Kent and Medway Hormone Replacement Therapy (HRT) Prescribing Guideline

Contents

Background & Scope

Please refer to the Contents above for links to each section of this guideline. Please see Key Points of the guideline below.

- HRT is the most used and effective treatment for managing menopausal symptoms[1]. This guideline has been developed to support primary and secondary care healthcare professionals prescribing HRT for menopausal patients in Kent and Medway, including those with premature ovarian insufficiency (POI). Most patients can be effectively managed in primary care, with the use of guidelines to inform clinical decision making
- This guideline provides information on current best practice and HRT treatment options available on formulary to prescribe for this group of patients; intending to ensure cost effective prescribing, a consistent approach by prescribers and consistent management, support, and information for menopausal patients across Kent and Medway. This prescribing guideline is based on guidance from NICE[2] and the British Menopause Society (BMS)[3]
- Regarding management of menopause, this guideline is not exhaustive e.g., it does not include definitions, symptoms and diagnosis of menopause or POI, information/advice to be given to patients, benefits and risks of HRT, and other treatment options or interventions where HRT is not tolerated or is contraindicated. This information can be found in National Guidance (see below). This guideline only discusses hormonal drug, and some complementary, treatment options only; non-hormonal drug treatment options licensed for menopausal symptoms e.g., oral clonidine are not included. For the purposes of this guideline, those included as menopausal patients are women and people assigned female at birth (AFAB) who are perimenopausal or menopausal.

National Guidance & Resources

For more information on the diagnosis and management of menopause please see:

- NICE Guideline (NG23), published in 2015 and last updated 2019, and NICE CKS – Menopause. (NG23 full update - publication expected August 2023)
- The following BNF treatment summary on Sex hormones for more information on HRT
- The Primary Care Women's Health Forum guidance on menopause management and HRT prescribing for GPs
- The NICE menopause quality standards which identify five key points from NG23 as a priority to improve patient care
- The British Menopause Society (BMS) website for healthcare professional resources and tools e.g. summary of the NICE guideline, information on the menopause, it's management and HRT, practice guidance and standards, prescribing guidance (HRT Guide, HRT – Practical prescribing), HRT risks and benefits, and treatment options

*N.B. this guideline does not cover osteoporosis management - see NICE Clinical Knowledge Summary: Osteoporosis – Prevention of fragility fractures: Assessment

Key Points

- There should be an individualised approach in all stages of management of menopausal patients. The HRT dosage, regimen and duration should be individualised based on age, symptoms, and co-morbidities, and reviewed regularly to ensure HRT is still appropriate/indicated and being used at the lowest effective dose
- There are many options for HRT with products varying in route of administration, dose/dosing schedule, preparation, and if local (vaginal) or systemic effects:
    - See Local (Vaginal) & Systemic HRT for a summary of the types and preparations of HRT available
    - See Systemic HRT Treatment Summary outlining when systemic HRT should be used
    - See Vaginal (Urogenital) Symptoms for a summary of local (vaginal) HRT and when they should be used
    - See Table 2 in Formulary Treatment Options to see which products are on formulary for use in Kent and Medway for each type of HRT
- Prescribing of unregulated bioidentical hormones is not supported/recommended in Kent and Medway. Patients should be encouraged that if they wish to take bioidentical hormones, they should obtain a prescription from their GP/Specialist for a regulated licensed product. See Bioidentical Hormones for more information
- Testosterone supplementation can be considered for menopausal patients with low sexual desire/altered sexual function if HRT alone is not effective, however, testosterone is not currently licensed for use in women and people AFAB in the UK. See Testosterone for the NHS Kent and Medway position statement and recommendations which have been agreed locally in Kent and Medway for this off-label use of topical testosterone gel. **Specialist advice/referral** to a healthcare professional with expertise in menopause should be sought on the appropriateness of and for initiation of testosterone[5]. (Specialist in menopause for the purposes of this guidance is defined as: a BMS accredited specialist or equivalent prescriber who can demonstrate that they have received training in and have clinical experience of treating menopausal patients with testosterone. This could therefore be a GP working in primary care).
- Non-hormonal vaginal moisturisers/lubricants can be purchased OTC and are not recommended for prescribing on NHS FP10 prescriptions in Kent and Medway
- The evidence for using/the safety of herbal medicines is unclear; they are not available on NHS prescription in Kent & Medway – see Complementary Therapy
- The most cost-effective option should be used where possible, unless stated otherwise. Only licensed products should be prescribed where possible
- Transdermal HRT is generally preferred compared to oral preparations, but choice depends on patient preference/clinician discussion. For more information on choosing routes of administration, regimens and combined HRT see Choice of HRT
- Patients should be encouraged to persist with treatment for 3 months before review/changing as side effects may resolve. See Side Effects & Bleeding Patterns
- HRT is not a contraceptive – see Contraception for more information
- There should be no arbitrary limits to duration of treatment, nor is there a definitive age cut off for HRT, as it should be individualised, and risk assessed for each patient - see Review & Treatment Duration for more information
- Patients should be offered a choice of gradually reducing (over 3-6 months) or immediately stopping HRT – see Stopping HRT for guidance
- Most patients with menopausal symptoms can be managed in primary care. See Referral for when patients with complex menopause healthcare problems should be referred to a specialist/healthcare professional with expertise in menopause
- For FAQs/information on HRT shortages, generic/branded prescribing, prescription charges and durations and private prescriptions see Practical Prescribing
- Patients should be aware help and support is available and should consult their GP/specialist for advice on how they can optimise their menopause condition and the options they have on managing their symptoms. Please see Patient Information & Resources for available resources, information, and support organisations for signposting.

Initiating & Managing HRT

- There should be an individualised approach in all stages of diagnosis, investigation, and management of menopausal patients, with particular reference to lifestyle advice, diet modification and discussing the role of HRT for the treatment of menopausal symptoms (if not contraindicated)[1,2]. The decision whether to take HRT, the dose, and duration of use should be made on an individual basis after discussing patients' health priorities and quality of life, HRT effectiveness, benefits (including symptom control as well as bone and cardiovascular benefits), risks (considering age and time since menopause), side effects, contraindications, bleeding patterns and personal preference with each patient so that they have realistic expectations (shared decision making)[1]. HRT should only be prescribed for the relief of menopause symptoms that adversely affect quality of life[4].
- Menopausal patients should be prescribed a cost-effective preparation appropriate for their needs and risk factors[4]. The HRT dosage, regimen and duration should be individualised based on age, symptoms, and co-morbidities, and reviewed regularly to ensure HRT is still appropriate/indicated and being used at the lowest effective dose[4,5]. Start with lowest dose and titrate upwards until desired therapeutic effect is achieved. Doses should not be changed too quickly, allowing at least 3 months trial.

