Menopause Toolkit one stop shop: education and resources

NHS
North East and North Cumbria

Jacqui McBurnie, NENC ICB Menopause Lead 2024

Contents

Menopause is about hormones: our commitment to inclusion

Menopause is predominantly experienced by women and most existing research is based upon cisgender women. This document recognises that and commits to going further. This pack is a dynamic learning pack, which will be developed as feedback from users is included.

We acknowledge that transgender, non-binary and intersex colleagues may also experience the menopause. There are specific needs and experiences for our colleagues in these groups, which may be (in part) due to medication/surgeries. Some of the information in the media, articles, guidance and even some policies may apply to these individuals yet not refer to them directly. As a result, where we use the term 'woman' in relation to our learning pack, we extend this to all our colleagues. However, we make an inclusive commitment to use the term '**people**' throughout. We use the term 'menopause hormone therapy' for clarity.

We note that **racial heritage does affect average age of the menopause,** the SWAN study demonstrates how race affects symptoms and age at menopause. For this reason we encourage individualised assessments and consideration of ethnicity alongside the presentation of symptoms.

Menopause definition

Menopause: A biological stage in a woman's life that occurs when she stops menstruating and reaches the end of her natural reproductive life. Usually, it is defined as having occurred when a woman has not had a period for 12 consecutive months (**for those reaching menopause naturally**). The changes associated with menopause occur when the ovaries stop maturing eggs and secreting oestrogen and progesterone.

Perimenopause The time in which a woman has irregular cycles of ovulation and menstruation leading up to menopause and continuing until 12 months after her final period. The perimenopause is also known as the menopausal transition or climacteric.

Postmenopause The time after menopause has occurred, starting when a woman has not had a period for 12 consecutive months.

The British Menopause Society (BMS) produce a helpful resource for all clinicians via BMS factsheet; what is the menopause

https://www.nice.org.uk/guidance/ng23/chapter/Recommendations#diagnosis-of-perimenopause-and-menopause

Early Menopause

Early Menopause

Menopause before the age of 45 is differentiated as either early or as Premature Ovarian Insufficiency (POI) if aged 40 years or younger.

If periods cease between 40-45 years, alongside a change in the menstrual cycle and menopause-type symptoms, Early menopause is indicated. Serum FSH (follicle stimulating hormone) measurements are indicated in this group. The NHS website provides information on potential causes that can be used as signposting for patients.

Premature Ovarian Insufficiency (POI) is diagnosed with a presentation of oligomenorrhoea / amenorrhoea (no periods) of more than 4 months' duration associated with elevated hormonal blood tests (gonadotropins FSH >40 iu/l) on at least two occasions. Measure 4-6 weeks apart in people **under the age of 40**. For clarity see NICE guidance here (TFT and thyroid antibodies, coeliac screen, B12+folate, HBA1c, chromosomal abnormalities and DEXA scan)

The Daisy Network offers specific advice and support for anyone in early menopause/POI and is thus a helpful signposting option.

Management of early menopause or POI is outlined by NICE in the following Scenario covering prescribing information, lifestyle changes, wellbeing and dietary advice alongside signposting information for patients.

The rationale: retention and wellbeing at work NHS and Social Care

- **77%** of the NHS workforce is recorded as female. Within this group are your mentors, coaches and organisational memory
- Approximately **80%** of those affected have problematic symptoms that affect them at work;
  - **25%** report severe symptoms
  - **69%** experience anxiety or depression due to menopause
  - **84%** experience trouble sleeping

  This was also supported by a study completed in Nov 2022 by The Strategy Unit
- **10%** who worked during the menopause have left a job due to their symptoms according to the Fawcett Society.
- **80%** say their employer hasn't shared information, trained staff, or put in place a menopause absence policy according to ACAS and Menopause APPG Manifesto
- The BMA reports (2020, 2022) recognise the impact on medical staff; **93%** of survey respondents had experienced symptoms as a result of the menopause, **65%** experiencing both physical and mental symptoms, **90%** said that these symptoms had impacted their working lives, **38%** saying that the impact was significant.
- This data was underpinned by a specific study asking What do working menopausal women want? To help them thrive at work
- Recent research from CIPD underlines that around 10% say they feel discriminated against at work due to menopausal symptoms

The rationale: retention at work (Social Care)

The adult social care sector and workforce - North East

Recent trends - workforce supply and demand

Download PowerPoint

Press here to view more data from the report

In adult social care in North East, as at 2021/22, there were:

91,000 total posts

Up 950 or 1.1% since 2020/21

83,000 filled posts

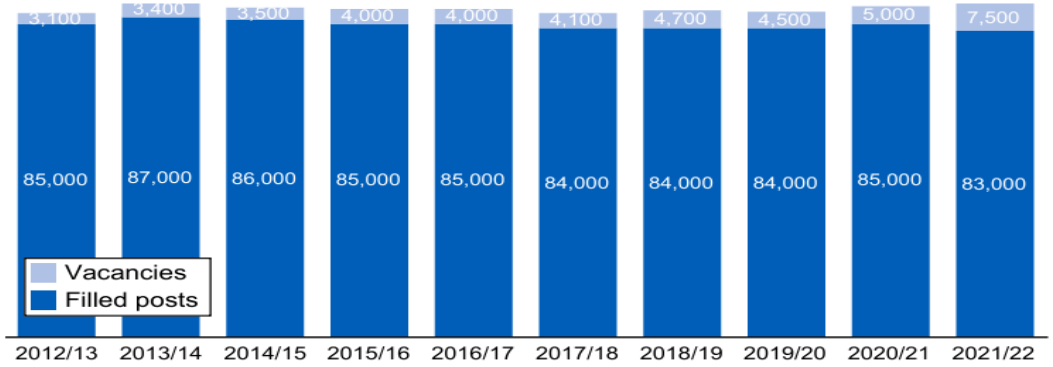
Down -1,500 or -1.8% since 2020/21

7,500 total vacancies

Up 2,500 or 49.8% since 2020/21

The total number of posts in the region has increased by 1.1% in 2021/22. However, fewer posts were filled, and more were vacant highlighting recruitment and retention difficulties and not a decrease in demand for social care staff.

Filled posts and vacancies between 2012/13 and 2021/22



Median care worker pay compared to other job roles 2021/22

The **starter rate** has fallen from

34.4% in 2018/19

25.9% in 2021/22

To view up to date monthly information on how the adult social care workforce has changed since March 2021, due to COVID-19 and other other reasons, press the button to go to our month tracking dashboards

Press here to go to COVID-19 information

Data published by Skills for care.
The data is published based on **local authority region** with in this case **North Cumbria being part of the North West.**
The numbers are the latest available but are based on data collected from local authorities in **September 2021** and from independent sector employers as at **March 2022**.

Resources and signposting

General awareness and rationale information;

- International Menopause Society; Online Events - International Menopause Society (imsociety.org)
- Health and Social Care Select Committee report published 25 July; Health and Social Care Committee - Reports, special reports and government responses - Committees - UK Parliament
- Home - Cycle of Change - Understanding Menopause
- Premature ovarian insufficiency: effectiveness of hormonal therapy
- Annual HRT certificate covers MOST medications for 1 year for less than £20; NHS Hormone Replacement Therapy Prescription Prepayment Certificate (HRT PPC) | NHSBSA

British Menopause Society;

- https://www.youtube.com/channel/UCz9m2gNQgI-2QCawAzgWC7w
- Women's Health Concern | Confidential Advice, Reassurance and Education (womens-health-concern.org)

Workplace guidance and standards

Support is part of our duty of care

The LEGAL FRAMEWORK spans both the Equality Act 2010 and the Health and Safety at Work Act 1974 Menopause is *currently* covered under three protected characteristics: age, sex and disability as well as safe working conditions when experiencing menopausal symptoms. It was recently decided that menopause would not be assigned as a protected characteristic.

