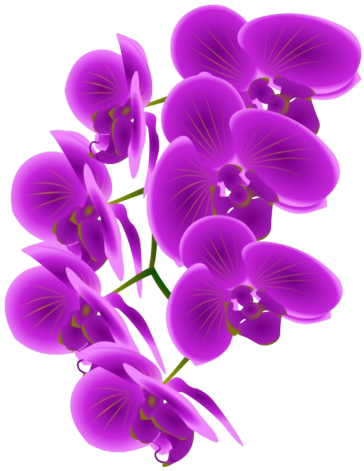


What type should you have? The HRT 101
(From the book Cracking the Menopause, while Keeping Yourself Together by MariellaFrostrup & Alice Smellie)

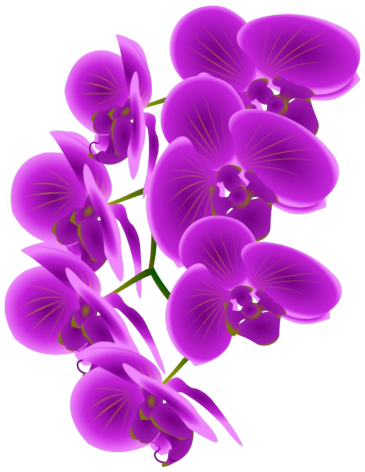
As every woman's menopause is different, so you are entitled to a personalized prescription. What suits one woman may be catastrophic for another. There are more than fifty variations available: patches, pills, gels and even implants. How on earth do you know which one you should take?

Dr Tonye Wokoma says: The best formulation is the one that is right for you, and depends on your medical background and family history. There is no one-size-fits-all. If you try one and it doesn't work, speak to your GP or menopause clinic.

If you still have a womb (i.e. you haven't had a hysterectomy), you need combined HRT, where you take oestrogen and a progestogen – either micronized progesterone or a synthetic progestogen. (This word is used as the generic term for this group of hormones, with progesterone being the main one in the human body.) This is needed to keep the lining of the womb thin and healthy. Without progestogen there is a small increased risk of womb cancer. If you don't have a womb, you will probably be prescribed oestrogen-only HRT.

There are two types of combined HRT.

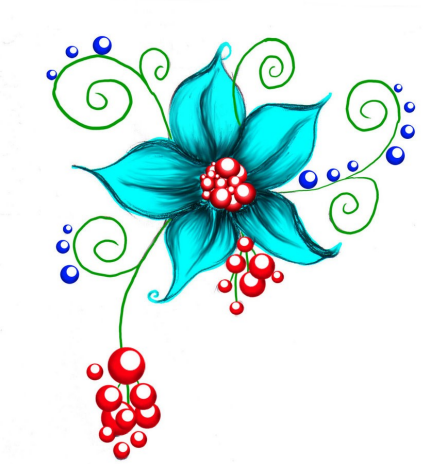
Firstly, there's sequential or cyclical HRT, which is used in perimenopause, where you have a regular withdrawal bleed. Alternatively, the Mirena Intrauterine System (IUS) is licensed to protect the womb lining. This delivers progestogen to the womb, with the added bonus of protecting against pregnancy. It consists of a T-shaped piece of plastic, which is inserted into the womb and has two thin threads hanging through the cervix. Obviously, you have to have it inserted, which can be a bit uncomfortable, but once in it lasts five years. Lots of women don't have any bleeding with it, and you can take daily oestrogen in your preferred form



Secondly, there's continuous combined HRT, which is appropriate for post-menopause. Here, you take oestrogen and a progestogen every day and you don't have a bleed.

HRT comes as various preparations: tablets, patches, gels, sprays and – rarely – implants. You can – in the case of gel and patches – tailor the dose to your needs; one or two squirts of oestrogen gel rubbed into the inner thigh daily is generally enough (but sometimes more is needed). The benefit of transdermal (absorbed through the skin) HRT is that there is no increased risk of blood clots. If you take tablets, there is a small risk. But some women prefer the ease of tablets.

Hard to know, you'll be thinking, when you can change from cyclical to continuous combined. The rule of thumb for changing is to swap at the age of fifty-five, as most women would be post-menopausal by then. However, if a woman starts a sequential preparation about nine months after her last period, it is likely that she would be post-menopausal one to two years later, and she does not need to wait till she is fifty-five.

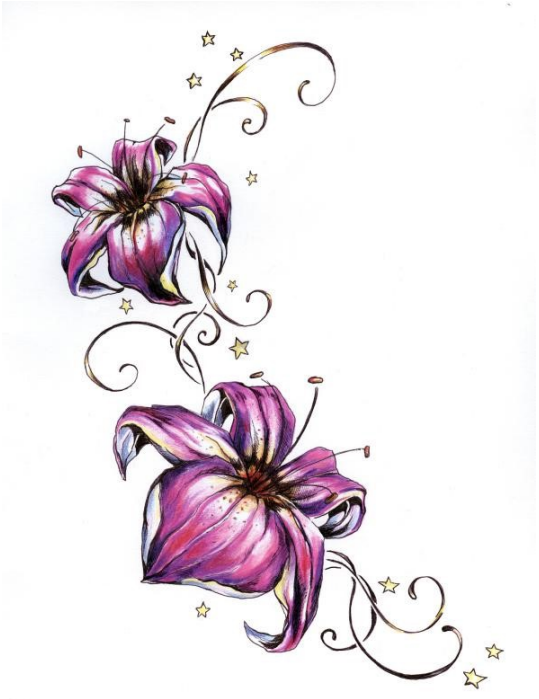


Incidentally, many women are progestogen sensitive. If you had PMS when younger, then you may find that this is the case, and an alternative regime may be to take micronized progesterone (which comes as a separate pill) for two weeks out of every twelve, rather than two weeks in four. (This is where the Mirena IUS comes in handy as well.)

