The MENOPAUSE,

"Menopause Management"

&

HORMONE REPLACEMENT THERAPY

Dr Deirdre Lundy

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SOME BASICS

The MENOPAUSE

- from the Greek words pausis (cessation) and the mensis meaning month
- 50-52 YEARS OF AGE
- WHO defines menopause as permanent cessation of menses for one year following the exhaustion of Graffian follicle and decreased ovarian activity. This results in loss of fertility, oestrogen deficiency symptoms & loss of oestrogen impact on tissues

PERIMENOPAUSE "CLIMACTERIC"

- "MENOPAUSE TRANSITION"
- Symptoms often precede final Menstrual Bleed by Years but typically in 40's.
- Don't out rule menopause just because patient still has periods
- Often juggling Contraception needs and Menopause symptoms

STAGES OF REPRODUCTIVE AGEING WORKSHOP (STRAW)
From the American Society of Reproductive Medicine Working Committee

FINAL MENSTRUAL PERIOD ↓↓

STAGES	-5	-4	-3	-2	-1	+1	+2	
TERMINOLOGY	REPRODUCTIVE			MENOPAUSAL TRANSITION		POST MENOPAUSE		
	EARLY	PEAK	LATE	EARLY	LATE	EARLY	LATE	
				PERI MENOPAUSE				
DURATION OF STAGE	**VARIABLE**			**VARIABLE**		1 YR / 4 YRS	**UNTIL DEATH**	
MENSTRUAL CYCLES	**VARIES-REGULAR**	**REGULAR**		**VARIES**	**SKIPPING**	**NONE**		
ENDOCRINE	**NORMAL FSH**		**↑ FSH**	**↑ FSH**		**↑ FSH**		

- **Vasomotor symptoms likely**

“UNNATURAL MENOPAUSE”

- POST OOPHRECTOMY
- POST CHEMOTHERAPY or RADIATION
- PREMATURE OVARIAN FAILURE

  (less than 35-40 years of age)

*USUALLY CAUSE MORE **SEVERE** SYMPTOMS & POSE **GREATER** LONG TERM HEALTH RISKS TO CERTAIN CONDITIONS*

DIAGNOSIS OF THE PERI-MENOPAUSE

- PRIMARILY CLINICAL

- BIOCHEMICAL INVESTIGATIONS OF LITTLE or NO BENEFIT IN DIAGNOSIS

  (Useful blood tests include **TSH, FBC, FASTING LIPIDS & GLUCOSE**, etc to help OUT RULE other conditions & provide info on current general health)

- SERUM **OESTROGEN** IS PARTICULARLY UNHELPFUL

- SERUM **FSH** ONLY OF HELP wrt FERTILITY

PERI-MENOPAUSAL SYMPTOMS

PHYSICAL

- NIGHT SWEATS
- HOT FLUSHES
- MENSTRUAL CHANGES: Menorrhagia, Irregularity
- LOSS OF VAGINAL ELASTICITY & LUBRICATION
- DECREASE IN METABOLISM
- HAIR & SKIN CHANGES
- JOINT COMPLAINTS
- BLADDER COMPLAINTS

EMOTIONAL

- DEPRESSION
- MOOD SWINGS
- ANXIETY
- TIREDNESS
- MEMORY LOSS
- CONCENTRATION LOSS
- LOSS OF LIBIDO
- PMS-TYPE SYMPTOMS

MANAGEMENT OF THE PERI MENOPAUSE

- Take a thorough history and ALWAYS ENQUIRE DIRECTLY ABOUT
  Incontinence
  Sexual Dysfunction

- EXCELLENT OPPORTUNITY FOR A **GENERAL MEDICAL EXAMINATION**

  Blood pressure
  Breast/ Pelvic examination +/- SMEAR TEST and
  MAMMOGRAPHY…
  2-4/52 off HRT may improve detection.
  Breast Density is increased by factors of 5% for E2 only,15% for Sequential and 30% for Continuous Combined respectively. Less so with Tibolone

- COUNSEL AND ADVISE wrt

  Diet & Exercise
  Contraception
  Health Screening

Mention THE OPTION OF HORMONE REPLACEMENT THERAPY

HORMONE REPLACEMENT THERAPY ‘HRT’

Replacing the FALLING levels of endogenous Oestrogen with small doses of exogenous Oestrogen+/- additional Progestagen

HRT & MISINFORMATION

- >50% of women say their symptoms are SEVERE but
- Patients either don't attend at all or refuse to even discuss HRT because of the general consensus that HRT causes Breast Cancer (among other things)
- This fear is NOT supported by reliable data.