Menopause tribunals have increased 43% since 2021 There was also a 75% increase in other cases mentioning the word menopause, even if that wasn't the direct subject of the tribunal. The word was mentioned 207 times in tribunal documents in 2021, up from 118 in 2020. HR Magazine - Rise in menopause tribunals attributed to increased awareness

- **Daley v Optiva (2020)**
  - Symptoms agree as long term because when the claimant came to tribunal they'd persisted for more than two years. The tribunal thus ruled that she was disabled.
- **Gallacher v Abellio Scotrail Ltd (2020)**
- **Kownacka v Textbook Teachers Ltd (2021);** The tribunal found in her favour in relation to harassment and her employer showed a lack of insight, sensitivity and empathy which violated the claimant's dignity and created an offensive environment.
- **Donnachie v Telent Technology Services Ltd (2020);** the judge said: "*I see no reason why, in principle, typical menopausal symptoms cannot have the relevant disabling effect on an individual. I have little hesitation in concluding that the effect of her menopausal impairment on her day-to-day activities is more than minor or trivial. The range of her daily activities and her ability to undertake them when she would wish, with the rhythm and frequency she did, is markedly affected*."

Further resources; Acas has introduced **new codes of practice** surrounding flexible working, Menopause and the Workplace (fawcettsociety.org.uk)

British Standards Institute BSI report 2023: Lifting the Second Glass Ceiling

Key recommendations of the BSI Group Second Glass Ceiling insight report

Recognize the benefits of lifting the Second Glass Ceiling
Individuals, organizations, and society **all stand to gain from tackling the departure of women**. Ultimately, it is an opportunity to boost growth and innovation and accelerate progress towards a sustainable world.

- **Open the dialogue**
  Ask people experiencing symptoms what they want – and act on it. Looking at what is driving women to leave the workforce early can help to uncover solutions that can reverse the trends and enable more of those to thrive. **Ensure support is available and accessible.** People can only access support around menopause or any other factor if it is first available and they are aware of what is on offer.

Resources and signposting

Workplace impact and rationale information;

- Menopause costs UK economy 14 million working days per year - HRreview
- Menopause at centre of increasing number of UK employment tribunals | UK news | The Guardian
- Menopause and the Workplace (fawcettsociety.org.uk)
- Menopause and the NHS workforce | The Strategy Unit (strategyunitwm.nhs.uk)
- A guide to managing menopause at work: guidance for line managers (cipd.co.uk)
- The menopause at work: guidance for line managers | CIPD guides
- Menopause: The ultimate taboo | Podcast | CIPD
- menopause-leaflet_tcm18-55569.pdf (cipd.co.uk)

NENC signposting

- Boost platform for menopause support
- Hartlepool & Stockton Menopause Clinic and website
- Age UK Sunderland (AUKS) Menopause Project
- Menopause After Breast Cancer

Menopause Specialist: Application, training, trainers

Menopause Specialist Training: process

Recognised BMS menopause specialists are either Doctors, Nurses or Pharmacists. There is no formal charging structure for training, it is at the discretion of trainers and/or their employers. **The application process is** here

Menopause Specialists are expected to:

- follow national guidance, e.g. NICE Guideline: Diagnosis and Management of the Menopause (NG23);
- follow BMS recommendations and guidance for practice and prescribing, e.g. *BMS and WHC's 2020 recommendations on hormone replacement therapy in menopausal women* and the *BMS consensus statement on Bioidentical HRT*;
- provide menopause education and training in line with national guidance and BMS recommendations for practice and prescribing;
- engage with multidisciplinary teams across specialties to develop local pathways, formularies and guidelines; and
- practice within their own capabilities and in line with the requirements of their regulatory body.

Trainees must be registered with the GMC/NMC/GPhC/IMC/NMBI/PSI and hold current BMS membership. The BMS will provide a list of Menopause Trainers to trainees on request.

Menopause Specialist Nurse

The BMS has defined a specialist as:

A health care professional who has obtained the British Menopause Society (BMS)/Faculty of Sexual Reproductive Health (FSRH) Advanced Menopause Certificate, or completed the (Royal College of Obstetrics and Gynaecology (RCOG)/BMS Advanced Training Skills Module (ATSM- **only available for medical staff**)* in Menopause Care (or equivalent, for example, the menopause and premature ovarian failure module of the subspecialty training programme in reproductive medicine)

and who:

1. is a member of the British Menopause Society (BMS)
2. attends a National (BMS), European or International Menopause Society conference at least once every three years (BMS, 2018)
3. provides a minimum of 100 menopause-related consultations per year, of which at least 50 are new • has the responsibility documented as part of their job plan and discussed at their annual appraisal.

Health professionals wishing to register as a specialist do so at the British Menopause Society

Re-certification with BMS is required **every three years**, when specialists will be asked to confirm that they still fulfil the criteria.

Looking after our menopausal workforce:

Nurse Specialist in Menopause RCN paper

Menopause guidance from RCN

Clinical training courses

- A selection of introductory '**shorts**' here from the British Menopause Society
- The BMS **resources library** which includes links to prescribing guidelines/alternatives, practice standards and lifestyle advice here
- Specific **healthcare professional training** from basic principles to the advanced practitioner courses here
- The specific BMS courses designed **for nurses** accessed here
- The BMS also links to **IMPART**; International activity for refresher training via IMS IMPART

The International Menopause Society (IMS);

- Menopause Hormonal Replacement therapy (MHRT), the Dos and Donts
- Cardiovascular disease from the IMS training session

FourteenFish provides a course covering all aspects of menopause to build confidence, know when to refer, symptoms management strategies, **free** for all healthcare professionals via this link

Training from the Faculty of Sexual and Reproductive Healthcare

Red Whale provide online courses and Podcasts directed at Primary Care Professionals for varied cost levels accessed here

Subdermal implants via the Faculty of Sexual and Reproductive Healthcare

Intrauterine devices info Education & Training

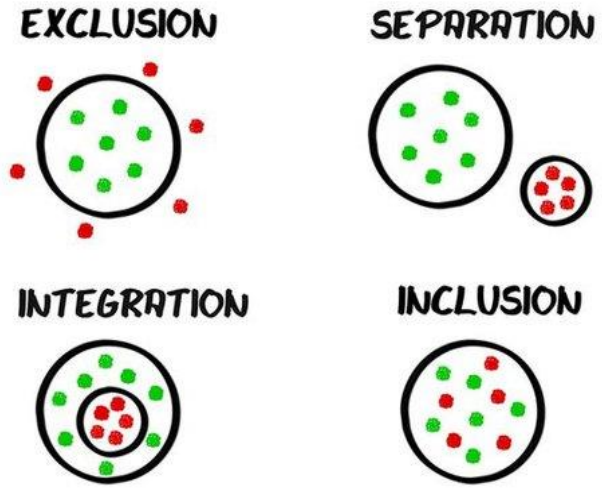
For **continued professional development**, see the BMS Reproductive Health Journal It is also important to note that formal training and experiential learning are both critical to knowledge development and confidence in management

