POST REPRODUCTIVE HEALTH

Post Reproductive Health
2022, Vol. 0(0) 1–2

DOI: 10.1177/20533691221104879
journals.sagepub.com/home/min
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Joint position statement by the British Menopause Society, Royal College of Obstetricians and Gynaecologists and Society for Endocrinology on best practice recommendations for the care of women experiencing the menopause

The British Menopause Society, Royal College of Obstetricians and Gynaecologists and the Society for Endocrinology have produced this joint position statement to provide guidance to healthcare practitioners who offer care to women experiencing the menopause.

The menopause transition can have a significant impact on many women, with more than 75% experiencing menopausal symptoms and a quarter describing their symptoms as severe. A third experience long-term symptoms, which may last as much as 7 years or longer.

The aim of this Position Statement is to provide evidence-based recommendations on best practice in line with current national and international guidelines and recommendations.

Our recommendations are as follows:

- All women should be able to access advice on how they can optimise their menopause transition and the years beyond. There should be an individualised approach in assessing women experiencing the menopause, with particular reference to lifestyle advice, diet modification as well as discussion of the role of interventions including HRT.
- Women should be advised that implementing or maintaining a healthy lifestyle can improve menopause symptoms. A healthy diet (one low in saturated fat and salt and rich in calcium and vitamin D), stopping smoking, reducing alcohol intake and including regular exercise can be beneficial. Reducing caffeine intake may also improve symptoms.
- Alternative therapies, including cognitive behavioural therapy, may also improve hot flushes, nights sweats and other menopausal symptoms and can be considered in women who do not wish to take HRT or have contraindications to taking HRT.
- The decision whether to take HRT, the dose and duration of its use should be made on an individualised basis after discussing the benefits and risks with each patient. This should be considered in the context of the overall benefits obtained from using HRT including symptom control and improving quality of life as well as considering the bone and cardiovascular benefits associated with HRT use. Discussions with women should also cover aspects such as when to consider stopping HRT and how this can be done (by gradually reducing the dose of HRT). No arbitrary limits should be set on age or duration of HRT intake.
- HRT, compared with placebo, has been consistently shown to improve menopausal symptoms and it remains the most effective treatment that is also associated with significant improvement in overall quality of life.
- In addition, HRT has been shown to have an effective role in the prevention and treatment of osteoporosis. Bisphosphonates are considered as first-line options for most patients with postmenopausal osteoporosis due to their broad spectrum of anti-fracture efficacy. HRT may be considered as an additional alternative option, particularly in younger postmenopausal women with menopausal symptoms who are at increased risk of fractures.
- HRT is considered as first-line intervention for the prevention and treatment of osteoporosis in women with premature ovarian insufficiency (POI) and early menopause (40–45 years old).
- Evidence from Cochrane database analysis suggests that HRT started before the age of 60 or within 10 years of the menopause may result in reduction in atherosclerosis progression, coronary heart disease and may lower cardiovascular and all-cause mortality.
- Current evidence suggests that oestrogen alone HRT is associated with a lower risk of breast cancer than combined HRT. Breast cancer risk is duration dependent and may vary with the type of progestogen used. The risk of breast cancer should be considered in the context of the overall benefits and risks associated with HRT intake.
- Women with POI and early menopause (40–45 years old) should be advised that HRT is unlikely to increase risk of breast cancer in younger menopausal women under the age of 50. The meta-analysis by the Collaborative Group on Hormonal Factors in Breast Cancer in

2019 reported that the use of HRT in postmenopausal women younger than 50 increases the risk of breast cancer diagnosis which contradicts previous evidence and advice to date. However, the control group, of age-matched postmenopausal women was inappropriate as an early menopause reduces breast cancer risk. Current recommendations are that the risk of breast cancer in relation to the years of HRT exposure in women with POI/early menopause should be counted from the average age of natural menopause (from the age 50 years).

- A history of breast cancer should be considered a contraindication to systemic HRT. The risk of breast cancer recurrence with HRT is higher in women with oestrogen receptor positive cancer, but women with oestrogen receptor negative breast cancer are also considered to have an increased risk of recurrence with HRT. HRT may, in exceptional cases, be offered to women with breast cancer with severe menopausal symptoms if lifestyle modifications and non-hormonal treatment options are not effective. This should be done after discussion with the woman, her menopause specialist and her breast/oncology team.
- Women should be reassured that HRT is unlikely to increase the risk of dementia or to have a detrimental effect on cognitive function in women initiating HRT before the age of 65. However, HRT should not be initiated for the purpose of reducing the risk of dementia in women experiencing the menopause. National as well as international recommendations do not support the use of HRT for the primary or secondary prevention of dementia.
- Transdermal administration of estradiol is unlikely to increase the risk of venous thrombosis or stroke above that in non-users and is associated with a lower risk compared with oral administration of estradiol. The transdermal route should therefore be considered as the first choice route of estradiol administration in women with related risk factors.
- For most women, initiating HRT has a favourable benefit/risk profile. However, HRT should not be used without a clear indication and should not be used for the sole purpose of disease prevention. Menopause is a life stage and does not represent a deficiency state. Menopause should not be compared with conditions such as hypothyroidism or type 1 diabetes mellitus.
- Women with a uterus require progestogen (administered for 12–14 days a cycle in a sequential regimen in perimenopausal women and daily in a continuous combined regimen in menopausal women) to minimise the risk of endometrial hyperplasia and endometrial cancer associated with unopposed oestrogen exposure. Sequential regimens can be delivered through oral and transdermal patch preparations while continuous combined regimens can be delivered through oral and transdermal patch preparations or through a 52 mg levonorgestrel releasing intrauterine system.
- The dose of the progestogen should be proportionate to the dose of oestrogen. Women who require higher doses of oestrogen intake should consider having their progestogen dose increased to ensure adequate endometrial protection.
- Low-dose and ultra-low dose vaginal oestrogen preparations can be taken by perimenopausal and menopausal women experiencing genitourinary symptoms and continued for as long as required. All vaginal oestrogen preparations have been shown to be effective in this context and there is no requirement to combine vaginal oestrogens with systemic progestogen treatment for endometrial protection, as low-dose and ultra-low dose vaginal oestrogen preparations do not result in significant systemic absorption or endometrial hyperplasia.
- Testosterone supplementation can be considered in women with low sexual desire if systemic HRT resulting in adequate levels of oestrogen with or without progestogen has not been effective.
- There is lack of evidence to support testosterone supplementation for the purpose of prevention or improving cognitive function, musculoskeletal health, improving bone density or fracture prevention. Testosterone supplementations should therefore not be offered for these indications.
- Women with POI and early menopause (40–45 years old) should be advised to take hormone replacement at least until the average age of the menopause.
- HRT should not be recommended for the primary or secondary prevention of chronic disease in women experiencing the menopause in keeping with national and international guidelines.
- The use of compounded bioidentical hormone replacement therapies is not recommended given the issues related to their purity, potency and safety. The potential benefits of bioidentical hormone therapy can be achieved using conventionally licensed products available through NHS prescribing without having to resort to compounded varieties from specialist pharmacies.

Conclusion

Women experience the menopause in different ways. Whilst some women experience minimal or no symptoms going through the menopause, many women experience menopausal symptoms that can significantly impact their quality of life. There should be an individualised approach in assessing women going through the menopause, with particular reference to lifestyle advice, diet modification as well as discussing the role of interventions including HRT. Women should be aware that help and support is available to them and should consult their GP for advice.