So let's look at that data:

HRT
BENEFITS vs UNCERTAINTIES

Worries about HRT are based on three main studies:

1. **H**eart **E**strogen/Progestin **R**eplacement **S**tudy (1998 : USA)

2. **W**omen's **H**ealth **I**nitiative (2002 : USA)

&

3. **M**illion **W**omen **S**tudy (2003 : UK)

Relative Risk

Relative risk data can seem more important than they are.

Which of the following gives women the least relative risk of developing breast cancer?

- **-Eating one extra serving of french fries every week.**
- **-Eating more than a quarter of a grapefruit every day.**
- **-Working night shifts.**
- **-Taking antibiotics.**
- **-Using an electric blanket if you are an African American.**
- **-Taking hormone replacement therapy to alleviate the effects of menopause.**

Of course…. HRT is the “safest”

FACTOR/ Study		RR
HRT (Conj EE) *WHI 2002*		**.77**
FRIES *International Journal of Cancer 2006*		1.27
GRAPEFRUIT British Journal of cancer 2007		1.3
NIGHT SHIFT WORK *European Journal of Cancer 2005*		1.51
ANTIBIOTIC USE *JAMA 2004*		2.07
ELECTRIC BLANKET USE *American Journal of Epidemiology 2003*		**4.9**

COMPARE THIS TO THE RR OF 26 THAT WAS REPORTED IN A 2002 STUDY OF CIGARETTE SMOKING & LUNG CANCER

Hormone Replacement Therapy: Real Concerns and False Alarms
Bluming, Avrum Z. MD; Tavris, Carol PhD The Cancer Journal march 2009

WOMEN'S HEALTH INITIATIVE

USA JAMA 2002

- Largest **randomised clinical trial**

  (> 68,000 women) conducted to determine if older, post menopausal women might obtain Cardiovascular, Malignant & Osteoporosis Disease Protection from HRT

- *Should* have been higher quality study than the other two (Level I Evidence)

WHI

- Aged from 50-79 (**average 63yo. & only 3.5 % of participants were in 50-54 group**)

  Women with severe symptoms were excluded.

  Women with previous serious CVD were included.

- Only used CEE .625mg (E only) for the hysterectomised ladies (WHI- ERT arm) or CEE .625mg + MPA 2.5mg (E+P) for the non-hysterectomised (WHI- PERT arm)

WHI Limitations cntd.

- While originally set to run for 8.5 years the WHI-PERT arm was halted after a mean follow up of only 5.2 years because the pre -specified occurrence of invasive breast cancer had been reached (even tho it failed to reach statistical significance) & the global index statistic showed risks > benefits.

- During the study there was 45 % unblinding in the treatment group (due mainly to PV bleeding)

Huge media attention followed the premature cessation of the study and Controversy still surrounds the way in which the data was reported

Let's Examine the WHI Data….

- Regarding BREAST CANCER
- Regarding CARDIOVASCULAR DISEASE
- Regarding VTE

WHI BREAST CANCER DATA

Initially concluded that Breast Cancer Rates in relation to HRT were:

- Never used …… **16** cases/ 1000 women/ 5 yrs treatment
- E only…… **16** cases/1000 women/5 yrs treatment
- EE+MPA…… **20** cases/1000 women/5 yrs treatment

.. risk returns to normal within 5 years of discontinuing

RATES OF PRE INVASIVE BREAST CA & BREAST CA MORTALITY WERE THE SAME FOR PLACEBO & HRT GROUPS

- When they published this breast cancer data they wrote that

  'a small increased RR in Breast CA (1.26) was observed which ***did not reach statistical significance'***

  (Similar to what we saw in the MWS & what we were already telling the patients)

- BUT the following year a JAMA editorial reported the WHI study demonstrated that ….