For **mental health** training FREE create an account with The Royal College of Psychiatrists for a 90 minute module titled Mental health during the perimenopause and menopause

Position statements: Menopause

- RCOG, BMS and FSRH Joint Statement on Menopause
- RCGP-Brief_Menopause.pdf
- The NHS England guidance on supporting people through menopause and the guidance on supporting people late in their career
- Take 20 minutes to complete the free e-learning module which covers common symptoms of the menopause, how it can impact people at work and how colleagues can support those going through menopause
- HRT and breast cancer joint statement
- IMS and postmenopausal women
- RCN Position statement

Menopause and me: visibility



Ethnicity, inclusion

Launched in 1994, SWAN is a pioneering multi-site longitudinal study into women's health and the menopause, examining physical, biological, psychological and social changes. This study underlines the need for clinicians to think beyond assumptions and averages – consider racial heritage alongside symptoms. Further longitudinal studies from an inclusion point of view; Four studies explore women's brain and heart health during midlife

The Practitioner's Toolkit for Managing Menopause underlines that some symptoms appear to be more predominant in some countries. Similar prevalences of VMS have been reported in many countries e.g. Japan, Bangladesh and Iran. In many countries musculoskeletal pain is more problematic. This is the case for Asian women. It is therefore critical that all practitioners have individualised discussions with women. As underlined in recent studies from the International Menopause Society's global view of vasomotor symptoms and sleep disturbance, there are variances depending on ethnicity between sleep disturbance, VMS and treatment with MHT. This research illustrated that white women report more sleep disturbance and access treatment more than other groups studied and black women reported more VMS.

It is essential that language is sensitive and appropriate for all women – especially women from ethnic minorities who may have a range of words or phrases that do not easily map to English words. This could potentially challenge the ability for the patient to be fully informed. Where English is not the first language, consider if more time is needed to ensure all points are explored. Some research also underlines that we should treat ethnic groups with consideration of the bio-psycho-social elements.

Black women and menopause

- The British Menopause Society give a perspective on ethnicity and menopause
- black women in menopause
- Black Girl's Guide to Surviving Menopause
- 3 people share their experiences
- sista 2 sista
- Facebook Page; **Black Women in Menopause or** via instagram @blackwomeninmenopause **or** twitter @blkmenopause
- Podcast; Anita Powell Black Menopause and Beyond
- Karen Arthur a long term menopause champion
- Black women in menopause

  Dr Tonye Wokoma is a British Menopause Society (BMS) recognised Menopause Specialist. Dr Tonye educates and empowers women to take control of their health care and lifestyle choices.
- An article from the New York Times on Women of Color

Muslim, Asian and menopause

Muslim Women's Network; Muslim Women Network (mwnuk.co.uk)

Menopause and Islam - Menopause (bellaonline.com)

Dr Nighat Arif; Videos by Dr Nighat Arif - The Menopause Directory & School

https://youtu.be/xPfUn8ATKnI?si=KbJTLWGloWIh_8tC

Your Next Episode: Menopause, organ donation & Asian communities with Dr Nighat Arif on Apple Podcasts

Nighat Arif (@drnighatarif) Official | TikTok

Nighat Arif, Your Guide to Female Health

Menopause & Me: Dr Shahzadi Harper - Hylda (hyldalife.com)

Dr Newson; balance - Hindi Menopause Library (balance-menopause.com)

Entrepreneur Shafi talks about her work raising awareness of menopause and recording the experiences in the Pakistani community in West Yorkshire. balance - Empowering women unheard during menopause (balance-menopause.com)

Lavina Mehta MBE - is a personal trainer and patron of **Menopause Mandate**, a not-for-profit pushing for greater support for women in perimenopause

Pharmaceutical Journal paper regarding menopause and ethnic groups

Meera Bhogal - runs personal training and nutrition support for women after struggling with her own perimenopause.

LGBTQ+ and menopause

Resources;

LGBTQ+ and the Menopause via Menopause Care website

LGBTQIA+ and menopause: a paper from The Lancet

Queermenopause.com

Queer menopause – Mental Health At Work

We need to talk about the LGBTQ+ menopause experience item from Good Housekeeping

The menopause and me – a gender neutral article

Transgender health and the impact of aging and menopause

Podcast: menopause as a Trans Man

Learning disabilities

The Mental Capacity Act makes it clear that individuals must be given every opportunity to make their own informed decision with the relevant information.

People with learning disabilities will experience a menopause but may have less understanding or have less preparedness for it. Learning Disabilities research is growing and underlines that people with a learning disability may experience an earlier menopause. It is therefore important for family, friends and health professionals to be aware of information/symptoms disclosed and be open to the potential that hormonal changes appear earlier than expected.

Individuals may struggle to recognise any symptoms or find it difficult to describe their symptoms, how 'bothersome' they are and when symptoms are most difficult through the day. They may be less aware of psychological changes.

Individual conversations are important to facilitate understanding and choice. Easy read information is available via the Balance website, established by Dr Louise Newson here

Information to empower, equip and inform the individual is important to facilitate understanding, to maximise their wellbeing and encourage joint decision making. Individuals with a learning disability have equal rights to access menopause services and access information. They may have specific views on treatments (e.g. MHT) and should be supported to explore those.

Deep dive: Most Common Symptoms

Deep Dive: Mental health

Longitudinal studies (**SWAN**) and research completed by the **International Menopause Society (IMS)** recommend that **clinicians should differentiate between depression and low mood associated with hormonal changes** experienced at menopause for the first time.

As many as 3-4 women will have an exacerbation of Major Depressive Disorder (MDD) during the Menopause Transition (MT). Women with moderate to severe VMS are up to three-fold more likely to have moderate–severe depressive symptoms than other women as underlined in the Practitioner's Toolkit for Managing Menopause

Treating Vaso Motor Symptoms (VMS) will facilitate better sleep, therefore preventing consistent sleep disruption which can impact mood.

SWAN study Fact-Sheets can be accessed for review and indicate that;

*Classic depressive symptoms often occur in combination with, and may be a result of, other menopause symptoms such as hot flashes and night sweats, but they also **may be due to sleep disturbance**. Women who have had Major Depressive Disorder (MDD) prior to menopause may be more vulnerable to having depressive symptoms or MDD during the perimenopause and in the early post-menopausal years.*

Mental Health: resources

- Andrews PW, Thomson JA Jr, Amstadter A, et al (2012) Analysis of Whether Antidepressants Do More Harm than Good
- Professor Pauline Maki underlines the process for Treating perimenopausal depression
    1. Explore previous episodes of mental health
    2. Differentiate and treat if this is a hormonal response
- A recent Cambridge study gives guidance into Severe mental illness and the perimenopause
- New research to explore the impact of menopause on autistic people | Bournemouth University - as discussed around neurodiversity, gender identity and menopause.

Deep Dive: Sleep, signposting

The IMS reports that during the menopause “women have more severe insomnia and worse quality of sleep compared to women of reproductive age”.

