Guidelines for the administration of hormone replacement therapy. The Hong Kong College of Obstetricians and Gynaecologists

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Objective. To establish guidelines on the administration of hormone replacement therapy in Hong Kong for a primary audience of Fellows and Members of the Hong Kong College of Obstetricians and Gynaecologists and a secondary audience of all interested medical and paramedical personnel in Hong Kong.

Participants. The Quality Assurance Committee established a consensus panel of four College Fellows who had expertise of treating menopausal women by giving hormone replacement therapy. All the panelists were qualified obstetricians and gynaecologists.

Evidence. The panelists drew their conclusions from the available scientific literature on hormone replacement therapy from Hong Kong and overseas.

Consensus process. The consensus reached within the panel was presented to the Quality Assurance Committee on 23 June 1998, and subsequently revised and presented three times. The final version was approved by the Quality Assurance Committee on 2 March 1999 and the Council of the Hong Kong College of Obstetrics and Gynaecology on 11 March 1999.

Conclusions. The administration of hormone replacement therapy is effective in reducing the severity and frequency of menopausal hot flushes and sweating. Therapy protects against osteoporosis and reduces the risk of cardiovascular disease. There is some evidence to suggest that treatment also protects against Alzheimer’s disease and carcinoma of the colon. The most serious problem attributed to using hormone replacement therapy is the possible increase in the risk of breast cancer development; the exact risk is unknown. Side effects include unwanted bleeding and breast tenderness and sensitivity. The risks and benefits of using hormone replacement therapy should be explained to postmenopausal women so that they can make an informed decision about using this treatment.

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Key words: Estrogen replacement therapy; Hong Kong; Practice guidelines

(1) Benefits of hormone replacement therapy

The benefits of hormone replacement therapy (HRT)

are the following:

(a) Relief of menopausal symptoms
(b) Prevention of osteoporosis
(c) Prevention of cardiovascular disease

The administration of HRT may also reduce the risk of Alzheimer’s disease, but there are fewer supporting data.¹

Hormone replacement therapy may be offered to most postmenopausal or symptomatic perimenopausal women, and their decision to use HRT will depend on the balance between the advantages and disadvantages of treatment that are explained to them.

(1.1) Menopausal symptoms

Oestrogen is effective in reducing the severity and
frequency of hot flushes and sweating. There is less evidence to show that oestrogen is effective in controlling other acute symptoms attributable to the menopause. While severe vasomotor symptoms develop in some Chinese menopausal women, these symptoms occur less commonly than they do in Caucasians. Severe vasomotor symptoms may thus be a relatively less important indication for treatment in Chinese women.

(1.2) Prevention of osteoporosis
Bone loss after the menopause especially affects the femoral neck and lumbar spine. The administration of oestrogen is effective in preventing osteoporosis and osteoporotic fractures in these sites. Bone mineral density (BMD) studies performed in Hong Kong can provide information that may be beneficial when deciding to use HRT. Studies should especially be considered for women who are at risk of osteoporosis development (Box 1 lists the risk factors). The disadvantage of determining the BMD, however, is the cost involved. As far as osteoporosis is concerned, once oestrogen treatment is discontinued, protection against bone loss is largely lost.

(1.3) Prevention of cardiovascular disease
There is indirect evidence to suggest that the administration of oestrogen reduces cardiovascular risk by as much as 50%. The beneficial actions of oestrogen include an improvement in the serum lipid profile, a reduction in cholesterol uptake by the vessel wall, and an increase in blood flow due to arterial relaxation. Oestrogen is also thought to act as an antioxidant and a calcium antagonist, and it also increases insulin sensitivity. The cardioprotective effect of oestrogen applies to current as well as previous users of HRT. Women who are at increased risk of cardiovascular disease should especially benefit from treatment (Box 2 lists the risk factors).

(2) Disadvantages and risks of hormone replacement therapy
The main disadvantage of HRT is the necessity to use one or other of the hormone preparations for a relatively long period of time. In addition, for some women who have not had a hysterectomy, the resumption of menstrual-like bleeding may be considered to be a disadvantage of treatment.

The most serious risk attributed to the use of HRT is that of the development of breast cancer. The extent of the risk cannot at present be accurately estimated. Many studies suggest that the administration of HRT does not increase the risks of breast cancer, while others suggest a slight increase in risk. Studies are currently being performed overseas and may more accurately measure the risk.

The most common side effects of HRT are breast sensitivity or engorgement and fluid retention. These problems tend to improve within months of initiating treatment, but the dose of oestrogen given may be reduced to relieve the discomfort.