  Breast CA rates were markedly increased in the HRT group!

  How did that happen!?

Moreover

- In 2006 an update from the WHI reported NO INCREASE risk of Breast CA among the women randomised to the HRT group.

- The RR had disappeared ?!

Further WHI & **BREAST CA** data

Rossouw JAMA 2007

OESTROGEN + PROGESTAGEN:

Relative Risk of 1.24 (24% **Increased** Risk)

Absolute Risk= 9 **More** Cancers/ 10,000WYRS

OESTROGEN ONLY:

Relative Risk of .8 (20% **Decreased** Risk)

Absolute Risk= 7 **Fewer** Cancers/10,000 WYRS

"The short (5.2 years) duration of the WHI makes it unlikely that the breast cancers were formed after HRT was started. Oestrogen may be breast cancer Promoting but is unlikely to be breast cancer Initiating"

Critique of the Report from the Writing Group of the WHI, Goodman, N. et al Menopausal Medicine Vol 10(4) 2003

So do we really know what exactly is the Relationship between Breast CA & Hormones ?

- Women who carry a mutation BRCA genes are more at risk of breast CA.
- If these women have their ovaries removed the risk falls by half.
- If those ladies then take HRT for surgical menopause symptom relief you should expect their breast CA rates to increase…. They don't.
- Their risk of breast CA remains just as low????

Hormone therapy & the risk of breast cancer in BRCA 1 mutation carriers. Eisen, A. et al. Journal of the National Cancer Institute Oct 2008

& what about AGE & Breast CA ?

- WE KNOW…..Oestrogen levels in older women -not on HRT- are virtually **nil**
- WE KNOW…The incidence of Breast Cancer INCREASES as women age
- So ….IF Oestrogen causes BREAST CA why aren't rates lower in older age ?

& what about the COCP & Breast CA?

- How is it that millions of women have been taking potent, synthetic Oestrogens & Progestagens for decades at a time (in the OCP) and yet we have not seen an epidemic of Breast CA among these women?

(remember OC pills use Ethinyloestradiol & pre 1980's in relatively big doses)

Oral Contraceptives and the Risk of Breast Cancer
Polly A. Marchbanks, Ph.D., et al NEJM 2002

On the other hand…..

- Breast Cancer incidence has gone down in many developed countries in the last 10 years!

Some authors suggest this is to do with the big drop in HRT use since the WHI's publication in 2002.

However; this trend started in 1999 (3 yrs prior to WHI) and became very obvious in 2003 (only 1 yr after WHI).

We know Breast CA lead in time to be on average 8 years so how could the discontinuation of HRT show a drop in detection so quickly??

- The California Teacher's Study (Observational) finds that increased use of EPT increases the risk for breast cancer associated with HT, as does longer duration of HT.

---- Also, women with a BMI lower than 25 kg/m2 had a significant increase in breast cancer risk, whereas those with a BMI higher than 30 kg/m2 had no further increased risk.

----HT increased the risk for hormone receptor–positive tumors only.

See California Teachers Study data reported in Breast Cancer Research 5/7/10

So what do we tell the patients ?

- HRT USE BEFORE THE AGE OF 50 YO CARRIES **NO ADDITIONAL** RISK OF BREAST CA (***don't discourage access to HRT to the younger patients particularly those who go through PREMATURE MENOPAUSE*)**

- HRT USE BETWEEN 50-54 YOA IS LINKED TO A **SMALL ADDITIONAL** RISK OF BREAST CA

- HRT USE **OVER 54 YOA** IS LINKED TO AN **INCREASED BREAST CA RISK-going** from 30 cases/10,000 women who never used it to 38 cases/10,000women **(** Keep the dose low –minimum effective for symptoms. Mind the type(s) you prescribe:?tibolone, 17 beta, Dydro,Neta, Drospir vs MPA ??, and the routes of administration, transdermal??)

