BESINS HEALTHCARE
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MARS
MENOPAUSE ACCESS, ASSESSMENT AND REVIEW SERVICE

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REFERRAL GUIDE

This document is intended for Pharmacists in Primary Care. However, it may also be used by other healthcare professionals (HCPs) in Primary Care, such as General Practitioners (GPs), Nurses, or any other relevant HCPs involved in initiating or developing a Menopause service.

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store.

Adverse events should also be reported to Besins Healthcare (UK) Ltd. Drug Safety on 0203 862 0920 or Email: drugsafety@besins-healthcare.com.

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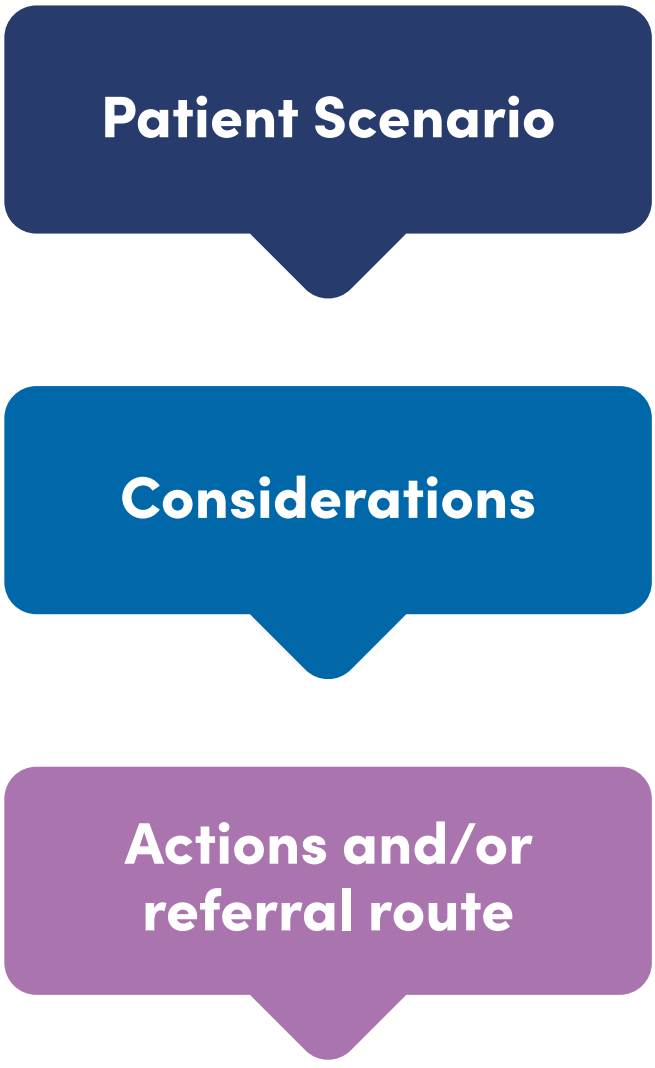
Introduction

- The Menopause Access, Assessment and Review Service (MAARS) referral guide has been developed by Besins Healthcare (UK) Ltd in collaboration with a healthcare professional with expertise in running dedicated menopause services in primary care. The aim is to offer guidance in menopause management situations with complex patients or patients with additional considerations
- The referral guide outlines a number of typical concerns and circumstances and provides both considerations and recommended actions
- A colour coded approach has been adopted for ease of use



- A quick reference checklist to assist preparation for referral to a specialist and a glossary is included at the end of this guide

Contents

Symptomatic of menopause and history of breast cancer or hormone driven cancer

HRT Status

On HRT

Not on HRT

Review HRT[1,2,3]

Do not routinely offer SSRIs/SNRIs first-line for vasomotor symptoms (NG23)[4]; if HRT is contraindicated or declined, consider SSRIs/SNRIs (avoid fluoxetine/paroxetine with tamoxifen)[1]; consider clonidine[1]

Refer for specialist advice to oncologist and/or gynaecologist[1,3]
CBT may be an option to explore[1,4,5]

All HRT is contraindicated in: Known, past or suspected breast cancer and known or suspected oestrogen-dependent malignant tumours (e.g. endometrial cancer).

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Early menopause/premature ovarian insufficiency (POI) (under 40 years old)[3,4]

Check TFT, prolactin, antibody testing & FSH x2 (4-6 weeks apart) to diagnose[4]

Stop COCP or high dose progesterone contraception before FSH[4]

Establish risk to bone health[4]

Discuss importance of replacing hormones for long term bone, heart and brain health

Consider COCP or HRT (risk factors to be considered)[4]

Refer to specialist with expertise in menopause and reproductive medicine particularly in very young premature ovarian insufficiency (POI) patients and/or complex cases[3,4]
Consider referring women with premature ovarian insufficiency (POI) to healthcare professionals who have the relevant experience to help them manage all aspects of physical and psychosocial health related to their condition[4]

Data on HRT is limited for patient with early menopause and POI

Medical or surgically induced menopause[4]

Ascertain HRT status and appropriateness

HRT is required and appropriate – prescribe in line with label

If symptomatic, review dose, discuss adherence and consider alternative HRT formulation

Refer to GP and/or menopause specialist doctors to discuss available licensed treatment options[4]

Bleeding in post-menopause[2,3,6,7,8]

Ascertain reason for bleeding

Is it post coital bleeding?