Managing Co-morbidities

- As per the NICE CKS – Menopause, for patients with co-morbidities offer hormonal, non-hormonal, or non-drug treatment options depending on the risks, benefits, adverse effects, and contraindications. If there is any uncertainty about appropriate management, seek specialist advice from a healthcare professional with expertise in menopause or refer to the relevant specialist team[5].
- **Breast cancer:** For advice on the treatment of menopausal symptoms in patients with breast cancer or at high risk of breast cancer, please see recommendations on complications of local treatment and menopausal symptoms in the NICE guideline on early and locally advanced breast cancer and recommendations on risk reduction and treatment strategies in the NICE guideline on familial breast cancer[2]. Offer patients information on all available treatment options, and referral to a healthcare professional with expertise in menopause[2]. Oral or transdermal HRT should not routinely be offered to patients with a history of breast cancer and should be stopped in patients who are diagnosed with breast cancer[4]. With patients at moderate or high risk of breast cancer, HRT should not generally be used in those over 50 years of age[4]. Any treatment/prescribing (if appropriate) should be initiated by a specialist following review and discussion with the patient. The NICE CKS – Menopause has more information on breast cancer and the BMS has a tool on HRT and breast cancer risk.

Cautions & Contraindications

- For cautions and contraindications of HRT please see the NICE CKS. For a full list please see the individual products SPCs.
- **HRT & Breastfeeding:** https://breastfeeding-and-medication.co.uk/wp-content/uploads/2021/10/the-menopause-and-breastfeeding.pdf

Risks & Benefits

- For the treatment of menopausal symptoms, the benefits of short-term HRT outweigh the risks in most patients, especially those <60 years of age[9]. Risk/benefit ratios should be reviewed annually for patients using HRT. The NICE guideline NG23 has more information on long-term benefits and risks of HRT, and the BNF treatment summary on Sex hormones outlines HRT Risk. It is important to consider the individual risks and benefits of the different treatment options available - please see the individual products SPCs
- The MHRA have produced tables to aid communication about risks and benefits of HRT – Table 1 summarises HRT risks and benefits during current use, and current use plus post-treatment (please note that menopausal symptom relief is not included in this table but is a key benefit of HRT and plays a major part in the decision to prescribe HRT). Table 2 is a detailed summary of relative and absolute risks and benefits during current use
- Please see the MHRA Drug Safety Update for further information on the known increased risk of breast cancer with HRT. Risks and benefits of HRT should be discussed with patients. See the Patient Information & Resources section of this guideline for sources of information on risks and benefits for patients.

Local (Vaginal) & Systemic HRT

- The hormone oestrogen is the main component of HRT which is effective in controlling menopausal symptoms[1]. There are many HRT options including products varying in route of administration/delivery, dose/dosing schedule, preparation, and whether it has local (vaginal) or systemic effects. Table 1 below summarises vaginal and systemic HRT: when indicated, and the types and preparations of HRT available. Figure 1 is a Systemic HRT Treatment Summary outlining when it should be used
- For more information on each type of systemic HRT and when they should be used, see the following sections: Progestogens, Non-Oestrogens, Bioidentical Hormones, Testosterone. The section Vaginal (Urogenital) Symptoms summarises local (vaginal) HRT (vaginal oestrogen, and ospemifene, prasterone (Non-Oestrogens) and when they should be used
- See Table 2 in the Formulary Treatment Options section to see which products (with the different strengths, forms/routes, and brands available) are on formulary for use in Kent and Medway for each type of HRT.

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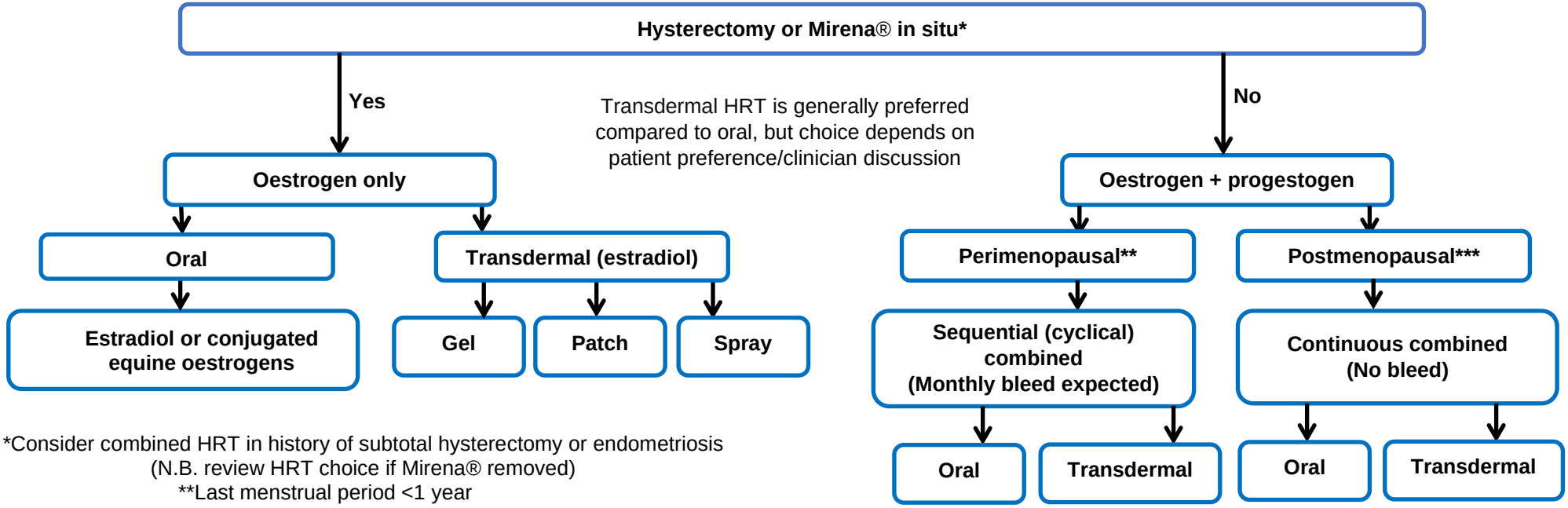
Table 1 *Summary of Local (Vaginal) and Systemic HRT*[3]

	Indication	Type of HRT	Route/Delivery
Local (Vaginal) HRT	- When vaginal and/or bladder symptoms of urogenital atrophy predominate, vaginal oestrogen alone can be used - Vaginal oestrogen may also be required in addition for some patients taking systemic HRT	Oestrogens (estradiol, estriol)	- Vaginal (ring, tablets, creams, pessaries, gel)
		Non-oestrogens (prasterone (DHEA)	- Vaginal (pessaries)
Systemic HRT	- Symptom control - Treatment of POI	Oestrogens	- Oral (tablets) - Transdermal (patches, gels, spray)
		Progestogens	- Oral (tablets/capsules) - Intrauterine (IUS)
		Combined oestrogen + progestogen (Combination product, or oestrogen only product and separate progestogen only product)	- Oral (tablets/capsules) - Transdermal (patches)
		Non-Oestrogens (tibolone, ospemifene)	- Oral (tablets)
		Testosterone (off-label)	- Transdermal (gel)

Systemic HRT Treatment Summary



Adapted from the British Menopause Society - Tools for Clinicians - HRT Guide (July 2020)[3]