- **EXAMINE REGULARLY**

- **REMEMBER …MORE WOMEN DIE FROM OSTEOPOROTIC FRACTURE-RELATED DISEASE THAN FROM CANCERS OF THE BREAST , UTERUS & CERVIX COMBINED…BUT OFTEN NOT LISTED ON DEATHS CERTS**

Mortality after admission to hospital with fractured neck of femur: database study
BMJ 2002;325:868

WHI + *Cardiovascular* SUMMARY

Rossouw JAMA ***2007***

EFFECTS PER 10,000 WYRS of E only Use:

10 Fewer DEATHS

10 Fewer CHD Events

2 Fewer STROKES

EFFECTS PER 10,000 WYRS of E+P Use:

9 Fewer DEATHS

5 More CHD Events in >60's in the 1st year*

5 More STROKES in >60's in the 1st year*

NO OVERALL ↑ IN CVD OVERALL*

*HRT: Putting Benefits & Risks into Perspective M.Warren MD; Columbia Univ Med School

So what do we really know about HRT & Cardiovascular Disease ?

- Exogenous Oestrogen has complex, counteracting effects on the coronary system when observed in animal studies.
- **The effects vary with the stage of disease at which they are introduced aka "Therapeutic Window"**

*** Early on: E2 improves lipids (↓ oxidation of LDL's), improves endothelial function/dilatation & may delay onset of CVD but**

*** Later on: E2's pro-thrombotic & pro-inflammatory effects may act to cause rupture of established plaques.**

New Evidence rekindles the HT debate. N. Goldman, J FP& RHC 2010 &

Estrogen replacement therapy, atherosclerosis, & vascular function.
Mikkola, TS. Cardiovascular Research 2002

So what do we tell the patients ?

- Women with known CVD (Angina, MI, etc) should avoid HRT as should women > 10 years past the menopause
- Women with a very strong Family Hx of CVD (eg. First degree pre menopausal female relative) should consider some CV screening in the peri-Menopausal years (BP monitoring, ECG, fasting Lipids, Glucose, etc)
- Women < 10 years from the menopause or under 60 yo ***may*** in fact derive some cardio-protection from HRT use but further studies need to be done.

HRT & Thrombosis

- WHI did show ↑ risk in VTE within the first 2 years (although the absolute risk remained low) particularly for the E+ P group
- PE rates were NOT increased

- Limited observational data also suggest that Transdermal HRT may be less thrombogenic than Oral

So what do we tell the patients ?

- In the first year or two from starting HRT the risk of getting a DVT is slightly elevated
- HRT should be avoided in women with a past Hx of DVT particularly if it occurred around pregnancy or while on the COCP
- Women with a strong FHx of or multiple risk factors for DVT might benefit from Haematological review before Rx and then may be safer on Transdermal products

We need more information

- We need better studies…….

Just off the presses…..

- KEEPS TRIAL: (Kronos Early Estrogen Prevention Study)
- included 727 women who were newly menopausal, within 3 years of the onset of menopause
- average age of 52.7 yrs
- tested 2 different types of oestrogen vs.placebo: oral conjugated oestrogen (0.45 mg/day), & transdermal estradiol patch (50 µg/day) both opposed with cyclic micronized progesterone x 12/28
- Looking at: quality-of-life , atherosclerosis of carotid and coronary arteries, cardiovascular risk-factor changes & biomarkers, cognitive function, mammographic breast density, et.al.

Findings due to be published this week

Positive

- substantial ↓ in hot flashes, night sweats, etc,
- some ↑ in bone mineral density (vs. placebo group)
- BP: neutral effect
- CEE: **reduction in LDL's, increase in HDL's,**
- **TRANSDERMAL E2**: **neutral effect on lipids. favourable effect on insulin resistance**

Negative

- CEE: ↑ in triglyceride levels,

SJH NMIC bulletin- June 2012:

- Classic vasomotor symptoms in a woman in her late 40s to mid-50s do not require laboratory evaluation unless there is reason to suspect another cause.
- The routine measurement of FSH is not recommended as levels may fluctuate during the perimenopausal period and increased levels may occur in the presence of ovulatory cycles.
- They do not predict when the last menstrual period will occur and are not a guide to fertility status
- Estimates of luteinising hormone, oestradiol, progesterone and testosterone are of no value in the diagnosis of ovarian failure.