Alongside the many detrimental aspects of poor sleep, both functionally and cognitively, the IMS also notes the importance of managing VMS symptoms and the beneficial effects of MHT to improve sleep in this analysis of MHT and its effects on the quality of sleep

Sleep is recognised by many as a symptom of itself but also as a symptom that can exacerbate others; concentration, mood and low energy levels. Many report sleep as a major disruption of the menopause according to the National Institute on Aging. Sleep hygiene advice;

- **Follow a regular sleep schedule.** Go to sleep and get up at the same time each day.
- **Avoid napping in the late afternoon or evening** if you can. It may keep you awake at night.
- **Develop a bedtime routine.** Some people read a book, listen to soothing music, or soak in a warm bath.
- **Try not to watch television or use your computer or mobile device in the bedroom.** The light from these devices may make it difficult for you to fall asleep.
- **Keep the bedroom at a comfortable temperature**, not too hot or too cold, and as quiet as possible.
- **Exercise at regular times each day to improve** Sleep but not close to bedtime.
- **Avoid large meals close to bedtime.**
- **Caffeine** (found in many coffees, teas, and chocolate) late in the day.
- **Alcohol can disrupt sleep.** Even small amounts make it harder to stay asleep.

Signposting: Symptoms assessment

- MENO-D symptoms checker
- Menopause symptom scale also known as the Greene Climacteric Scale
- A Menopause Passport is also included at the end of the pack for direct use/discussion

Symptoms management: Menopause Hormone therapy (MHT)

What does Menopausal Hormone Therapy (MHT) look like?

MHT prescribing principles

- The menopausal hormone therapy (MHT) regimen and route of administration used depends on the **informed choice of the woman** and whether the woman is perimenopausal or postmenopausal.
- Women should be encouraged to **book sufficient time** with their Doctor or Nurse to discuss symptoms, concerns and ask questions to support decision making
- Signposting to symptoms trackers, and/or using a workplace passport, dietary and lifestyle advice, exercise and sleep hygiene are important tools alongside pharmacological interventions/MHT
- Serum FSH is **ONLY** indicated for specific presentations described here and for those over 45 years with atypical symptoms. Use serum FSH to support advice in women over 50 who have no periods, use contraception till 55 years as per FSRH Clinical Guideline
- **Assessment should explore**; change to menstrual pattern, night sweats, hot flushes (VMS), anxiety, palpitations, cognitive impairment (brain fog), low mood, urogenital symptoms including UTI, itching, urgency, altered sexual function or loss of sexual desire, sleep disturbance, headaches and/or joint aches
- Practical **prescribing guidance** from the BMS here
- Note: women may use a **Mirena®** levonorgestrel-releasing intrauterine system (LNG-IUS) with oestrogen for **up to 5 years for endometrial protection**, as part of an MHT regimen. [FSRH, 2019].

Symptoms

Symptoms of the menopause span physical and mental health and we recognise every individual's menopause is very different. For that reason, we discourage comparisons, averages and assumptions.

About 8 in every 10 women will have significant symptoms for some time. These can have a substantial impact on daily life as a result. Some of the most common symptoms are outlined in the NHS website here

The top six symptoms may particularly affect the individual in the workplace and are closely related – ie. Some can exacerbate others. For example sleep can be disrupted by vasomotor symptoms (VMS) which goes on to negatively affect mood the next day.

1. Fatigue/poor sleep
2. hot flushes
3. concentration problems
4. anxiety
5. insomnia
6. recall/memory

The safety of MHT largely depends on age. Healthy women younger than 60 years should not be concerned about the safety profile of MHT. (BMS)

Reminder *the* Annual HRT certificate covers MOST medications for 1 year for less than £20; NHS Hormone Replacement Therapy Prescription Prepayment Certificate (HRT PPC) | NHSBSA

MHT: estrogen and progesterone

There are more than 50 types of Menopausal Hormone Therapy (MHT) (estrogen and progesterone) available:

HRT can be given orally (tablets), transdermally (through the skin); subcutaneously (a long-lasting implant); or vaginally.

- Cyclical MHT mimics the normal menstrual cycle. Estrogen is taken every day and progestogen for 12 to 14 days. At the end of each course of progestogen there is some bleeding as the body “withdraws” from the hormone and the womb lining (endometrium) is shed. Progestogen regulates bleeding and protects the endometrium from harmful pre-cancerous changes
- Estrogen-alone HRT is normally prescribed to women who have had their womb removed (hysterectomy). The benefits of all MHTs are derived from estrogen; progestogen protects the womb lining
- In continuous combined therapy HRT (CCT) combinations of an estrogen and progestogen are prescribed continuously to achieve period-free MHT. Usually, women start on cyclical MHT and change to CCT post-menopause. (Note: sensitivities to progesterone levels can prompt CCT earlier for some patients who do not tolerate a cyclical regime)
- Tibolone is a synthetic form of period-free MHT which may have similar benefits to CCT. It is taken continuously in tablet form
- Long cycle MHT uses a formulation which causes withdrawal bleeds every three months instead of every month and is most suited to women who suffer side effects when taking a progestogen. Its safety in long-term use with regard to the lining of the womb is questionable
- Local estrogen, such as vaginal tablets, creams, or rings, is used for treating local uro-genital problems, such as vaginal atrophy/dry vagina, irritations, bladder problems or infections

Estrogen

- **Menopausal Hormone Therapy (MHT) is available as oral or transdermal preparations,** depending on the woman's informed choice.
  - Oestrogen-only preparations are given to women without a uterus, and combined oestrogen and progestogen preparations are given to women with an intact uterus [NICE, 2019].
  - Transdermal preparations may be appropriate if the woman has a history of CVD, gall bladder, migraine, DVT risk [Stuenkel, 2015; North American Menopause Society, 2018; Anagnostis, 2020; Ayres, 2020]
  - Transdermal preparations are available as a gel (oestrogen only), patch (oestrogen only or combined oestrogen and progestogen), or spray (oestrogen only) [Ayres, 2020].
    - If using combined HRT, the progestogen component may also be given separately as an oral tablet or as the levonorgestrel-releasing intrauterine system (LNG-IUS, Mirena®).

Estradiol-approximate equivalent doses				
	Ultra low	Low	Medium	High
Oral	0.5mg	1.0mg	2.0mg	3.0mg
Patch	Half 25	25	50	75-100
Gel-pump	½ pump	1 pump	2 pumps	3-4 pumps
Gel-Sachet	½ x 0.5mg sachet-0.25mg	0.5mg	1mg	1.5 – 2mg
Spray	1 spray	2 sprays	3 sprays	—

It should be noted that response to any preparation is unique to each woman, some women responding well to a low dose of one preparation while not responding well to a high dose of another.

Vaginal or local Estrogen

Contains a very small hormonal measure,

- can be used in patients previously treated with breast cancer, including Estrogen Receptive (ER) +ve
- Recommend it is used daily for 2 weeks initially, then 2 or 3 days per week.
- Is safe to use alongside systemic estrogen; Oestrogel, patches (e.g. Evorel, Estradot) or Lenzetto spray
- *Check if patient is prescribed aromatase inhibitor

Cream; Ovestin 1%	Tablet pessary Vagirux	Ring pessary Estring 3 monthly
		

Progesterone

- Progesterone protects from the introduction of estrogen (unopposed). Unopposed estrogen is associated with a significant increase in the risk of endometrial hyperplasia that is both dose and duration dependent with exposure between one and three years.
- Mirena coil (52 mg levonorgestrel releasing intrauterine system provides adequate endometrial protection.
- Oral micronized progesterone provides endometrial protection if applied sequentially for 12–14 days/month in a dose of 200mg/day taken in the evening (Sequential) in the peri menopausal woman or (continuous) 100mg/day taken every evening in the postmenopausal woman
- Note: the dose of progesterone should be reviewed according to the dose of estrogen to ensure a proportionate dose and adequate endometrial protection.
- if a woman experiences side effects with the oral micronized progesterone, consider vaginal administration (out of license use). This should be given in similar doses and durations to those applied to oral progesterone intake with MHT.
- The BMS provides a full outline here
- LARC fitting and training info via the Faculty of Sexual and Reproductive Healthcare

Testosterone

Approximately half of endogenous testosterone and precursors are derived from the ovaries. Testosterone production and release thus declines alongside estrogen and progesterone.