(2.1) Absolute contra-indications to hormone replacement therapy
Absolute contra-indications to HRT are existing breast carcinoma, existing endometrial carcinoma, venous thrombosis, and acute liver disease.

(3) Prescription of hormone replacement therapy
An algorithm for the prescription of HRT is shown in the Figure. For the purpose of hormone replacement, oestrogen may be administered orally, percutaneously, transdermally, or by using a subcutaneous implant. Vaginal administration of oestrogen is usually reserved for the short-term treatment of lower-genital tract symptoms. For most women, the route of administration of oestrogen can be chosen according to their preference. Those with medical conditions that can in theory be affected by the hepatic ‘first pass’ effect of

Box 1. Risk factors for osteoporosis

1. Prolonged oligomenorrhoea/amenorrhoea or premature menopause
2. Prolonged immobilisation/inactivity
3. Excessive intake of alcohol or caffeine; smoking
4. Low body mass index, short stature, family history of osteoporosis
5. Use of drugs that predispose to osteoporosis, eg steroids, thyroxine, anticonvulsants
6. Medical conditions that predispose to osteoporosis such as: Cushing’s syndrome, hyperthyroidism, hyperparathyroidism, chronic disease of the liver or kidney, malabsorptive disorders, gastrectomy, rheumatoid arthritis

Box 2. Risk factors for cardiovascular disease

1. Existing cardiovascular disease
2. Family history of cardiovascular disease
3. Hypercholesterolaemia
4. Smoking
5. Diabetes mellitus
6. Hypertension
7. Obesity
Hormone replacement therapy guidelines

* HRT  hormone replacement therapy

Fig. An algorithm for the administration of hormone replacement therapy

Table 1. Examples of hormone preparations available in Hong Kong*

(1a) Unopposed oestrogen therapy

<table>
<thead>
<tr>
<th>Route</th>
<th>Generic drug (normal dosage)</th>
<th>Trade name (manufacturer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Conjugated equine oestrogens (0.625 mg/d)</td>
<td>Premarin (Wyeth)</td>
</tr>
<tr>
<td>Oral</td>
<td>Oestradiol (2 mg/d)</td>
<td>Estrofem (Novo Nordisk)</td>
</tr>
<tr>
<td>Oral</td>
<td>Oestradiol valerate (2 mg/d)</td>
<td>Progynova (Schering AG)</td>
</tr>
<tr>
<td>Percutaneous gel</td>
<td>Oestradiol gel (2.5 g/d)</td>
<td>Oestrogel (Hoechst Marion Roussel)</td>
</tr>
<tr>
<td>Percutaneous patch</td>
<td>Oestradiol (two 4-mg patches per week)</td>
<td>Dermestril (Sanofi Winthrop) or Estraderm TTS (Novartis)</td>
</tr>
</tbody>
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(1b) Combined cyclical (sequential) hormone replacement therapy

<table>
<thead>
<tr>
<th>Route</th>
<th>Generic drug (normal dosage)</th>
<th>Trade name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Oestradiol (2 mg/d) + dydrogesterone (10 mg/d, 14/28 days)</td>
<td>Femoston (Solvay)</td>
</tr>
<tr>
<td>Oral</td>
<td>Oestradiol (2 mg/d, 22 days; 1 mg/d, 6 days) + norethisterone acetate (1 mg/d, 10/28 days)</td>
<td>Trisequens (Novo Nordisk)</td>
</tr>
<tr>
<td>Oral</td>
<td>Oestradiol valerate (2 mg/d, 21 days) + cyproterone acetate (1 mg/d, 10/28 days)</td>
<td>Climen (Schering AG)</td>
</tr>
<tr>
<td>Oral</td>
<td>Conjugated equine oestrogens (0.625 mg/d, 21/28 days) + medrogestone (5 mg/d, 10/28 days)</td>
<td>Prempak (Wyeth)</td>
</tr>
<tr>
<td>Oral</td>
<td>Conjugated equine oestrogens (0.625 mg/d) + medroxyprogesterone acetate (5 mg/d, 14/28 days)</td>
<td>Premelle Cycle (Wyeth)</td>
</tr>
<tr>
<td>Percutaneous patch</td>
<td>Oestradiol (two 4-mg patches per week for 2 weeks) followed by patches containing oestradiol (10 mg/d) + norethisterone acetate (30 mg/d) [two patches per week for 2 weeks]</td>
<td>Estracomb TTS (Novartis)</td>
</tr>
</tbody>
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(1c) Continuous combined hormone replacement therapy

