

# MYTHS AND MISCONCEPTIONS OF HRT AND THE MENOPAUSE

Managing the menopause can be difficult for GPs. This article looks at some common myths and misconceptions GPs might encounter

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I am constantly surprised how many of my patients are denied hormone replacement therapy (HRT) by their GPs when they do not actually have true contra-indications. This often results in many women trying to self-manage their symptoms of the menopause, which can be extremely hard or even impossible. I also worry about the huge amounts of money they spend on either ineffective or potential dangerous medications.

It is not uncommon for women to have tried numerous different herbal preparations and also been prescribed antidepressants for their mood symptoms before they come and see me in my menopause clinic.

I hope this article will help to dispel some myths about HRT and lead to health professionals being more confident about prescribing HRT to their patients.

**Myth 1 –  
HRT is associated with a risk of breast cancer in younger women with premature ovarian insufficiency (POI)**

POI is when the menopause occurs in women under the age of 40 years. It occurs in around one in a hundred women under the age of 40 and around one in a thousand women under 30 in the UK and is still underdiagnosed and undertreated. Women with POI should be given replacement hormones either in the form of hormone replacement therapy (HRT) or the combined oral contraceptive pill (COCP) until at least the average age of the menopause (51 years).<sup>1</sup> This is not just for symptom control but also to maintain their long-term health and reduce their increased risk of osteoporosis, cardiovascular, psychological and cognitive diseases. Any risks of HRT (for example, breast cancer risk) do not apply to younger women with POI taking HRT. The risks and benefits of HRT for women with POI is completely different from those of women using HRT for their menopause who are older than 51 years of age. It is essential that these women are made aware of this.

**Myth 2 –  
The menopause only lasts a year or two so women should just put up with their symptoms**

Symptoms of the menopause last far longer than most women anticipate. The average length of time is four years and many women still have some symptoms for longer than 10 years. On average, women spend nearly a third of their life being postmenopausal. The retirement age is increasing and elderly people are far more active, physically and mentally, than they were in the past. This means it is important that women are given choices regarding actually managing their menopause to reduce the detrimental impact it may have on their home and work lives.

**Myth 3 –  
All women with menopausal symptoms need to have their follicle stimulating hormone (FSH) levels taken to diagnose their menopause**

NICE is very clear regarding making a diagnosis of the menopause.<sup>2</sup> In women over 45 years with menopausal symptoms or presenting with amenorrhoea over 12 months, investigations are now no longer necessary. In those women aged under 45 years, FSH may be used to diagnose the menopause. Other tests are largely unnecessary. This means that in practice women can start treatment sooner, which will be advantageous for many women, especially those with more severe symptoms.

## **Myth 4 – Women with a past history of DVT cannot take HRT**

There is an increased risk of venous thrombo-embolic disease (VTE) in those women taking oral oestrogen; the risk is approximately double. This increased risk is far lower than that experienced when taking the combined oral contraceptive pill or with pregnancy. The background risk of VTE increases with increasing age.

However, transdermal oestrogen is not associated with an increased risk of clot. This is due to oral preparations undergoing first-pass hepatic metabolism. They therefore have a greater effect on clotting factors produced by the liver than transdermal preparations, which avoid the first-pass effect. Women with an increased risk of VTE should be offered HRT as either a gel or patch. NICE recommends that transdermal preparations should be considered for those women with a higher risk of VTE, including those with a BMI >30 kg/m<sup>2</sup>.

## **Myth 5 – Women with cardiovascular disease should not take HRT**

The controversial Women's Health Initiative (WHI) study started women on HRT when they were over 60 years of age and some were given high doses of oral HRT.<sup>3</sup> More recent studies have looked at the timing of starting HRT after the menopause, as this seems to be important regarding CVD risk.

There is a lower incidence of CVD in those women who take HRT within 10 years of their menopause.<sup>4</sup> The number needed to treat (NNT) has been estimated to be 89 to prevent one cardiovascular event for 10 years' treatment. The CVD benefit of taking HRT is greater the earlier a woman starts HRT. A recent large Finnish study has shown that using any HRT for at least 10 years is associated with 19 fewer CHD deaths and seven fewer stroke deaths per 1,000 women.<sup>5</sup>

NICE states that women should be informed that:

- HRT with oestrogen alone is associated with no, or reduced, risk of coronary heart disease
- HRT with oestrogen and progestogen is associated with little or no increase in the risk of coronary heart disease
- Taking HRT under 60 years does not increase a woman's risk of CVD
- The presence of cardiovascular risk factors is not a contra-indication to HRT
- It is essential to optimally manage any underlying cardiovascular risk factors (eg blood pressure, cholesterol).