Grady D, Management of Menopausal Symptoms, N Engl J Med 2006;355:2338-47

Management of the menopause 5th Edition, Rees M, Stevenson J, Hope S et al, published by the royal Society of Medicine press Ltd and British Menopause Society Publications Ltd 2009

PRESCRIBING HORMONE REPLACEMENT THERAPY

CONTRAINDICATIONS/ PRECAUTIONS

ABSOLUTE

- Suspected Breast or Endometrial cancer
- Undiagnosed abnormal genital bleeding
- Active TE disorder
- Active liver or gall bladder disease
- Pregnancy or Breast feeding

RELATIVE

- Heart disease
- Migraine headache
- History of liver or gall bladder disease
- History of Endometrial cancer
- History of TE events

FAMILY HISTORY OF BREAST CA IS NOT AN ABSOLUTE CONTRAINDICATION

CONTROLLED HYPERTENSION IS OK

CATEGORIES OF HRT

Oestrogen must be combined with a progestagen in a non-hysterectomised woman

CYCLICAL

Progestagen

suitable if

Menstruating within the last 6-12 months

WILL CONTINUE TO CREATE PERIODS

CONTINUOUS

Progestagen

suitable if

Amenorrhoeic for more than 6-12 months

WON'T CREATE A PERIOD

CHOICES IN HRT

9 pages in MIMS dedicated to Menopausal Disorders
49 products (less than half) actual HRT, some other hormone products & 27 Osteoporosis medications !!

OESTROGEN

- Oral
- Transdermal Patch
- Transdermal Gel
- IntraVaginal Gel
- IntraVaginal Pessary
- IntraVaginal Ring
- IntraNasal Spray
- IntraAbdominal Implant

PROGESTAGEN

- Oral
- Transdermal Patch
- IUS (Mirena)

- Plus…..**TIBOLONE**; a synthetic steroid whose metabolites have Oestrogenic, Progestagenic & Androgenic properties

CURRENT BLEED-PRODUCING HRT in MIMS

FEMOSTON 2/10 -Sequential Oral
2mgOestradiol+/- 10mg.Dydrogesterone

NOVOFEM -Sequential Oral
1mg.Estradiol+/- 1mg.Norethisterone

ESTALIS SEQUI-Sequential Transdermal
Estradiol 50 microg.+/- 250microg. Norethisterone

ESTRACOMBI-Sequential Transdermal
50microg.Oestradiol+/- 250microg.Norethisterone

PREMPAK-C- Sequential Oral
Conj Oestrogen 0.625 & 1.25mg.+/- Norgestrel 0.15mg.

TRISEQUENS- Sequential Oral
Estradiol 2 & 1mg+/- 1mg.Norethisterone

NUVELLE-Sequential Oral
2mg.Oestradiol+/- 75microg.Levonorgestrel

PREMIQUE CYCLE 10 - Sequential Oral
Conj. Equine Oestrogen.625mg.+/-10mg.MPA

PLUS…
UTROGESTAN- Oral Micronised Progesterone 100mg.
& DUPHASTON Oral Dydrogesterone 10mg

CURRENT NON-BLEED -PRODUCING HRT

ACTIVELLE – Continuous Combined Oral
1mg. Estradiol + .5mg Norethisterone

ANGELIQ- Continuous Combined Oral
1mg.Estradiol + 2mg.Drospirenone

EVOREL CONTI - ContComb.Transdermal
50microg.Oestradiol + 170microg.Norethisterone