Figure 1 *Systemic HRT Treatment Summary*

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Progestogens

- If long-term oestrogen therapy is required in patients with a uterus, adjunctive progestogen should be used (either on a cyclical (with bleeds) or continuous basis (no bleeds) alongside either oral or transdermal oestrogen to provide endometrial protection (progestogenic opposition)[9]
- Progestogens are available as natural micronised progesterone capsules (plant derived) which are bioidentical (see Bioidentical Hormones) or synthetic progestogens (medroxyprogesterone tablets, levonorgestrel IUS)
- Combined packs incorporating suitable progestogen with oestrogen tablets are available, or oestrogen can be administered orally or transdermally, with progestogen supplied by the Mirena® IUS or by an oral progestogen such as micronised progesterone or medroxyprogesterone[5]
- The Mirena® is a useful option if progestogenic side effects are an issue with systemic treatment, if heavy bleeding is experienced with sequential preparation, and has the advantage of also providing contraception. Some guidance (Faculty of Sexual & Reproductive Healthcare (FSRH) guidance and the BMS) states that the Mirena® should be changed every 5 years if it is being used as the progestogenic component of HRT, but please note that licensed use for this indication is to replace after 4 years[9] so this is an off-label use
- Oral micronized progesterone can be used (either sequential combined or continued combined) if the Mirena® is unsuitable or has been declined.

Non-Oestrogens

- **Tibolone:** A synthetic steroid compound, combining oestrogenic and progestogenic activity with weak androgenic activity; a type of continuous combined HRT (no bleeding) given without cyclical progestogen[9]. It is classified as HRT and is indicated for postmenopausal patients (>1 year since last menstrual period) with systemic symptoms. It conserves bone mass and treats vasomotor, psychological and libido symptoms (due to its androgenic effects). It is not recommended as a first line option due to unfavourable risk profile, similar to combined HRT (increased risk of breast cancer and venous thromboembolism (VTE)[9]. Use needs to be cautious in older patients because of increased risk of stroke[9]
- **Prasterone: At the time of writing this guideline, prasterone is not currently on formulary across Kent and Medway.** It is biochemically and biologically identical to endogenous dehydroepiandrosterone (DHEA) and is converted to oestrogens and androgens[4]. Available as vaginal pessaries (Intrarosa®), it is indicated for the treatment of vaginal and vulvar atrophy (VVA) in postmenopausal patients having moderate to severe symptoms adversely affecting quality of life (genitourinary symptoms)[4]. It was not included in the 2015 NICE Guideline (NG23), however, the 2019 surveillance of menopause (updated when prasterone had recently become licensed in the UK) identified new evidence for prasterone use up to 3 months
- **Ospemifene: At the time of writing this guideline, ospemifene is not currently on formulary across Kent and Medway.** It is a selective oestrogen receptor modulator (SERM) that has an oestrogen-like effect in the vagina, increasing cellular mucification and maturation of the vaginal epithelium[4], available as oral tablets (Senshio®), It is indicated for the treatment of moderate to severe symptomatic VVA in postmenopausal patients who are not candidates for local vaginal oestrogen therapy (genitourinary symptoms)[4]. It was not included in the 2015 NICE Guideline (NG23), but is in the more recent 2022 NICE CKS – Menopause. The 2019 surveillance of menopause identified evidence indicating that it improves sexual function, vaginal dryness, and dyspareunia[2].

*N.B. tibolone, prasterone, and ospemifene are contraindicated in known, past or suspected breast cancer, known or suspected oestrogen-dependent malignant tumours (e.g., endometrial cancer) and previous or current VTE.

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Bioidentical Hormones

- Bioidentical ("body identical") hormones are plant-derived and have a similar chemical structure to those produced by the human ovary[1]. They have advantages over non-bioidentical or synthetic alternatives as they have a more neutral effect on the risk of blood clots and a lower risk of breast cancer[1]. NICE (NG23) does not recommend the use of bioidentical hormones[5]
- The BMS has guidance on Bioidentical HRT including explanations of the differences between custom 'compounded' bioidentical HRT (cBHRT) and conventionally prescribed 'regulated' bioidentical HRT (rBHRT). Regulated bioidentical hormones are available through the NHS as prescribed licensed medicines, which should be distinguished from compounded custom-made bioidentical hormones which are not regulated by the MHRA, do not have a strong evidence base, and the amount of hormone present, or the potency, may not be consistent in each dose[11]. They are manufactured by specialist pharmacies (often selling online)[11]. The BMS warns that cBHRT is often prescribed by healthcare professionals who do not possess recognised training in treating menopause, and that blood and saliva tests offered privately to monitor the precise components of cBHRT have no evidence base.[11] cBHRT is not available on the NHS, NICE and the BMS do not recommend its use.
  Prescribing of unregulated bioidentical hormones is not supported/recommended in Kent and Medway[11]
- Patients should be encouraged that if they wish to take bioidentical hormones, they should obtain a prescription from their GP/Specialist, which will allow them to have **regulated bioidentical hormones** which are safe and effective and avoid compounded bioidentical hormones[11]. **Licensed** bioidentical hormone preparations include Utrogestan®, the only adjunctive micronised progesterone oral capsules licensed in the UK for progestogenic opposition of oestrogen HRT, which is on formulary across Kent and Medway. Current evidence shows that micronised progesterone is unlikely to increase risk of VTE and is associated with lower breast cancer risk compared to synthetic oral progestogens[4]
- Bijuve® (oral estradiol/micronised progesterone) is the only continuous combined bioidentical HRT licensed in the UK for oestrogen deficiency menopausal symptoms in postmenopausal patients with a uterus. It is not a recognised treatment option in national menopause guidelines, although NICE recognises that it has been approved, and the BMS list it in their HRT preparations and equivalent alternatives. **At the time of writing this guideline, Bijuve® is <u>not</u> currently on formulary across Kent and Medway.**

Vaginal (Urogenital) Symptoms

Advise patients that symptoms of urogenital atrophy often come back when treatment is stopped. Unscheduled vaginal bleeding should be reported.

- **<u>Vaginal Oestrogen:</u>** May be offered to patients with urogenital atrophy (including alongside systemic HRT and/or vaginal moisturisers or lubricants if needed, or alone when urogenital atrophy predominates) and treatment continued for as long as needed to relieve symptoms[2]. It may also be considered for patients with urogenital atrophy if systemic HRT is contraindicated, after seeking advice from a healthcare professional with expertise in menopause/specialist[2]. If vaginal oestrogen does not relieve symptoms, consider increasing the dose after seeking advice from a specialist. All topical products are low dose estradiol or estriol. Adverse effects are rare[2]. Systemic absorption is minimal, so progestogen is not required[5]
  - From September 2022, Gina® (estradiol) 10 microgram vaginal tablets (low-dose oestrogen) can be purchased over the counter (OTC) without a prescription after consultation with a pharmacist; following an MHRA consultation resulting in reclassification. They can be used by postmenopausal patients (who have not had a period for >1 year) aged years and above. Other brands of estradiol vaginal tablets remain prescription-only (see Table 2 for Formulary Treatment Options).
- **<u>Ospemifene:</u>** Consider a trial for moderate to severe symptoms if vaginal oestrogen is not tolerated or is contraindicated[5]
- **<u>Prasterone:</u>** See Non-Oestrogens for more information on prasterone and ospemifene and when they should be used
  ***At the time of writing this guideline, ospemifene and prasterone are <u>not</u> currently on formulary across Kent and Medway**
- **<u>Vaginal Moisturisers & Lubricants:</u>** OTC non-hormonal vaginal moisturisers and lubricants should be recommended; they can be used alone or in addition to vaginal oestrogen at least twice a week, for vaginal dryness and symptoms/sexual function[2]. These can be purchased over the counter (OTC) at pharmacies and supermarkets[4] (e.g., Replens MD®, Yes VM®) and are not recommended for prescribing on an NHS FP10 prescription in Kent and Medway. Treatment may be continued indefinitely if required[5].