Some women experience a persistent low sex drive or Hypoactive Sexual Desire Disorder (HSDD), which is the indication for using testosterone after all other possible factors, including taking adequate estrogen, have been addressed. HSDD in women is managed according to NICE guidelines (NG23).

Testosterone is given as a daily (or 2 x a week) gel, rubbed into the skin on the lower abdomen or thighs and takes around 3-6 months to feel the effects. Using the correct dosage and changing the site of application minimises side effects. On commencing treatment check FAI/SHBG, at 6 months do fasting lipids and glucose testing. Monitor the bloods and potential side effects annually to maintain bloods within the female physiological range.

The BMS underlines the appropriate use of Testosterone replacement

Prescribing options;

- Testogel sachet, 40.5mg/2.5g sachet; 1 sachet used over 8 days
- Testim 50mg/5g tube; 1 tube used over 10 days
- Tostran (2% testosterone gel in the prep containing 60g) starting dose 1 pump on alternate days

Tibolone and Veoza (Fezolinetant)

Tibolone is prescribed in the post menopause phase

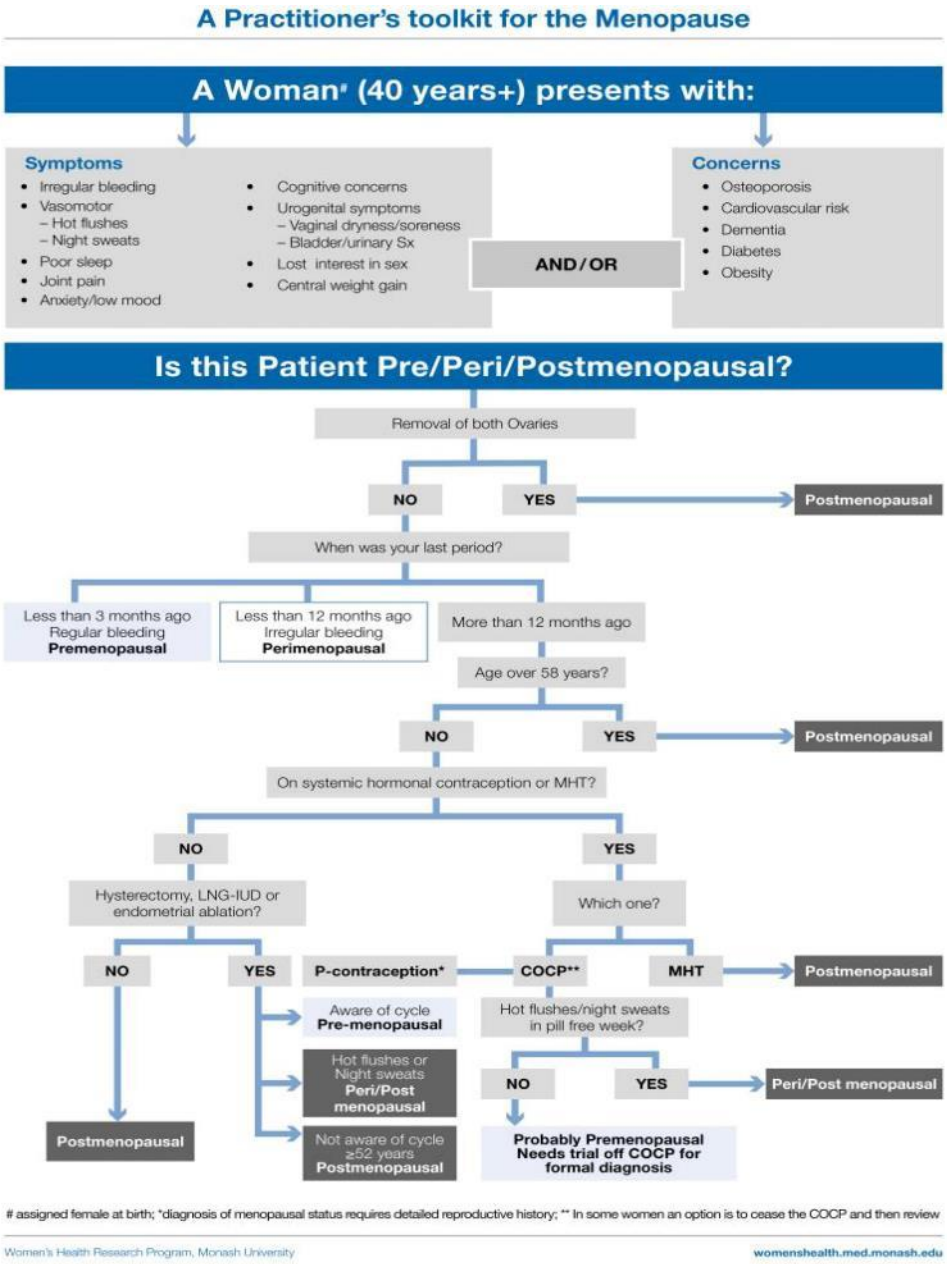
The BMS Practitioner's Toolkit for Managing Menopause outlines the clinical indications and use **as an alternative** to estrogen–progestogen therapy.

- Tibolone is commenced 12 months after the last natural menstrual period for 'bothersome' symptoms in hysterectomized women.
- Tibolone is contraindicated in women with breast cancer; metabolized in the gastrointestinal tract, it targets tissues to metabolites that have estrogenic, progestogenic and androgenic effects.
- Tibolone does not require progestogen as it does not stimulate the endometrium.
- Tibolone does not increase mammographic density.