FEMOSTON-CONTI 1/5 -Cont.Comb. Oral
1mg Oestradiol + 5mg.Dydrogesterone

INDIVINA - Cont.Comb. Oral
1 mg. Oestradiol
+Medroxyprogesterone acetate(MPA);2.5 or 5mg

KLIOGEST- Cont.Comb. Oral
2mg.Oestradiol/ 1mg.Norethisterone

PREMIQUE - Cont.Comb. Oral
Conj Oestrogen .625mg + 5mg. MPA

& **LIVIAL-2.5mg.** Tibolone..
Synthetic steroid, Gonadomimetic

CURRENT OESTROGEN-ONLY

Hysterectomised Women or Mirena IUS < 5 yrs old

CLIMARA-Transdermal Estradiol patch 50microg/day-(weekly)
DIVIGEL-Transdermal .1%Oestradiol gel
ESTROFEM - Oral 2mg.Estradiol
EVOREL -Transdermal 50microg. Oestradiol
FEMATAB -Oral 2 mg.Oestradiol
ESTRADOT-Transdermal Estradiol 37.5, 50. 75 & 100 microg.
PREMARIN - Oral Conj.Equine Oestrogen .625 & 1.25 mg.
AERODIOL-IntraNasal Oestradiol spray
***OESTROGEL** - Transdermal 17beta-Oestradiol 1.5mg.*
***ESTRADERM TTS** -Transdermal Oestradiol 25, 50 & 100microg.*

****

VAGIFEM - Intra Vaginal Oestradiol .025mg. (Minimal systemic absorption. Ideal for women with local symptoms- unlikely to have direct influence on Breast, Cardiovascular, etc)

Additional Menopause Preparations

- Progestagens (‘Duphaston’ dydrogesterone tab, Mirena IUS, ~~‘Utrogestan’ micronised progesterone tab~~)
- Androgen (‘Intrinsa’ testosterone patch)

And…..

- “S.E.R.M.”s

S.E.R.M.s SELECTIVE oESTROGEN RECEPTOR MODULATORS

- **E 2 –LIKE EFFECTS**

Increases BONE DENSITY

Decreases LDLs

Increases TE risk

- **TAMOXIFEN-LIKE EFFECTS**

Decreases BREAST CA RISK

Decreases ENDOMETRIAL CA RISK

Increases VASOMOTOR SYMPTOMS

T.S.E.C.s
Tissue Selective oEstrogen Complexes

Evista (raloxifene) & Conbriza (bazedoxifene) can be combined with an oestrogen to give an alternative delivery of HRT such as…

"APRELA" = Conbriza + Premarin

due for launch in Ireland soon…
might help rejuvenate the pharmaceutical management of the Menopause ?☺

Back to conventional HRT

Minor SIDE EFFECTS of HRT

- **BREAST TENDERNESS** (usually an E2 effect)

Common

Can cause anxiety & reduce Compliance

Usually temporary, can be controlled by manipulating the dose and/or type of HRT

(Other E2 s/effects include: bloating, nausea, headaches, leg cramps, dyspepsia)

- **BLEEDING DISRUPTION** (usually a Prog effect)

i.e. Irregular Periods, Heavier Periods

Common

Can be controlled by manipulating the dose and/or type of HRT

Be mindful of pathological causes of persistent PV Bleeding

(Other Prog s/effects include: bloating, headaches, mood alteration, acne)

But if a patient isn’t happy to try HRT

No matter how much you try to reassure her ?

What are her options?

Pitfalls of HRT Alternatives

- EFFICACY

No large, reliable trials done.

Data is poor

Most smaller available data show HRT to be more effective than any alternatives

- SAFETY

Concerns about quality & standardization of some products as well as serious issues with herb-drug interactions

Common HRT Alternatives in Ireland

- VASOMOTOR SYMPTOMS
  COC's, Plain Progestagens, Clonidine, SSRI's, COCPs
  Black Cohosh, Mexican Yam, Soya , Sage et. al. *Ideal for menopausal plants* ☺

- EMOTIONAL SYMPTOMS
  SSRI'S, Behavioral therapies

- VAGINAL DRYNESS
  'KY jelly'/ KY SILK moisturiser & 'Senselle' lubricants, '**Replens**' **vaginal moisturizer, 'Yes'** moisturiser
  If No improvement ……encourage her to consider **VAGIFEM** please !