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NICE states testosterone supplementation can be considered for menopausal patients with low sexual desire/altered sexual function if HRT alone is not effective[2]. However, testosterone is **not currently licensed for use in women or people assigned female at birth (AFAB) in the UK**, so this is an **off-label use**[2,4]. Using medicines outside product licences should meet GMC proposed criteria and the MHRA's Off-label or unlicensed use of medicines: prescribers' responsibilities. As testosterone for menopausal patients falls outside current licensing and national prescribing guidelines, the RCGP, RCOG and BMS Position Statement has information to help healthcare professionals while national menopause guidance (NICE), and the women's health care pathway (NHS England), are being updated. The International Menopause Society (IMS) have a Global Consensus Position Statement, which notes larger studies are needed to inform clinical recommendations and establish longer-term safety of testosterone use in women or people AFAB.

The following NHS Kent and Medway position statement and recommendations have been agreed for the off-label use of testosterone for menopausal patients with low sexual desire/altered sexual function locally in Kent and Medway:

Initiation: NICE and the BMS recommend a trial of conventional HRT is given before testosterone supplementation is considered. **Specialist advice/referral** to a healthcare professional with expertise in menopause should be sought on the appropriateness of testosterone[5]. (Specialist in menopause for the purposes of this guidance is defined as: a BMS accredited specialist or equivalent prescriber who can demonstrate that they have received training in and have clinical experience of treating menopausal patients with testosterone. This could therefore be a GP working in primary care). Before initiating, other causes of low libido should be investigated and, if necessary, treated first[3]

- Oral oestrogens (especially conjugated oestrogens) can reduce testosterone effectiveness, so switching oral oestrogen to transdermal preparations can be beneficial[3]. Symptoms of VVA should be adequately treated/oestrogenised when considering testosterone
- **Testosterone should only be initiated by a specialist**[5], who will **issue the first prescriptions (min. 3 months)**. The BMS recommends a **3–6-month initial trial** of testosterone to fully evaluate efficacy and tolerability; before deciding to continue, or to **discontinue after 6 months if lack of efficacy**[3]
- If/when testosterone is indicated, a shared decision with the patient should be made and informed consent gained to start off-label testosterone after discussion/counselling.

Ongoing treatment: Once patients are **stabilised** on treatment (dose/levels are stable/effectiveness reviewed following initial trial), the initiating specialist will **hand over** prescribing, management, and monitoring responsibility **to primary care**, under an individual management plan (e.g., a detailed clinic letter/assurance from the specialist to the primary care healthcare professional with clear instructions including dose, plan for review/monitoring/tests, discontinuation criteria etc.)

- **Primary care can take on prescribing** if patients' clinical circumstances meet the criteria, the specialist is following prescribing/monitoring responsibilities, and the testosterone preparation is on formulary; otherwise, specialists should retain prescribing
- Treatment duration should be individualised with **regular ongoing review (annually)** to ensure ongoing effectiveness and continued need/appropriateness; considering pros/cons i.e., risks/benefits[3]; unless clinical indications suggest earlier review (e.g., treatment ineffectiveness, side effects/adverse events).

Monitoring: The BMS recommends **total testosterone levels are checked before starting treatment** to establish a baseline for future monitoring, and ensure levels are not in the upper range before starting (although not mandatory)[3]. It is recommended blood tests for total testosterone are then performed at **3- and 6-months post-initiating treatment**, then **annually once treatment is stable**. Blood tests should be performed sooner if patients have symptoms/androgenic adverse effects. Blood test monitoring should be undertaken by the clinician responsible for prescribing at that time. The **initiating specialist will therefore carry out baseline and initial monitoring until the patient is stable**, then **primary care can continue annual monitoring of total testosterone levels once treatment is stable.** Specialist input/advice can be sought if needed

- Please note that the only tests required are total testosterone levels. Although tests can demonstrate if there has been an increase in levels, clinical response is of paramount importance[3]. The response (efficacy/adverse effects) is highly variable, likely due to varying absorption, metabolism, and sensitivity to testosterone[4]
- Adverse effects often occur due to confusion about appropriate preparations and doses in women or people AFAB, due to lack of specific preparations/information sheets[3]. Treatment should only be with formulations that achieve blood concentrations which approximate what is normal for premenopausal patients; so male preparations can be used cautiously in small doses with levels monitored regularly[4]. Replacement of testosterone in female physiological doses is unlikely to cause adverse side effects[1]
- If there are concerns or changes, e.g., troublesome adverse effects, patient investigated for/diagnosed with cancer, patient pregnant/breastfeeding, acute liver disease; the patient should be re-referred to the specialist (see Referral). The BMS tool for clinicians, Testosterone replacement in menopause, has further information about testosterone e.g., when to prescribe, appropriate starting doses, how to use it, how long to prescribe for, monitoring, benefits, adverse effects/risks, cautions and contraindications

Testosterone prescribing: Use **topical testosterone gel** (oral/other formulations are **not** recommended). Preparations licensed for use in men but have been agreed for off-label use in Kent and Medway (in a modified regime) can be found in Table 2 under Formulary Treatment Options, which also contains some information on differences between products/switching between them. Other testosterone preparations which are **not** licensed in the UK (for any indication) should not be prescribed on NHS prescriptions, but may be suitable for private use only as per the BMS e.g., Androfeme cream and testosterone implants. Please note testosterone gel products are **Schedule 4 (part 2) controlled drugs (anabolic steroids)**. Patients should be informed that testosterone product patient information leaflets (PILs)/instructions only relate to male use and should be **counselled on use/administration instructions by the initiating specialist**. The BMS has published a **factsheet which can be given to patients**, found on the Women's Health Concern (WHC website). Please see MHRA Drug Safety Update, about risk of harm to children following accidental exposure to topical testosterone, for information/counselling to be provided.