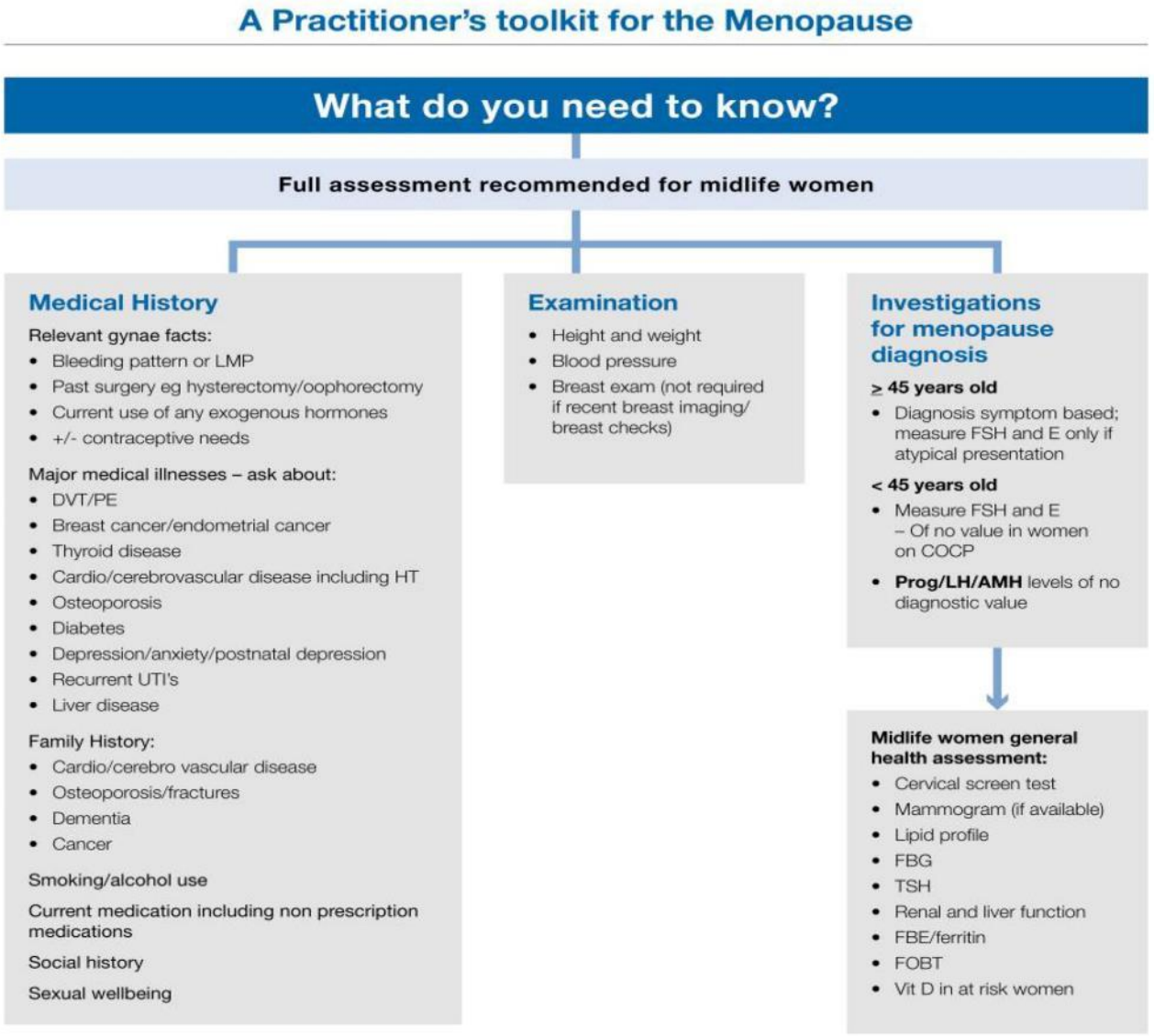
Veoza Fezolinetant

- Available in Private Menopause Clinics, licensed for mod-severe VMS and is non hormonal. Liver function testing is required prior to initiating treatment, observe contraindications and potential side effects
- A 45mg tablet is taken daily, orally to manage VMS
- Awaiting review from NICE and any indications for wider rollout (expected early 2024)

Decision tree



Clinical Assessment



MHT: Cautions

Contraindications and cautions according to NICE

- **Do not prescribe menopausal hormone therapy (MHT) in women with:**
  - Current, past, or suspected breast cancer.
  - Known or suspected oestrogen-dependent cancer.
  - Undiagnosed vaginal bleeding.
  - Untreated endometrial hyperplasia.
  - Previous idiopathic or current venous thromboembolism (deep vein thrombosis or pulmonary embolism), unless the woman is already on anticoagulant treatment.
  - Active or recent arterial thromboembolic disease (for example angina or myocardial infarction).
  - Active liver disease with abnormal liver function tests.
  - Pregnancy.
  - Thrombophilic disorder.

Prescribe MHT with caution in women with:

- Porphyria cutanea tarda.
- Diabetes mellitus (increased risk of heart disease).
- Factors predisposing to venous thromboembolism.
- History of endometrial hyperplasia.
- Migraine and migraine-like headaches.
- Increased risk of breast cancer. See the CKS topic on Breast cancer - managing FH for more information.

Breast cancer: side effects summary

With thanks to Caroline Tweedie, Specialist Breast Care Nurse

	Vasomotor Symptoms: **- Hot flushes** **- Night sweats**	**Psychological and Cognitive Symptoms:** **- Mood changes** **- Low mood** **- Irritability** **- Fatigue** **- Memory loss** **- Poor concentration** **- Brain fog**	**Genitourinary Syndrome of Menopause (GSM):** **- Vaginal dryness** **- Dyspareunia** **- Urinary symptoms**	**Other Symptoms:** **- Arthralgia** **- Dry skin** **- Thinning hair** **- Fatigue** **- Headaches** **- Palpitations** **- Sleep disturbance**
Prescriptive options	Consider 3 months prescription then review: Venlafaxine 37.5mg OD titrated up to 150mg per day. SE include dry mouth, nausea, constipation. Other SSRIs can be used but fluoxetine and paroxetine should not be given with tamoxifen Gabapentin 300mg daily, increased to 300mg TDS. SE include dizziness, weight gain and dry mouth OR Pregabalin 75-150mg BD Clonidine 25mcg BD, up to maximum does of 50mcg TDS. SE include sleep disturbance; should not be stopped abruptly	Venlafaxine 37.5mg OD titrated up to 150mg per day. SE include dry mouth, nausea, constipation. Other SSRIs can be used but fluoxetine and paroxetine should not be given with tamoxifen Consider switching brand of endocrine therapy	Discuss option of low dose vaginal oestrogen – **Estriol 1 pessary or applicatorful daily for 3 weeks then twice weekly**	Consider switching brand of endocrine therapy

SERMS: Selective Estrogen Receptive Modulators

Described as ‘selective’ because they either act as agonist or antagonist effects when meeting the oestrogen receptor in different tissues. This allows SERMs to be used as targeted options depending on the needs of the individual.

- SERMs – their role in menopause management - Australasian Menopause Society
- Discuss with women the naturally occurring SERMS; phytoestrogens and any associated cautionary notes
- Ensure the appropriate SERMS are matched to the needs of the individual and thus offer the endometrial protection and targeted outcome needed
- Tamoxifen; breast tissue (ER) antagonist, endometrial tissue agonist, bone tissue agonist. Avoid Paroxetine and Fluoxetine with Tamoxifen
- Raloxifene; spinal bone density, no support for menopausal symptoms, breast tissue antagonist, uterine antagonist (so beneficial compared to Tamoxifen re uterine tissue)
- Badezoxifene; osteoporosis and supports menopausal symptoms
- Ospenifene; dyspareunia
- Lasofoxifene; osteoporosis, vaginal atrophy

Signposting and resources

- Selective Estrogen Receptor Modulators explained
- Signposting; about SERMS from Breastcancer
- Menopause After Breast Cancer from Dr Alison MacBeth
- The considerations with regard to HRT and breast cancer from the British Menopause Society
- Why we need to understand breast cancer risk from the National Institute for Health and Care Research (NIHR)
- Surgical and Cancer-Induced Menopause info from Spiced Pear Health
- Menopausal symptoms from Cancer Research UK
- A beginner's guide to BRCA1 and BRCA2 from the Royal Marsden Patient Info sheet
- Menopausal symptoms from macmillan
- Specific advice for anyone living with HIV and menopause via the Sophia Forum here
- Predict Breast is a helpful resource for anyone having had breast cancer and considering options
- NICE Guideline for Early and locally advanced breast cancer
- My Wellbeing Space provides info and resources re cancer care
- Managing menopause after cancer - The Lancet