- OSTEOPOROSIS
  Calcium, Vit D, Diet, Moderate weight -bearing Exercise, SMOKING cessation, Bisphosphonates, Denusomab(Prolia), Strontium ("Protelos"), etc etc

“BIO IDENTICALS”

as seen on ‘Oprah’, Dr Phil, Sex & the City film, etc

- Progesterone creams and *natural* or *bioidentical* compounded estrogen preparations (creams, pills & lozenges !) are being promoted to consumers as safe alternatives to conventional menopausal hormone therapy and as health-promoting tonics.

- No reliable data support these claims

See the FDA downloadable leaflet under “identicals”

http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049311.htm

- **Saliva & blood testing** is often used to ascertain hormonal deficit- no such assay has ever been scientifically established.

- Whereas compounded preparations may be useful for creating lower-dose preparations of hormones, these preparations lack the **consistency** and **regulatory** oversight required of commercial hormonal drugs (they may be stronger than standard prescription pharmaceuticals!)

- Women who wish to use compounded hormones to treat menopausal symptoms should be counseled that bioidentical hormones have the **same risks** as conventional hormones.

Some MIMS HRT *are* " Bio- identical "

- Estragel: 17-β Oestradiol
- Estradot: 17-β Oestradiol
- Utrogestan: PV or PO Progesterone
- Crinone: PV gel Progesterone
- Cyclogest: PV Progesterone

In France a study involving 100,000 women using natural progestagens seems to show breast much less breast effects than MPA

Possibly similar safety from DVT with natural progestagens

Qlaira

- First COC to use ‘Oestradiol Valerate’ (E2V) instead of Ethinyl Oestradiol (EE)
- E2V combined with a well- known European progestagen (Dienogest or ‘DNG’) in an “oestrogen step-down and progestogen step-up” regimen.
- Pearl Index same as EE pills (<1)
- Has minimal effect on haemostatic parameters and may have a favourable effect on lipid profiles

Zoely

- Also uses Oestradiol
- Added to a potent

  progestin Nomegestrol which has a 46 hr duration so can be taken
- MONOPHASIC (24/4)
- Similar minimal effect on haemostatic parameters and may have a favourable effect on lipid profiles

New Developments in Menopause Preparations

- An ultra low dose oestrogen only patch is available in the US which doesn’t cause endometrial proliferation so won’t require opposition with progestagen
- A new progestagen vaginal ring is being developed which is not absorbed systemically

CASE 1

- 30 yo Woman with Amenorrhoea x 6 mos.

  Biochemical investigations reveal elevated FSH. Referred to Gynae OPD where diagnosis of Premature Ovarian Failure confirmed.

Worried about HRT but content to take COC…

CASE 2

- 47 yo woman with persistent flushes, sweats, vaginal dryness, etc.
- No HRT contraindications, Cardiovascular disease or risk factors.
- Commenced on HRT
- CVA 3 months later.

CASE 3

- 49 yo lady with perimenopausal symptoms.
- Wearing a Mirena inserted 6 years ago but was reassured she was still quite safe.
- Now interested in HRT

CASE 4

- 55 yo lady on HRT (first cyclical now tibolone) since 46.
- Has tried stopping but got symptoms again
- Worried about remaining on HRT

CASE 5

- 42 yo lady with severe flushes, etc
- Hx of eating disorder as teenager
- Heavy smoker, slim but sedentary
- Afraid of using HRT because of breast cancer