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Choice of HRT

- The choice of HRT for an individual patient depends on a balance of indication, risk/side effects, efficacy, patient choice/adherence/convenience[9]
- **The most cost-effective option should be used where possible,** unless stated otherwise. Only prescribe licensed products where possible (except testosterone off-label as per the Kent and Medway position statement and recommendations)
- For symptom control, start with low dose preparations of oestrogen (especially in patients >60 years of age who may also be maintained on lower doses) and for treatment of POI or premature menopause, generally medium or higher doses are required[3]
- A woman or a person assigned female at birth **with a uterus** normally requires oestrogen with cyclical progestogen for the last 12 to 14 days of the monthly cycle, continuous progestogen, or a combined preparation of both an oestrogen and a progestogen[9]. Oral oestrogens in patients with a uterus may be inappropriate if prescribed without concurrent progestogen[3]
- An oestrogen alone is suitable for continuous use in patients **without a uterus**[9]
- Low-dose vaginal oestrogen should be offered first-line for **urogenital symptoms**[5]
- Continuous combined HRT or tibolone are not suitable for use in the perimenopause or within 12 months of the last menstrual period as patients may bleed irregularly in the early stages of treatment – if bleeding continues endometrial abnormality should be ruled out and consideration given to changing to cyclical HRT
- Micronised progesterone is preferred for people with a high risk of breast cancer, venous thromboembolism (VTE) or cardiovascular disease or in those who cannot tolerate synthetic progesterone[4]
- **Routes of administration:** Systemic HRT is available as oral or transdermal preparations
    - **Transdermal HRT (which avoids first pass metabolism) is generally preferred** compared to oral preparations, but choice depends on patient preference/clinician discussion. Transdermal preparations may be particularly indicated if the patient prefers, or has persistent symptoms or troublesome adverse effects with oral treatment, history/increased risk of VTE, cardiovascular risk factors, history of migraine or gallbladder disease, lactose sensitivity, BMI >30kg/m^2, concomitant hepatic enzyme-inducing drug treatment, or a gastrointestinal disorder that may affect absorption of oral treatment[3,5]
    - If the patient is using combined HRT, the progestogen component may be given in a variety of ways depending on how the oestrogen is being taken e.g., combined with oestrogen in a single tablet or patch, or separately as an oral tablet or the levonorgestrel-releasing IUS (e.g. Mirena®) if the oestrogen is being applied transdermally/taken orally separately
    - See Formulary Treatment Options for HRT preparations available on formulary
- **Regimen:** HRT regimen depends on whether the patent is peri- or postmenopausal, the route of administration and patient wishes[5]. Combined HRT, oestrogen-only, progestogens, non-oestrogens (e.g. tibolone), and vaginal oestrogen therapy regimens depend on the preparation used – refer to product SPCs or the BNF for doses
- **Combined HRT:** Choices include continuous combined regimens (oestrogen and progestogen are taken daily), three-monthly cyclical regimens (oestrogen is taken daily and progestogen is given for 14 days every 13 weeks), or monthly cyclical regimens (oestrogen is taken daily and progestogen is given at the end of the cycle for 10–14 days, depending on the type of progestogen)[5]. Formulary Treatment Options has information on "bleeds" with different HRT preparations
    - A 3-monthly regimen may be more suitable for patients intolerant of progestogens or with infrequent periods, while continuous combined regimens are not suitable in the perimenopause or <1 year since the last menstrual period[5]
    - For perimenopausal patients, monthly or 3-monthly cyclical regimens may be used (monthly produces monthly bleeding, 3-monthly produces a bleed every 3 months/quarterly)[5]. If HRT initiated during perimenopause, consider switching from monthly or 3-monthly cyclical regimens to continuous regimens when the patient becomes menopausal[5]
    - For postmenopausal patients, monthly or 3-monthly cyclical regimens, or a continuous combined regimen be used. Continuous combined regimens may be preferred as no bleeding, although irregular bleeding or spotting may occur during first 4-6 months of treatment[5].

Please see NICE CKS[5] sections on Prescribing information for detailed information on choosing a route of administration, choice of hormone, and recommended regimes.

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Formulary Treatment Options

- Table 2 below lists the agreed HRT products which are "On Formulary" for use in Kent and Medway (unless otherwise stated e.g., "Non-Formulary" or "Specialist Initiation")
- As outlined in Choice of HRT above, for systemic HRT (not local (vaginal) HRT (see Table 1), transdermal HRT is generally preferred compared to oral preparations, but choice depends on patient preference/clinician discussion
- The most cost-effective option should be used where possible, unless stated otherwise
- Formulary status keys/colour coding varies across Kent and Medway, so please see the Kent and Medway formulary websites for this in each area; as well as product pack sizes and prices, and links to the BNF drug monographs and SPCs for each product (East Kent Prescribing Formulary, EKHUFT Formulary, West Kent Interface Adult Formulary, Medway and Swale Joint Formulary)
- Products should be prescribed according to manufacturers' recommended dosage (except off-label testosterone, or if clinically indicated/appropriate under the direction of a specialist). Please refer to individual product SPCs or the BNF for doses
- A formulary application form must be used to document all requests for new products to be considered for inclusion in the Kent and Medway Joint Formulary. This will need to go via the Medicines Optimisation team for approval through the agreed governance pathway. Any requests for new medicines must be completed by a healthcare professional employed by one of the local healthcare organisations
- As part of the campaign for a greener NHS, sustainability and the NHS Net Zero commitment, relevant updates on choice/prescribing of products in support of this e.g., to reduce plastic waste (such as using Vagirux vaginal tablets first-line over Vagifem) will be updated on formulary websites alongside HRT products, or through ScriptSwitch messages to Primary care healthcare professionals.

Table 2 *Kent and Medway HRT Formulary*

Type of HRT	Drug Name(s)	Route/ Delivery	Product Strength/Form	Brand Name
Oestrogen only	Estradiol	Transdermal gel	0.06% gel (0.75mg per actuation)	Oestrogel Pump-Pack
			500microgram gel sachets	Sandrena
			1mg gel sachets	Sandrena
		Oral	1mg tablets	Elleste Solo 1mg
				Progynova 1mg
				Zumenon 1mg
			2mg tablets	Bedol
				Elleste Solo 2mg
				Progynova 2mg
				Zumenon 2mg
		Transdermal patches	25microgram/24hour patches	Estraderm MX 25
				Estradot 25 (Smallest patches)
				Evorel 25
			37.5micrograms/24hour patches	Estradot 37.5 (Smallest patches)
			50microgram/24hour patches	Estraderm MX 50
				Estradot 50 (Smallest patches)
				Evorel 50