Hormonal support after cancer

	Effect of MHT on cancer outcomes	Level of evidence	MHT use
Breast cancer: overall	Systematic review and meta-analysis (n=4050) found increased risk of recurrence with tibolone or MHT (HR 1·46)[46]	Moderate	Avoid MHT
Breast cancer: oestrogen-receptor-negative	Subgroup analysis found no increased risk of recurrence with tibolone or MHT (HR 1·19)[46]	Moderate	Consider MHT in specific patients*
Breast cancer: oestrogen-receptor-positive	Subgroup analysis found increased risk of recurrence (HR 1·80) with tibolone or MHT[46]	Moderate	Avoid MHT
Uterine sarcomas	European guidelines suggest avoiding MHT, might be oestrogen sensitive[48]	Very low	Avoid MHT
Ovarian cancer: low-grade serous and granulosa cell	European guidelines suggest avoiding MHT, might be oestrogen sensitive[48]	Very low	Avoid MHT
Low-grade, early-stage endometrial cancer	Systematic review found no effect on cancer outcomes[49]	Moderate	Consider MHT
Cervical cancer	One small retrospective study (n=120) found no effect on cancer outcomes;[50] European guidelines suggest offering MHT[51]	Very low	Consider MHT
Haematological cancer	One small study (n=130) showed no effect on cancer outcomes[52]	Very low	Consider MHT
Early cutaneous malignant melanoma	One small study (n=206) showed no effect on cancer outcomes[53]	Very low	Consider MHT
Colorectal cancer	One large prospective study (n=834)[54] and one national cohort study[55] reported improved cancer outcomes	Low	Consider MHT
Hepatocellular cancer	One case–control study (n=244) reported improved cancer outcomes[56]	Very low	Consider MHT
Ovarian germ cell tumours	European guidelines suggest offering on an individualised basis[48]	Very low	Consider MHT
Epithelial ovarian cancer	Systematic review found uncertain evidence for efficacy or safety of MHT[57]	Moderate	Consider MHT
Vaginal, vulval, and anal squamous cell carcinoma	Do not express oestrogen receptors, MHT thought to be safe[58]	Very low	Consider MHT
Kidney cancer	Meta-analysis suggests better cancer outcomes with MHT[59]	Low	Consider MHT
Lung cancer	Mixed evidence: prospective cohort study (n=727)[60] and SEER data (n=485)[61] showed improved cancer outcomes; retrospective study (n=498)[62] and RCT[63] showed increased mortality	Moderate	Consider MHT

[Managing menopause after cancer - The Lancet]

Non hormonal therapies: side effects

	Vasomotor symptoms	Sexual dysfunction	Vaginal dryness
Selected SSRIs and SNRIs	Likely	Unlikely*	Unlikely
Specific anticonvulsants	Likely	Unlikely	Unlikely
Oxybutynin	Likely	Unlikely	Unlikely
Clonidine	Likely	Unlikely	Unlikely
Vaginal lubricants or moisturisers	Unlikely	Possible	Possible
Vaginal carbon dioxide laser	Unlikely	Unlikely	Unlikely
Stellate ganglion block	Possible	Unlikely	Unlikely
Cognitive behavioural therapy	Likely	Likely	Unlikely
Physical exercise	Unlikely	Unlikely	Unlikely
Acupuncture	Possible	Unlikely	Unlikely
Hypnosis	Likely	Unlikely	Unlikely
Yoga and mindfulness-based stress reduction	Possible	Unlikely	Unlikely

Effectiveness is defined as likely (evidence from randomised controlled trials), possible (evidence from single-arm studies), or unlikely (no evidence of effectiveness). SNRIs=serotonin norepinephrine reuptake inhibitors. SSRIs=selective serotonin reuptake inhibitors. All trials are in patients with breast cancer. Adapted from Franzoi and colleagues with permission.[44] *Does not worsen sexual function when used for vasomotor symptoms.

Table: **Effectiveness of non-hormonal treatments for vasomotor symptoms, sexual difficulties, and vaginal dryness**

Managing menopause after cancer - The Lancet

Trouble shooting: bleeding

HRT and bleeding; 3-6 months

- Bleeding patterns should settle within/around 3 months of starting HRT
- Check compliance with the HRT treatment schedule
- If bleeding is problematic from 3-6 months consider changes to the progesterone;
    - Switch to Utrogestan if not already
    - Consider switching from oral Utrogestan to vaginal
    - Offer the Mirena coil
    - If on a continuous schedule, consider cyclical for 6 months to try to re-establish patterns
    - Consider investigation

6 months

If bleeding/change in bleeding pattern is present after 6 months of HRT – check compliance with treatment – investigate, refer.

Further info and case studies can be accessed here

MHT: duration

Current research indicates that there is not a firm timeline for prescribing and discontinuing MHT as long as the individual receives benefit, symptoms relief and is making an informed choice. According to Menopause Matters and NICE

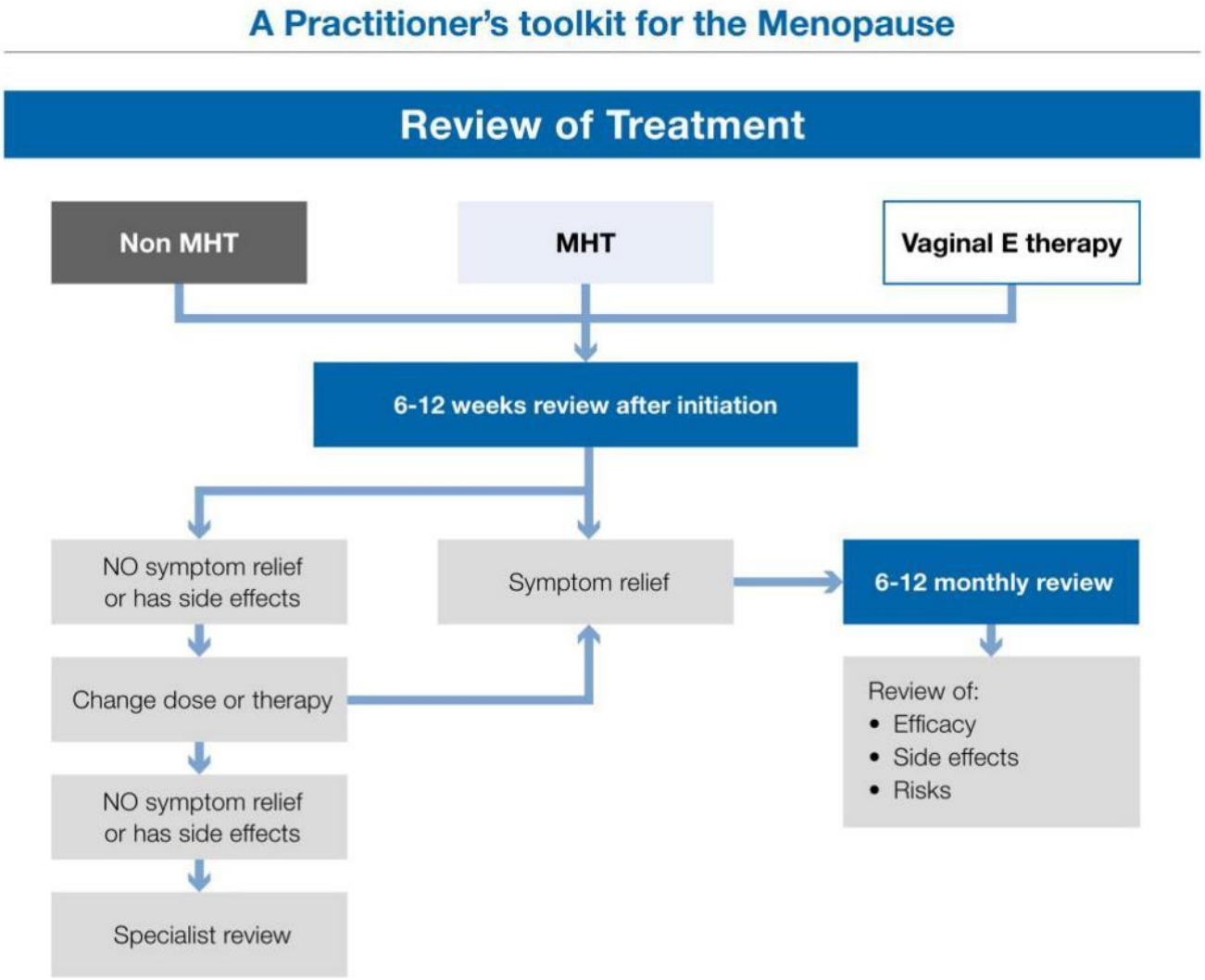
- Links with MHT and breast cancer are very small when using estrogen and progesterone and little to no risk with transdermal estrogen only.