## **Myth 6 – The maximum length of time a woman should take HRT for is five years**

When discussing menopause with women, it is so important that they receive individualised care. They should all receive appropriate information, which will enable them to make informed choices regarding the treatment they receive. Women need to be made aware that the HRT benefits and risks vary by dosage, regimen and timing of initiation. They need to be informed that vaginal bleeding may occur in first three months of treatment. In general, they should be prescribed the lowest effective dose of HRT for the shortest length of time. However, as the menopause can last for many years, this results in some women taking HRT for longer than five years. Women taking HRT should be reviewed annually. Women who do stop HRT can either have their HRT gradually reduced or stopped immediately. Many women prefer to reduce slowly, which allows them to determine if they have any background menopausal symptoms with a lower dose. Lower dose preparations of HRT are available for older women.

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### **Myth 7 – Topical oestrogen for symptoms of atrophic vaginitis should never be used in the long term**

Some women present during or after their menopause with symptoms of urogenital atrophy; one of the commonest symptoms are those of recurrent urinary tract infections with negative MSUs. These symptoms are often effectively managed with giving women topical vaginal oestrogen in the form of pessaries, creams or rings.

The NICE guidance states that vaginal oestrogen should be offered to women (including those on systemic HRT) with symptoms of urogenital atrophy and then continued for as long as needed to relieve symptoms.<sup>2</sup> The only real contra-indication to these preparations is active breast cancer. After all, a year's supply of topical oestrogen is equivalent to having one oral tablet of HRT.<sup>6</sup> This means that vaginal oestrogens can safely be given as a repeat prescription. Vaginal lubricants and moisturisers can be used with vaginal oestrogen and the combination of treatments is often effective for many women. A number of women taking HRT still need to use topical oestrogen so it is important that women are asked about any potential symptoms at their review appointments.

### **Myth 9 – Antidepressants should be used first line for women who have symptoms of depression or anxiety during the menopause**

The NICE guidelines state that HRT should be considered to alleviate low mood that arises as a result of the menopause.<sup>2</sup> This is because there is some evidence that women receiving oestradiol have a significantly greater improvement in mood compared to those receiving placebo.<sup>10</sup> Cognitive behavioural therapy (CBT) may be beneficial for some women. It is therefore very important that women who present with low mood or symptoms of depression are asked about the date of their last period and also if they have any menopausal symptoms. There is no clear evidence that antidepressants actually work to improve low mood in menopausal women who do not have depression.

### **Myth 8 – The recent study in the *British Journal of Cancer* has demonstrated a huge increased risk of breast cancer with all types of HRT**

This study used information from serial questionnaires from the UK Generations Study cohort to estimate hazard ratios for breast cancer among post-menopausal women with known menopausal age.<sup>7</sup> Their results showed that there is a 2.74-times increased risk of developing breast cancer (or preinvasive DCIS) for women using combined HRT for five years. This risk increases to around threefold with prolonged treatment – over 15 years. As shown with other studies, there was no increased risk of breast cancer seen for users of oestrogen only therapy. This increased risk returned to normal within two years of stopping HRT.

This study has not differentiated between the various combined HRT products nor between different progestogens used. This is a shame as there is considerable evidence to suggest that certain synthetic progestogens, such as medroxyprogesterone acetate, may increase breast cancer risk when used in combined HRT and when compared to using micronised progesterone.<sup>8,9</sup> The progesterone is micronised, or reduced to tiny particles, and mixed with oil so that it is better absorbed.

Women should be made aware that this increased risk of developing breast cancer is less than being overweight or having a glass or two of wine each night.

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## Myth 10 – HRT is not effective at reducing osteoporosis risk

The incidence of fragility fractures increases in women at the menopause, coinciding with lower oestrogen levels, a decrease in bone mineral density (BMD) and higher rates of bone turnover.<sup>11</sup> Oestrogens are the most effective way of increasing bone mineral density and preventing osteoporotic fractures in women.<sup>12</sup> There is good evidence from randomised and cohort studies which has demonstrated that the risk of any fragility fracture and non-vertebral fracture is significantly lower for women taking HRT (either oestrogen alone or for the combination of oestrogen plus progestogen) compared with non-users.<sup>12</sup>

NICE recommends that women should be informed that their risk of fragility fracture is decreased while taking HRT and that this benefit:

- Is maintained during treatment but decreases once treatment stops.
- May continue for longer in women who take HRT for a longer period of time.

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In summary, we should be more pro-active at asking women about the menopausal symptoms they are experiencing and how these symptoms are affecting their lives. There are few contra-indications to HRT and women should be reassured about the safety of HRT and also educated about the effectiveness of HRT for their symptoms.

The preparations are usually oral or transdermal and then are sequential or continuous combined. Oestrogen can be given unopposed or combined with a progestogen. Women with an intact uterus need to take oestrogen and progestogen whereas women who have had a hysterectomy only need to take oestrogen. Women who have not had a period for at least a year can be given continuous combined HRT. Women who have taken a sequential preparation for at least a year can be given continuous combined HRT.

Women should be informed that they may have unscheduled vaginal bleeding in the first three months of taking HRT. The dose of oestrogen may have to be increased to higher doses, especially in younger women.

## References

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