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				FemSeven 50
				Progynova TS 50
			75microgram/24hour patches	Estraderm MX 75
				Estradot 75 (Smallest patches)
				Evorel 75
				FemSeven 75
			100microgram/24hour patches	Estraderm MX 100
				Estradot 100 (Smallest patches)
				Evorel 100
				FemSeven 100
				Progynova TS 100
		Transdermal spray	1.53mg/dose spray	Lenzetto
		Local (vaginal) (Creams and pessaries may affect condom integrity)	10microgram vaginal tablets (pessaries)	Vagifem **(2nd line)**
				Vagirux **(1st line)** (Reusable applicator; use up to 24 times)
				Gina **(OTC)**
			7.5micrograms/24hours vaginal delivery system (2mg vaginal ring)	Estring (Worn continuously, replaced every 3 months. Max. duration continuous treatment 2 years)
	Estriol	Local (vaginal) (Creams and pessaries may affect condom integrity)	0.03mg pessaries	Imvaggis **(non-formulary)**
			50micrograms/g vaginal gel with applicator	Blissel **(non-formulary)**
			0.01% cream*	Generic **(2nd line)**
			0.1% cream*	Ovestin 1mg/g **(1st line)** (Preferred cost-effective estriol cream/vaginal oestrogen)
			*Ovestin 0.1% cream delivers the same dose of estriol (0.5mg) per applicator as the generic 0.01% cream (formerly Ortho-Gynest) and is the preferred cost-effective option for estriol vaginal cream.	
	Conjugated oestrogens (Equine oestrogen from pregnant horse urine; may not be acceptable to all)	Oral	0.3mg tablets (low dose)	Premarin
			0.625mg tablets	Premarin
			1.25mg tablets	Premarin
Non-Oestrogens (No bleed)	Tibolone	Oral	2.5mg tablets	Generic
				Livial **(non-formulary)**
	Prasterone	Local (vaginal)	6.5mg pessaries	Intrarosa **(non-formulary)**
	Ospemifene	Oral	60mg tablets	Senshio **(non-formulary)**
Progestogens (Mirena licensed to remove/replace after 4 years; but can be 5 years (off-label) as per FSRH/BMS for this indication)	Micronised progesterone	Oral	100mg capsules	Utrogestan
	Levonorgestrel (IUS)	Intra-uterine system	20micrograms/24hour IUS	Mirena
	Medroxyprogesterone acetate	Oral	2.5mg tablets	Provera
			5mg tablets	Provera
				Climanor
			10mg tablets	Provera
Sequential combined HRT	Estradiol and estradiol/norethisterone acetate	Oral	1mg and 1mg/1mg tablets	Elleste Duet 1mg (Monthly bleed)
				Novofem

(2 prescription charges) (Bleed specified for each brand)				(Monthly bleed)
			2mg and 2mg/1mg tablets	Elleste Duet 2mg (Monthly bleed)
				Clinorette (Monthly bleed)
	Estradiol and estradiol/dydrogesterone	Oral	1mg and 1mg/10mg tablets	Femoston 1mg/10mg (Monthly bleed)
			2mg and 2mg/10mg tablets	Femoston 2mg/10mg (Monthly bleed)
	Estradiol valerate and estradiol valerate/medroxyprogesterone acetate	Oral	2mg and 2mg/20mg tablets	Tridestra (Quarterly bleed)
	Estradiol and estradiol/norethisterone acetate and estradiol	Oral	2mg / 2mg/1mg /1mg tablets	Trisequens (Monthly bleed)
	Estradiol hemihydrate and estradiol/norethisterone acetate	Transdermal patches	50micrograms/24hours and 50micrograms/170micrograms /24hours patches	Evorel Sequi (combination of Evorel 50 & Evorel Conti) (Monthly bleed)
	Estradiol and estradiol/levonorgestrel	Transdermal patches	50micrograms /24hours and 50micrograms/10micrograms /24hours patches	FemSeven Sequi Phase 2 (Monthly bleed)
Continuous combined HRT (No bleed)	Estradiol/norethisterone acetate	Oral	2mg/1mg tablets	Elleste Duet Conti
				Kliofem
			1mg/500microgram tablets	Kliovance
		Transdermal patches	50micrograms/170micrograms /24hours patches	Evorel Conti
	Estradiol/levonorgestrel	Transdermal patches	50micrograms/7micrograms /24hours patches	FemSeven Conti
	Estradiol hemihydrate/dydrogesterone	Oral	500microgram/2.5mg tablets	Femoston Conti 0.5mg/2.5mg
			1mg/5mg tablets	Femoston Conti 1mg/5mg
	Estradiol valerate/medroxyprogesterone acetate	Oral	1mg/2.5mg tablets	Indivina 1mg/2.5mg
			1mg/5mg tablets	Indivina 1mg/5mg
			2mg/5mg tablets	Indivina 2mg/5mg
	Estradiol hemihydrate/progesterone	Oral	1mg/100mg capsules	Bijuve (bioidentical) **(non-formulary)**
	Conjugated oestrogens /medroxyprogesterone acetate	Oral	0.3mg/1.5mg modified release tablets	Premique Low Dose (Contains equine oestrogen from pregnant horse urine; may not be acceptable to all)
Testosterone (off-label) (Other preparations **not** licensed in the UK (for any indication) should not be prescribed on the NHS, but may be suitable for private use only e.g., Androfeme cream and testosterone implants, as per the BMS).	Testosterone **(Specialist Initiation)** (Can be considered by Consultant Obstetricians & Gynaecologists in menopausal patients with low sexual desire/altered sexual function if HRT alone not effective)	Transdermal Gel (See MHRA Drug Safety Update, about risk of harm to children following accidental exposure to topical testosterone, for information and counselling to be provided to patients by healthcare professionals when prescribing)	20mg/1g gel pump (Each 60g canister should last 240 days)	Tostran
			40.5mg/2.5g gel sachets* (Each 2.5g sachet should last 8 days)	Testogel
			50mg/5g gel sachets **(being discontinued)** **	
			16.2mg/1g gel*	
			50mg/5g gel (Each 5g tube should last 10 days)	Testim
			20mg/1g transdermal gel	Testavan **(non-formulary)**
	*Testogel 40.5mg/2.5g transdermal gel in sachets contain the same gel as the Testogel 16.2mg/1g gel pump, so patients can switch between the two as they are interchangeable (1 sachet = 2x 16.2mg/g gel pump actuations. **Testogel 50mg/5g transdermal gel in sachet) is being discontinued and is being replaced by the more concentrated Testogel 40.5mg/2.5g transdermal gel in sachet. Note that the volume of gel and the application sites are different for each of the gels. Less volume of the Testogel 40.5mg/2.5g transdermal gel in sachet is needed than the Testogel 50mg/5g transdermal gel in sachet so more convenient to apply the recommended dose. Patients should be counselled on the differences. Please refer to the Testogel 40.5mg/2.5g SPC for more information.			

Complementary Therapy

- The evidence for using, and the safety of, herbal medicines is unclear; **they are not available on the NHS in Kent & Medway and should not be prescribed on an FP10 prescription**
- Patients who wish to try complementary therapies should be advised that the purity, quality, and constituents of products may not be known as they are often not regulated by the MHRA (look for Traditional Herbal Registration logo on products to see if they are)[2]
- There is some evidence that black cohosh or isoflavones may relieve vasomotor symptoms, but multiple preparations are available, safety is uncertain, different preparations may vary and interactions with other medicines have been reported[2]
- For patients with history/at high risk of breast cancer, there is some evidence that St John's Wort may be beneficial in relieving vasomotor symptoms, but there is uncertainty about dose, persistence of effect, there is variation in nature and potency of preparations, and there are potential serious interactions with other drugs; patients must speak to a doctor/pharmacist before taking[2]. Isoflavane, black cohosh, vitamin E, red clover, or magnetic devices should not be used by patients with breast cancer[4]
- Cognitive Behavioural Therapy (CBT) is an option for improving menopausal symptoms in patients who do not wish to or are unable to take HRT[1]
- Patients can be directed to www.menopausematters.co.uk/remedies.php for more information on alternative therapy. The RCOG's patient-facing site has a leaflet on complementary therapies for menopausal symptoms written by WHC, which patients may find useful
- Healthcare professionals are reminded to be vigilant for suspected adverse reactions/interactions with other medicines associated with herbal and homeopathic medicines and report them to the MHRA's Yellow Card scheme.