Stopping MHT

If supporting an individual who wants to stop MHT, it is important to explain that the MHT should be reduced gradually to acclimatise the body to the reduction.

- Med-high dose (2mg oral or 75-100mcg patches) should have a 2-3 months gradual reduction
- Low dose estrogen is generally not required to need gradual reduction
- Support the individual to observe symptoms for 2-3 months to determine whether they require MHT, or to recognise symptoms have fully subsided. If symptoms reapper/are bothersome, re-start MHT
- Local/vaginal estrogen may be continued to support Genitourinary Symptoms.

When to review treatment



Non Hormonal support

With a focus on evidence based treatments, the Practitioner's Toolkit for Managing Menopause offers specific interventions;

- The selective serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors are effective in some with VMS.
- Paroxetine/sertraline/fluoxetine **not to be used with tamoxifen**
- Fezolinetant may improve sleep by reducing nocturnal VMS. It is approved in some countries (45mg/day).
- Other potential, (probably less effective), options include clonidine and gabapentin/pregabalin. Clonidine **may** be prescribed for VMS for women who cannot take estrogen at a dose of 100–150 µg/day, although this is inconsistent. (The side effect, dry mouth, is dose related). Gabapentin (300–900 mg/day **may** alleviate VMS. Side effects; headache, dizziness and somnolence are dose related, withdrawal may occur.
- Hypnosis and CBT have been shown to diminish VMS frequency and severity and can be considered a treatment option for women who are unable to take MHT or, alongside MHT. CBT is now recommended in the updated NICE guidelines.

Managing bone density/risk

It is of note that age at menopause, ethnicity and BMI may affect bone loss (bone mineral density BMD) and as a result these are important elements of the assessment.

Bone loss accelerates from the onset of the menopause transition in naturally menopausal women and peaks at about 2 years after the final menstrual period. Overall vertebral bone loss from 1 year before to 2 years after the final menstrual period is in the order of 7.4% for the lumbar spine and 5.8% for the femoral neck according to the Practitioner's Toolkit for Managing Menopause

MHT has been shown to reduce fracture incidence by 34% in women aged 50 years and older. It is therefore important to consider for all with osteopenia before the age of 65 years (alongside other fracture risks).

The UK NICE Guideline covering assessment and treatment for Osteoporosis recommends **MHT for the prevention of osteoporosis and fragility fractures** and MHT is licensed in many countries for this purpose. Guidance as to when postmenopausal women with osteopenia merit MHT to protect against fragility fracture is absent.

When considering MHT use as a mechanism to manage fracture risk;

- Age: postmenopausal women aged <65 years.
- Other factors: BMI and time since menopause

Cancer and Menopause at Maggies

Some cancer treatments can affect hormones and trigger menopause symptoms or an early menopause. During cancer treatment, some individuals can experience symptoms, even when that person has experienced a natural menopause earlier. In some cases, the menopause caused by your cancer treatment will be temporary, but for others it will be permanent. This depends on the type of treatment given and how near that induvial is to their natural menopause age. As a result of medication given, symptoms of the menopause may be more intense/immediate.

Discussions about MHT and non-hormonal therapies to relieve the symptoms of the menopause can be explored with a specialist via **Maggies**, especially critical if the cancer is estrogen sensitive. Alongside immediate symptoms relief, long term health management is supported and risks minimised with this access to specialist information.

In women, the relevant treatments include:

- chemotherapy
- surgery to remove both ovaries
- radiotherapy to the pelvis
- drugs that block or lower the production of certain hormones in the body (hormone therapy).

Maggies centres are open access to all patients with a diagnosis of cancer. Free expert advice and support is available for the symptoms of menopause. Maggies centres have access to clinical specialists, sexual health and intimacy specialists and informal peer to peer discussion. There are 26 Maggies centres across England

Workplace Passport

Mapping symptoms: Passport

Menopause Passports are helpful to map the symptoms of menopause and can help identify when symptoms are experienced and how ‘bothersome’ they appear. They can also be used to support a conversation with line managers (if the individual feels able) about wellbeing at work. Passports can remove the need to repeat conversations when changing roles.

Symptoms of menopause are very individual and can be embarrassing. Sensitive, confidential conversations are needed to explore what support may be helpful to maximise wellbeing.

If the passport is used as part of a confidential, sensitive discussion in the workplace it should also indicate what mechanisms or routes to support there are. (such as Occ Health specific support).

Managers should be aware and reiterate to colleagues that support and/or flexibilities can be kept under review as symptoms change.

Passport 1

Symptom	Location you have the symptom (if both tick both)		Severity of the symptom				How frequently do you experience the symptom						Adjustments you feel may assist (Examples included)
	Home	Work	Mild	Moderate	Intense	Severe	Less than monthly	Monthly	Weekly	Daily	Hourly	Constant	
Hot flushes													Fan/ extra uniform/ close to a window/ access to showers if applicable
Night Sweats													Flexible shift times
Irregular Periods													Procedures allowing for flexibility without drawing attention (Panel meetings etc.)
Loss of Libido													
Vaginal Dryness													
Mood Swings													Inform the team/colleagues to be mindful. Quiet/ Private breakout room.
Fatigue													Flexible shift times.
Hair Loss													Flexibility and sensitivity
Sleep Disorders													
Difficulty Concentrating													Flexibility in breaks.
Memory Lapses													Aide memoirs
Dizziness													Access to fresh drinking water and quiet areas
Weight Gain													Access to food preparation facilities to allow healthy eating options
Incontinence													Procedures allowing for flexibility without drawing attention (Panel meetings etc.) Access to showers/extra uniform if applicable
Bloating													
Allergies													
Brittle Nails													
Changes in Odour													Access to showers/lockers to store toiletries/extra uniform if applicable

Passport 2

Symptom	Location you have the symptom (if both tick both)		Severity of the symptom				How frequently do you experience the symptom						Adjustments you feel may assist. (Examples included)
	Home	Work	Mild	Moderate	Intense	Severe	Less than monthly	Monthly	weekly	Daily	Hourly	Constant	
Irregular Heartbeat													
Depression													
Anxiety													
Irritability													
Panic Disorder / Attacks													
Breast Pain													
Headache													Access to a private room
Joint Pain													
Burning Tongue													
Electric Shocks													
Digestive Problems													
Gum Problems													
Muscle Tension													
Itchy Skin													
Tingling Extremities													
Osteoporosis													