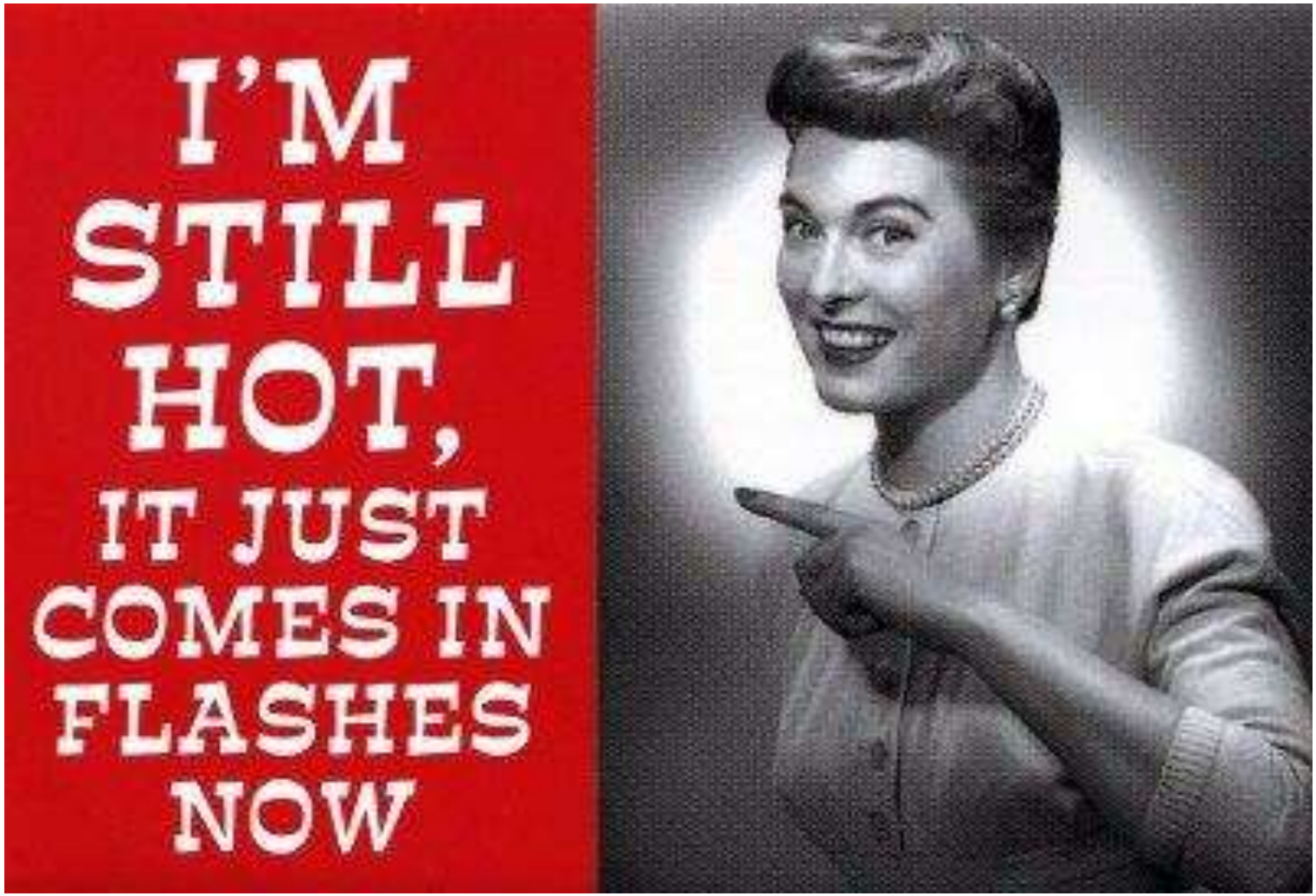
SOME RELIABLE READING/ SITES

www. news-medical.net
www.womens-health-concern.org
www. thebms.org.uk
www. disruptivewomen.net
www. cks.library.nhs.uk/menopause

"Hormone Replacement Therapy: Real Concerns & False Alarms" Dr A Bluming
The Cancer Journal Vol 15, Num 2 March 2009

www.menopausematters.co.uk

www.stjames.ie/GPsHealthcareProfessionals/Newsletters/NMICBulletins/Menopause%202010.pdf


I'M
STILL
HOT,
IT JUST
COMES IN
FLASHES
NOW