Side Effects & Bleeding Patterns

- Patients should be encouraged to persist with treatment for 3 months before review/changing as side effects may resolve
- Full side effect profiles of HRT products can be found in the individual product SPCs, or in the BNF
- Unscheduled vaginal bleeding is a common side effect in patients with a uterus within the first 3 months of treatment; clinical management is dependent on type of HRT but should be reported if occurs after 3 months[2]. Patients experiencing ongoing unscheduled bleeding more than 4-6 months after HRT, despite adjusting progestogen intake, should be referred to a specialist[3]. See recommendations on endometrial cancer in the NICE guideline Suspected cancer: recognition and referral
- Please see the NICE CKS section on Adverse Effects (including vaginal bleeding problems) for more information on adverse effects/how to manage them. The BMS Tool, HRT – Practical Prescribing, lists common HRT side effects.

Surgery

- As per the UKCPA Handbook of Perioperative Medicines, HRT can be continued prior to minor surgery if risk of prolonged immobilisation is low. Major surgery under general anaesthesia is a predisposing factor for VTE so it may be prudent to stop HRT 4-6 weeks before surgery; except transdermal HRT can be continued[9]
- If HRT is continued/discontinuation is not possible prior to admission (e.g., non-elective surgery), adequate thromboprophylaxis with unfractionated/low molecular weight heparin/graduated compression hosiery is advised[9]
- If stopped pre-operatively, HRT can be restarted after full mobilisation
- Patients likely to go through menopause resulting from medical or surgical treatment should be offered support/information about menopause and fertility before having treatment and referred to a healthcare professional with expertise in menopause[2]. Please see the BMS toolkit on surgical menopause.

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Contraception

- Information about contraception should be provided to patients who are peri- and postmenopausal, including that contraception does not affect onset or duration of symptoms, but may mask them[10]. Patients should be advised that they are potentially fertile for 2 years after last menstrual period if <50 years of age and for 1 year if >50 years of age, so contraception should be used during this time; and that in general patients can stop contraception at the age of 55 years (even in patients still experiencing menstrual bleeding)[4,5]
- HRT is not a contraceptive (only Mirena® is licensed as both HRT and hormonal contraception). Patients should be advised that combined HRT does not provide contraception/not to rely on it, so if they are still menopausal or menopausal status is uncertain then effective contraception should be maintained in conjunction with combined HRT (if they are still sexually active)[10]. Progestogen-only pills, depot injectables (consider changing to lower dose option), and implants as contraception are safe to use alongside combined HRT[4,10]. All progestogen-only methods of contraception (no vaginal bleeding) are safe to use alongside cyclical HRT[5]
- The Mirena® IUS can be used as progestogenic HRT alongside oestrogen and contraception, and as per the manufacturer's licensing should be removed (and replaced if needed) after 4 years but can be every 5 years (off-label) as per the FSRH/BMS for this indication (see Progestogens)[9]. There are no studies on the newer lower dose (19.5mg and 13.5mg) levonorgestrel IUS's (Kyleena® and Jaydess® respectively) as HRT, so these cannot be recommended currently[4]. Intrauterine contraception should not be left in situ indefinitely after it is no longer required as it could become focus of infection[4]
- Combined hormonal contraception should not be used in combination with HRT but can be used in eligible patients <50 years of age as an alternative to HRT for menopausal symptoms and prevention of bone mineral density loss[5,10]. If needed, patients should be advised to switch to a progestogen-only method of contraception at 50 years of age[5]. Patients with POI may be offered sex steroid replacement with a choice of HRT or a combined hormonal contraceptive (CHC) which has the added benefit of providing contraceptive cover
- Health care professionals should discuss sexually transmitted infections (STIs) and sexual health with patients <40 years of age and advise about condom use and protection from STIs even after contraception is no longer required[10]. Please see FSRH Guideline Contraception for Women Aged over 40 Years and the NICE CKS topics Contraception – assessment, Contraception – combined hormonal methods, and Contraception – progestogen-only methods for more information.

Referral

Most menopausal patients can be managed in primary care. The NICE CKS guides when a referral to a healthcare professional with expertise in menopause should be arranged. Patients with complex menopause healthcare problems should be referred to specialists/healthcare professionals with expertise in menopause, e.g.:

- If treatments do not improve menopausal symptoms or there are ongoing troublesome adverse effects[5]
- If there are menopausal symptoms and contraindications to HRT[5]
- If there is uncertainty about the most suitable treatment options for their symptoms (e.g.co-morbidities/complex medical history contraindications)[2,3]
- If there is uncertainty about diagnosis/management of POI[5] (it is likely that most patients <40 years age will need referral)
- Patients with history of/at high risk of breast cancer, or history of hormone dependent cancer[3]
- If treatments are ineffective for persistent altered sexual function. Seek specialist advice regarding the use of testosterone supplementation (off-label use)[5] – see the Testosterone section of this guideline. Consider for psychosocial counselling, depending on patient wishes[5]
- If there is increase in heaviness/duration of bleeding or irregular bleeding with sequential HRT, or bleeding beyond 6 months of therapy, or if bleeding occurs after spell of amenorrhoea with continuous combined HRT[3]
- If there is a sudden change in menstrual pattern or bleeding (intermenstrual, postcoital, postmenopausal) then assess and arrange urgent 2-week referral if gynaecological cancer is suspected[5]. If gynaecological cancer is not suspected, and a patient who is on HRT has a change in bleeding pattern then a general urgent referral is reasonable. Please see the NICE CKS on Gynaecological cancers – recognition and referral for more information
- If there is uncertainty about the appropriateness or safety of prescribing HRT, the patient's specialist should be liaised with, or advice sought from a healthcare professional with expertise in menopause[5].

Review & Treatment Duration

- There should be no arbitrary limits to duration of treatment, nor is there a definitive age cut off for HRT, as it should be individualised, and risk assessed for each patient. The BMS advises HRT should be used for as long as it is felt benefits (symptom control and improvement in quality of life) outweigh any risks
- For vasomotor symptoms, most patients require 2-5 years of treatment, but some may need longer[5]. Patients with POI and early menopause should be encouraged to use HRT until the average age of menopause (51 years in the UK), after which treatment should be reassessed[3,5]. Persistent symptoms or the need for bone protection may be indicators for ongoing treatment
- Benefits and risks should be reassessed on an annual basis as HRT should be used at the lowest effective dose for the shortest duration possible. Risks can rise with long-term use (e.g., breast cancer). Please see the links to MHRA risk/benefit tables to inform discussion in Risks & Benefits
- Regular review should be arranged to assess specific goals, efficacy, and tolerability (e.g., side effects, bleeding pattern), adjust dose/preparation if needed, assess ongoing risk/benefit balance, duration and to advise on Stopping HRT[5]
- Treatment should be adapted as needed based on changing symptoms[2]. The oestrogen replacement dose may need to be adjusted until the optimal dose is achieved, as there may be varied absorption between different individuals[1]
- For short-term menopausal symptoms, if commenced on HRT or HRT is changed, review treatment at three months, then at least annually thereafter once established unless there are clinical indications for earlier review (e.g., side effects, adverse events, treatment ineffectiveness)[1]
- If HRT was started in the perimenopause, discuss changing the treatment regimen and/or reducing the oestrogen dose[5]
- If progestogenic side effects occur, changing the progestogen component may be required[3]
- Oestrogen doses may need to be lowered as patients get older (lower doses generally sufficient for symptom control). The use of oestrogens in elderly patients is potentially inappropriate if prescribed in history of breast cancer or VTE[9]. For further information please see STOPP/START criteria in Prescribing in the elderly

The NICE CKS has more information on what to discuss/assess at reviews, and options for adjusting the HRT dose/preparation if appropriate.