If you have irregular bleeding on HRT, it may settle down (hopefully the case if taking a synthetic progestogen in a combined preparation), but you may need a bit more micronized progesterone, or you can use a Mirena IUS. If it doesn't stop it needs investigation. Micronized progesterone can also have a sedative effect, and Mariella takes it daily to help sleep.

Another option for post-menopause is a tablet called tibolone, which is slightly different. It's a sex steroid and works on receptors in the body to make oestrogen, progesterone and testosterone.

A significant number of women benefit from the addition of testosterone. The ovaries continue to make it after the menopause, but levels will drop. Low testosterone can mean tiredness, lack of energy and reduced libido. Try oestrogen-based HRT first; this may be sufficient for managing symptoms. It is likely, incidentally, that a testosterone prescription would be initiated by a menopause specialist rather than your GP, but this may be different in different areas.

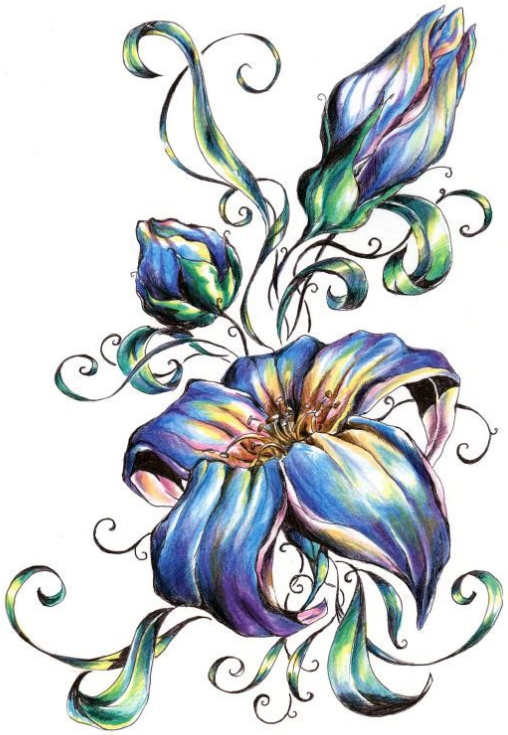


Menopause care is an art, involving evidence-based medicine, good communication and interpersonal relationships with patients, identifying and meeting them at their point of need and supporting them along this journey. There are so many permutations. Every woman is different and this needs to be recognized.

Bioidentical/body identical

The most recent types of HRT are known as body identical. With the same molecular structure as the hormones that we produce in our bodies, they have fewer side effects and risks. Available on the NHS and privately, the oestrogen (as estradiol) is in the form of patches or gel. The progestogen is micronized progesterone made from yams, and available as a tablet. They are often considered the gold-standard option. In fact, a 2018 systematic review revealed that taking micronized progesterone doesn't increase the risk of breast cancer within five years, and there is 'limited evidence' that there's an increased risk after five years. This is promising news.

Body identical HRT is also known as regulated bioidentical hormone replacement therapy (rBHRT) and is different from compounded bioidentical hormone replacement therapy (cBHRT), which takes the form of personalized prescriptions offered in the private sector. Official bodies cannot recommend compounded bioidentical hormones, as they haven't been subjected to the same rigorous testing and trials as the regulated products. 'There is no consistency with the ingredients or doses, and the people promoting them often charge women a lot of money for unnecessary, expensive tests,' says Janice Rymer.



Vaginal oestrogen

We cover dry vaginas, so to speak, in chapter ten (see page 235), but it's worth mentioning vaginal, or local, oestrogen here. This has no cancer risk at all, and there are plenty of new preparations – pessaries, gel, tablets and creams that are applied locally and are beneficial for the vagina and the bladder – both of which rely on oestrogen to stay supple and lubricated. By the way, you can have HRT and vaginal oestrogen at the same time.
There are huge benefits from making HRT your first rather than last port of call, and a vast body of evidence suggesting that, if you want the most out of it and you want it to be as safe as possible, then don't think of it as the last resort. It's proven and it's an almost-free (on the NHS) solution, which may solve many of your problems.

One of the most frequently asked questions is how long you can take HRT for. Tonye says that the NICE (official) guidance isn't entirely prescriptive or dogmatic. 'Many women are under the impression that it ought to be consumed in low quantities for as little time as possible. This is not true. NICE recommends a menopause review on an annual basis, and looking at risks weighed against benefits. My feeling, and that of many fellow experts, is that, yes, it's medication, but you should be allowed to take it for as long as you need to. This may mean as long as you live, ideally starting within ten years of the menopause or before you reach the age of sixty. This is what's known as the window of opportunity for cardiovascular benefit for HRT. The benefits outweigh the risks.' She adds that it can be started post sixty.

Women are very bad at looking after themselves, probably because we spend so much time looking after everyone else. When it comes to mid-life, it's no longer a choice; it's essential that you take the time for self-care.