HRT continuation / discharge plans for GPS

- This chart must be read in context with the last clinic letter.
- Prescriptions should be continued on a repeat basis.
- Prescription changes can be made by the GP, using comparative doses or brands, if required.
- To achieve symptom relief, Oestradiol doses may be increased up to the maximum licensed dose.
- Outside of this chart. off-license doses may be prescribed from clinic where it is clinically indicated: to achieve optimum serum Oestradiol and symptom relief.

	Serum Oestradiol	Mid-follicular range: 200-600pmol	Routine testing not required	Most women will be symptom free within this range	Testing indicated in treatment resistant women	Increase dose or change product / route if symptomatic
Opt	**Oestrogens (Bioidentical)**	**Low dose**	**Intermediate dose**	**Standard dose**	**Intermediate dose**	**High dose**
1	**Oestradiol PO**	0.5mg daily		1.0mg daily		2.0mg daily
2	**Sandrena Gel**	0.5mg daily		1.0mg daily	1.5mg daily	2.0mg daily (off-license)
3	**Oestrogel 0.06%**	X1 measure daily		X2 measures daily	X3 measures daily	X4 measures daily
4	**Patches (most tolerated: Estradot)**	25mcg biweekly	37.5mcg biweekly (Estradot or ½ Evorel 75mcg)	50mcg biweekly	75mcg biweekly	100mcg biweekly
Opt	**Progesterone or Progestogen**	**Continuous HRT (non-bleed)**		**¥Cyclical HRT (with bleed) 12 days per cycle**		
5	**Utrogestan capsule PO (Bioidentical)**	100mg capsule nocte daily		2x100mg capsule nocte		
6	**Utrogestan PV (Bioidentical, off label)**	100mg oral capsule nocte used PV daily (No applicator)		200mg pessary nocte (With applicator)		
7	**Lutigest 100mg PV (Bioidentical, off label)**	100mg capsule with applicator nocte daily				
8	**Norethisterone (synthetic)**	5mg daily		10mg daily		
9	**Provera-MPA (synthetic)**	5mg daily		10mg daily		
Opt	**Testosterone (off license)**					
10	**Tostran Gel 2%** Use with care	X1 measure per 2-3x per WEEK Titrated to efficacy and side effects				

Considerations to be read in context of the NICE 2015 guidelines: 'Diagnosis and Management of the Menopause'. The Chelsea and Westminster Guidelines are available on the Trust website.

For post-menopausal women over the age of 50

1. A yearly over 50's NHS health review is indicated only. Risks and benefits should be assessed on an individual basis. If benefit outweighs risk and the woman wishes to continue HRT, then there is no reason HRT cannot be used indefinitely. There is no mandatory age limit or time-frame of use with HRT.

2. Oestrogen only HRT for women following hysterectomy does not increase breast cancer risk.

3. Synthetic progestogens used in continuous combined HRT are associated with breast cancer risk.
   Natural progesterone has a non-significant breast cancer risk (including Dydrogesterone in Femoston).

4. Oral Oestradiol increases VTE risk due to liver first pass effect on clotting factors.
   Transdermal Oestradiol has a low or non-significant VTE risk. There is an uncertain but likely similar risk when used over the age of 60. Risk factors should be taken into account.

For women under the age of 50

5. Because hormones are being replaced at the normal physiological level, appropriate for age, HRT risks are not considered significant. All HRT should be continued until at least the average of the menopause (51).

6. Frequency of BMD/DEXA is determined by result, but may be yearly where there is clinical concern.

Progestogens / Progesterone

7. Any unscheduled or post-menopausal bleeding should be referred directly to the local Gynae Rapid Access Clinic (GRAS), for urgent US and Hysteroscopy.

8. Progestogens should be used at their licenced dose and recommend regimen. However, women with severe progestogen intolerance may be prescribed a modified regimen and will require yearly endometrial ultrasound surveillance. A new referral may be required.

9. ¥Cyclical HRT (with bleed)

   - Peri-menopausal regimen with irregular cycles: 1st-12th each calendar month.
   - Peri-menopausal regimen with regular cycles: D17-28 of cycle.

Testosterone

10. To be supplied by the GP. When not permissible by the CCG, and clinically indicated, on-going prescribing will be provided via the clinic. A new referral may be required.
11. Yearly testosterone and SHBG is indicated due to off-label use of testosterone. Effectiveness is based upon self-reported symptoms.

GnRHa and BMD/DEXA

12. Cycle suppression with GnRHa for severe PMS/PMDD, is usually continued as a shared care agreement with the GP. Frequency of BMD/DEXA is determined by result, but usually yearly due to off-label use of GnRHa.