Stopping HRT

- Patients should be offered a choice of gradually reducing (over 3-6 months) or immediately stopping treatment[2,5]. Gradually reducing HRT may limit recurrence of symptoms in the short term, but gradually reducing/suddenly stopping makes no difference to symptoms longer term[2]
- Patients should be supported to make individual decisions on when/how to stop HRT[5]. The BNF outlines reasons to stop HRT
- If troublesome symptoms recur, options include restarting low-dose HRT or considering alternative non-hormonal treatments[5]. Advise patients to address trigger factors for flushes before dose reduction (suggest visiting Menopause Matters)
- Vaginal oestrogen may be required long-term, but regular attempts (e.g., annually) to stop treatment can be made[5]; it may be needed when discontinuing systemic HRT in patients with history of urogenital problems/when still sexually active.

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Practical Prescribing[6]

- **Medicines Shortages:** HRT availability varies currently. Please check the SPS supply availability page for up-to-date availability/current stocks of HRT products (supply content is maintained regularly by DHSC). The BMS has updates on HRT supply and guidance on HRT preparations and equivalent alternatives which may be useful when switching preparations or switching to manage out of stock situations. NHS England encourages prescribers to liaise with local pharmacies to identify available stocks and agree suitable alternatives where necessary
- **Generic & Branded Prescribing:** Combination products should be prescribed by brand name. Brand name prescribing can be useful when products contain more than one ingredient, to aid identification, and to differentiate between similar products where patient familiarity with a brand is important. Some single ingredient tablets e.g., conjugated oestrogens & tibolone can be prescribed generically but where instructions may be product specific and patient familiarity is considered important e.g., oestradiol transdermal patches, then brand prescribing is appropriate[12]
- **Prescription Charges:** Currently, in England, sequential combined HRT preparations incur two prescription charges. Please see the PSNC Dispensing Factsheet: Multi-charge Items for more information. The NHS prescription charge per item in England is reviewed annually in April. Oestrogen only and continuous combined HRT products incur one prescription charge per product
    - From 1st April 2023, in England, the DHSC has confirmed that patients (who usually pay for their HRT prescriptions) will be able to purchase an annual HRT prescription prepayment certificate (PPC) equivalent to two single prescription charges. This is for all HRT prescriptions which are licensed for the treatment of menopause (therefore not off-label testosterone), for 12 months through a HRT PPC; meaning patients can access HRT with more frequency if needed, easing pressure on supply while keeping cost of HRT low[7]. Please note that patients with HRT PPCs will continue to pay for other prescribed medicines outside the PPC's scope. PPCs can be purchased through the NHS Business Services Authority, whose website has more information on PPCs, or in person at pharmacies registered to sell them (list found on NHS BSA website). The DHSC press release can be found here
- **Duration of Prescriptions:** Durations of HRT prescriptions supplied may be affected by current HRT supply chain issues. A number of serious shortage protocols (SSPs) have been issued to provide flexibility for pharmacists to substitute for appropriate products and restricting prescriptions to a maximum of 3 months' supply, to manage ongoing supply disruption/ensure supplies of HRT are maintained[8]. Clinical advice for these SSPs was taken from national experts including clinicians from the BMS and the Royal College of Obstetricians and Gynaecologists (RCOG). To keep up-to-date, please see the NHSBSA website for active SSPs. The Kent and Medway guidance for repeat prescribing durations states that 84 day prescriptions must be reserved only for those medications with that specific pack size e.g. some HRT products, and as such it is not recommended to exceed these quantities
- **Private Prescriptions[6]:** Some patients may choose to access menopausal services outside the NHS. The responsibility for prescribing lies with the healthcare professional who has clinical responsibility for that part of the patient's care. Further/ongoing treatment of HRT, recommended by a private specialist, can be prescribed by a primary care healthcare professional in Kent and Medway on an FP10 if: the product is allowed/funded on an NHS prescription (not blacklisted), the product is on formulary, and it is first-line/as per guidance or is being used if they have previously been tried on/considered for first-line; and the primary care healthcare professional agrees with the choice of treatment/considers it necessary. When the private specialist retains clinical responsibility e.g., when they continue to administer treatment or the treatment is recognised to be specialist in nature (e.g., unlicensed), then they should issue the prescriptions. NHS Kent and Medway has two leaflets "Information on prescriptions issued after a private consultation", which can be found here on the East Kent Prescribing Formulary.

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Patient Information & Resources

Patient Information: Patients should be aware that help and support is available and should consult their GP/specialist for advice on how they can optimise their menopause condition and the options they have on managing their symptoms[3]. Information and advice should be given to patients as per NICE NG23, (including explanation of the stages of menopause, common symptoms, diagnosis, long-term health implications, treatment options and risks/benefits) in different ways to help encourage them to discuss their symptoms and needs[2,4]. Modifiable lifestyle measures for menopause symptom relief, as well as general health, should be addressed that may improve symptoms and quality of life respectively[3,5]. The NICE CKS has more information.

Patient Resources: Please see below some of the resources, information, and support organisations available for signposting patients to[5]:

https://www.nhs.uk/conditions/menopause/ - the NHS leaflet on menopause

https://www.womens-health-concern.org/ - the patient arm of the BMS, with a range of factsheets (including one on benefits and risks of HRT) and an email advice service

https://www.menopausematters.co.uk/ - provides information on the menopause, menopausal symptoms, and treatment options

https://rockmymenopause.com/ - has a variety of factsheets and podcasts

www.rcog.org.uk - the RCOG has various patient leaflets in Menopause and women's health in later life, and Information on treatment for symptoms of the menopause

www.daisynetwork.org - a nationwide support group for patients diagnosed with POI or premature menopause

www.managemymenopause.co.uk

https://pcwhf.co.uk/resources

www.healthtalk.org - for interviews discussing menopause issues

www.nice.org.uk/guidance/ng23/ifp/chapter/menopause - NICE information for the public on menopause

Menopause and work: why it's so important (menopauseintheworkplace.co.uk)

NHS Employers: Menopause and the workplace

The menopause at work: printable resources - the CIPD provides printable resources to help break the stigma around the menopause in workplaces

Women's Health Concern (WHC website) - the BMS has published a factsheet on **testosterone** for women which can be given to patients

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