Hormone Therapy - When to start and when to stop?

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Introduction

The menopause will bring with it a number of health challenges that may significantly affect the quality of life of women. Not uncommonly, women feel overwhelmed and daunted by what they perceive, or are led to believe, will occur with the menopause. Yet, provided that women understand and their physicians individualise care, the menopause can be a time of positive change. ***(SA Fam Pract 2005;47(3): 42-44)***

At what age should HT be started?

The median age of the menopause is 51.3 years, although the range is between 46 and 54 years. The ovary ceases to function and, as a consequence, women become estrogen, progestogen and androgen deficient. It is the lack of estrogen that produces the symptomatology. The earliest and most overwhelming menopausal symptoms are hot flushes, insomnia, night sweats and mood swings. Irritability, anxiety, aggression, weepiness and depression are the most common psychological symptoms. Some years later symptoms pertaining to the genitor-urinary system commonly occur. These include vaginal irritation, burning, itchiness and pain with intercourse. The urinary symptoms include frequency, urgency, burning with micturition and waking up at night to pass urine. Involuntary loss of urine is a common symptom. Long term lack of estrogen is also associated with decreasing bone mineral density, osteoporosis and the risk of osteoporotic fractures.

Who should get HT? And when?

Approximately 85% of women will become symptomatic, of whom about 70% will require or seek medical attention for their symptoms. There is overwhelming evidence to support the fact that estrogen relieves menopausal symptoms more effectively than any other medication. In fact, currently, systemic estrogen is the only therapy that treats vasomotor and genitor-urinary symptoms, while also preserving bone. It therefore follows that women who will benefit most by taking hormone therapy, including low dose estrogen therapy, are those with vasomotor symptoms, vaginal atrophy and bone loss. Hormone therapy should be initiated once these symptoms become apparent. These symptoms may occur in a patient who is still having irregular or sporadic menstrual periods. Confirmation of a true menopausal status can be achieved by taking a blood sample and analysing the level of FSH. If the FSH exceeds 25 mu/l, the patient is menopausal and should be treated as such.

Which HT formulations are available?

Estrogens alone should be used only in patients who have had a hysterectomy. Any woman who still has a uterus in place must be given estrogen and progestogen, either in the form of sequential therapy (and will have a period), or continuously opposed (and have no periods). Hormone therapy can be given orally, transdermally (in the form of a patch which will stick on skin or a gel which is rubbed on the skin), as implants, or in the form of a topical vaginal cream or vaginal tablets. The progestogens can be given orally, as a patch, or inserted into the uterus in the form of an intrauterine device, namely the *Mirena*. Androgen therapy, with a view to improving libido, can be given as an implant or as a patch. If one elects to take the hormone therapy in the form of an oral supplementation, then it is advisable to commence the medication by taking it at night. This helps to minimise the effect of nausea and vomiting, should it arise.

How long does HT take to have an effect and which immediate side-effects can be expected?

The most common adverse events of

hormone therapy include nausea, vomiting, breast tenderness, some mild initial weight gain and painful periods. The concerns pertaining to blood clots, strokes and breast cancer when taking hormone therapy will be discussed in a later chapter. Most patients will feel some benefits between 3 and 5 days of commencement of therapy, but for a noticeable difference between 14 and 21 days of hormone therapy will be required. The pH of the postmeno-pausal vagina is alkaline and it takes approximately three weeks of hormone therapy for it to become acid i.e. the situation found in the pre-menopausal vagina. This acidity provides protection against common vaginal infections. Between 10 and 12 weeks of therapy is required before reasonably appropriate vaginal moisture is restored.

Who shouldn't get HT?

Women should be counselled about the benefits and the need to continue treatment to enable for them to make an informed decision about whether to reap or forego the other benefits of hormone therapy. Because the rationale between short and long term therapies differ, the counselling for each may occur separately, although ideally they should occur together. In any event, it is important to begin a discussion of long term benefits by the time a woman is taking hormone therapy for symptomatic relief. The contra-indications to hormone therapy include known or suspected pregnancy, any known or suspected estrogen dependant tumour, known or suspected breast cancer, any undiagnosed abnormal bleeding from the genital tract, acute thrombotic or thrombo-embolic disorders and active liver disease. It is important to bear in mind that the contra-indications to the oral contraceptive pill are not the same as the contra-indications to hormone therapy. Many women are concerned that hormone therapy may bring on the return of monthly bleeding. This, however, can be avoided by giving continuously opposed hormone therapy. Some women also erroneously assume that the return of their monthly periods will restore fertility. This is not the case. However, until a woman has had 6 months of amenorrhoea (i.e. has missed 6 menstrual periods), she is in the peri-menopausal phase and require contraceptive precautionary measures during this period or transition towards true menopause.

How to individualise a treatment plan – dose and duration

When deciding whether to prescribe hormone therapy, clinicians must individualise a woman's treatment plan according to specific risk factors. The most convenient and comfortable method of taking hormone therapy for each patient is recommended. The fact that there are so many different types of hormone therapy gives every woman a choice in deciding, not only on the type, but also on the mode of delivery. Dose, however, is very important. Decreasing the dose of estrogen used may provide a solution that minimises risks associated with hormone therapy, while still providing effective treatment for peri- and post menopausal symptoms. Once hormone therapy is commenced, it should be taken daily. It can be taken continuously for approximately 5 years, after which it is advisable to assess whether the hormone therapy should be continued. If no contra-indications and no significant complications arose during the 5 years of continuous use, and the patient feels she still requires the hormone therapy, It is reasonable to recommend that the therapy can continue until the age of 65 years. Approximately 15% of women will reach menopause without suffering any menopausal symptoms. There is no need for this small percentage of post-menopausal women to routinely taken hormone therapy other than if there are significant risk factors for the development of oestoporosis.

Treatment of every menopausal woman must also include life style modifications. This should include weight control, cessation of smoking, frequent exercise and control of any medical condition, of which blood pressure is probably the priority. An appropriate and adequate diet is equally as important.

How to stop and restart HT

The issue of how to discontinue hormone therapy is certainly not clear cut. Some doctors stop therapy abruptly, while others recommend tapering off the medication before stopping it completely. For patients on continuously combined therapy, reduction of the dosage to every other day for a month, then every third day for a month, then stopping entirely, may be recommended. Those who are taking sequential hormone therapy should only stop during the planned menstrual bleed i.e. during the placebo/sugar tablets phase. For women who want to recommence hormone therapy, the lowest effective dose must be used adhering to the abovementioned principles. Some patients who re-initiate therapy do well by taking less-than-every day doses to relieve their symptoms i.e. taking low dose hormone therapy on alternate days only. This regime, however, will not apply to sequential hormone therapy where it will have to be taken daily. A washout period is also helpful for women who begin raloxifene therapy for osteoporosis after stopping hormone therapy; without a washout period, it is impossible to determine whether hot flushes, if they do occur, are caused by estrogen withdrawal or by the initiation of raloxifene.