Vaginal/cervix exam and vaginal swabs[9]

Check smear history is up to date?

If pathology is suspected, refer to a gynaecologist via the suspected cancer pathway[10]

Provide a Cancer Antigen 125 (CA 125) blood test[6,7]

If pathology is not suspected, refer to gynaecologist as urgent[3]

Abnormal and irregular bleeding after starting HRT[2,3,8]

IRREGULAR BLEEDING – any variation outside of the normal menstrual cycle, flow, regularity and duration.[11] A cycle length ranging from 21 to 35 days is deemed as normal parameters.[12]

ABNORMAL BLEEDING (MENOPAUSE RELATED) – bleeding that persists 6 months after commencing continuous HRT[13] or bleeding 12 months post amenorrhea (without HRT)[14]

HRT use:

changed <3 months ago or initiated <6 months ago and taken as prescribed?[8]

Consider optimising HRT:

changing HRT route of administration/ regime[2,8]

Heavy or persistent bleeding?

HRT use:

changed >3 months ago or initiated >6 months ago and taken as prescribed?[8]

Bleeding ongoing or increasing?

Refer for TVS (within 6 weeks)[8]

Review endometrial cancer risk factors:

Major and minor risk factors[8]

Refer if 1 or more major risk factor for endometrial cancer

Refer if 3 or more minor risk factors for endometrial cancer[8]

Refer to urgent suspicious of cancer pathway for TVS[8]

Is contraception being taken as this may exacerbate the bleeding[8]

Consider if route/ regimen or progesterone dose needs amending[8]

Refer for ultrasound scan and/or hysteroscopy to check endometrial thickness[8]

Any **red flags** refer 2-week wait[10]

Symptomatic despite maximum HRT dose[3,4]

Check concordance with HRT

If patients taking transdermal HRT investigate potential absorption issue with gel/patch/spray

If oral: check compliance

If absorption issues suspected with transdermal HRT and no issues with adherence, compliance and use then consider alternative routes of administration such as oral HRT if appropriate.

Consider referral to menopause specialist or gynaecologist[3]

Previous myocardial infarction, cerebrovascular accident, pulmonary embolism, or hereditary thrombophilia, high cardiovascular/venous thromboembolism risk[3,4,15]

There is an increased risk of Venous thromboembolism (VTE) with oral HRT compared to transdermal HRT[4,16]

NICE recommends the use of transdermal rather than oral HRT for women at increased risk of VTE, including women with a BMI over 30[4]

HRT is associated with a 1.3 – 3 fold risk of developing VTE, i.e. deep vein thrombosis or pulmonary embolism. The occurrence of such an event is more likely in the first year of HRT than later[17]

Patients with risk factors for VTE should be closely supervised[17]

Alternative treatments and non-hormonal options should be discussed with women who are unable to take or do not wish to take HRT[3]

Consider a progesterone as an option for women with an intact uterus (if HRT is appropriate)

Refer women at high risk or previous VTE (for example strong family history or a hereditary thrombophilia), for robust risk assessment to either haematologist[3,4] or menopause specialist (if cardiac concerns)[18]

For high-risk patients already on HRT prior to MI, refer to specialist for risk assessment of continuation of current HRT, review of potential HRT options and consideration of cardiovascular risk

HRT is contraindicated in: Previous or current venous thromboembolism (e.g. deep venous thrombosis, pulmonary embolism);

- Active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction)

Genitourinary syndrome of menopause (GSM)[1,3,4]

Rule out urine infection, consider vaginal swabs/exam

Maximise systemic HRT and add in local vaginal oestrogen with lubricants and moisturisers[1,3,4]

Please note: Not all vaginal oestrogen preparation are licensed for use with systemic HRT. Please consult individual SmPCs.

If still symptomatic, consider referral to appropriate specialty (expert in menopause)[3,4]

Glossary

BMI - body mass index

COCP – combined oral contraceptive pill

CBT – cognitive behavioural therapy

CVA – cerebrovascular accident

GSM – genitourinary syndrome of menopause

HRT – hormone replacement therapy

POI – menopause occurring before the age of 40 years is known as premature ovarian insufficiency (it can occur naturally or as a result of medical or surgical treatment)

MI – myocardial infarction

SSRI – selective serotonin reuptake inhibitors

SNRIs – serotonin and norepinephrine reuptake inhibitors

TVS - transvaginal sonography

VTE – venous thromboembolism

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