<table>
<thead>
<tr>
<th>Route</th>
<th>Generic drug (normal dosage)</th>
<th>Trade name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Conjugated equine oestrogens (0.625 mg/d) + medroxyprogesterone acetate (2.5 mg/d)</td>
<td>Premelle (Wyeth)</td>
</tr>
<tr>
<td>Oral</td>
<td>Oestradiol (2 mg/d) + norethisterone acetate 1 mg/d</td>
<td>Kllogest (Novo Nordisk)</td>
</tr>
<tr>
<td>Oral</td>
<td>Tibolone (2.5 mg/d)</td>
<td>Livial (Organon)</td>
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* As of 1 January 1999
oral oestrogens may be better treated by giving non-
oral preparations. Such medical conditions include
diabetes mellitus, hypertension, hypertriglyceridaemia,
and a history of venous thrombosis.

(3.1) Unopposed oestrogen therapy
Unopposed oestrogen therapy implies the use of
oestrogen without a progestogen (Table 1a). In women
who have had a hysterectomy, unopposed oestrogen
should be prescribed. For those women who still have
a uterus, a progestogen should be given in addition to
oestrogen, to prevent endometrial hyperplasia and
carcinoma.8 The prescription of oestrogen as well as
progestogen is referred to as combined HRT, and this
combination may be given either cyclically (sequen-
tially) or continuously.

(3.2) Combined cyclical (sequential) hormone
replacement therapy
A cyclical (sequential) regimen implies that a pro-
gestogen is given on a cyclical basis (in addition to
oestrogen) [Table 1b]. The cyclical use of a progestogen
usually results in regular ‘withdrawal bleeding’ at the
end of each progestogen cycle. When prescribing HRT
at the time of (or soon after) the menopause, a cyclical
(regional) regimen is less likely to cause irregular
bleeding than would a continuous combined regimen
(see section 3.3). In a cyclical regimen, oestrogen is
usually prescribed for 21 or 28 days while the pro-
gestogen is given for 10 or 12 days each month. A
small percentage of women may become amenorrhoeic
during cyclical treatment.

(3.3) Continuous combined hormone replacement
therapy
Continuous combined HRT can be given to women
with an established menopause (>2 years), in which
case both the oestrogen and a progestogen are given
on a daily basis (Table 1c). The aim of using such a
regimen is for these women to remain amenorrhoeic.
Spotting is common during the first few months of
treatment. An alternative to continuous combined
HRT is the use of tibolone, a synthetic agent that has
weak oestrogenic, androgenic, and progestogenic
properties. This drug can be used under the same
circumstances as continuous combined oestrogen with
a progestogen.

(3.4) Selective estrogen receptor modulators
Recent data on a new class of drugs referred to as
selective estrogen receptor modulators (SERMs) have
suggested that these drugs reduce the risk of breast
and endometrial cancer.9 Although SERMs have a
beneficial effect on the serum lipid level and BMD,
they have little or no therapeutic effect on acute meno-
pausal symptoms. These drugs may thus be desirable
for asymptomatic women who have a fear of breast
cancer or those with risk factor(s) for the development
of breast cancer. Selective estrogen receptor modulators
may be prescribed whether or not the uterus is present.

(3.5) Duration of hormone replacement therapy
There are no rules regarding the duration of HRT.
While the treatment continues, the beneficial effects
of HRT will be maintained. Studies on the effect of
long-term treatment on breast cancer risks are currently
underway.

(4) Management of the menopause
Treatment can begin at any time after the onset of
menopause, and the type of HRT regimen will be
dictated by the duration of the menopause and whether
or not a hysterectomy has been performed. Some
women develop symptoms of oestrogen deficiency
before the menopause occurs; treatment may begin
at this time, although irregular bleeding in perimeno-
pausal women may be a problem.

In addition to using HRT, attention to life-style
factors that promote good health should be encouraged.
These factors include weight control and regular
weight-bearing exercise.

(4.1) Monitoring of women receiving hormone
replacement therapy
Cervical smears should be performed routinely as for

Table 2. Follow-up of women receiving hormone
replacement therapy

<table>
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<th>Visit</th>
<th>Tests</th>
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| At first visit     | Blood pressure measurement; monitoring of levels of follicle-
stimulating hormone, luteinizing hormone, and oestradiol to confirm
                  | menopause (if clinical features are atypical); lipid profile;
                  | liver function tests; bone biochemistry; mammography;
                  | urinanalysis                                                   |
| At each visit      | Urinanalysis; blood pressure measurement                              |
| Every 2 years      | Physical examination; lipid profile; liver function tests;
                  | determination of fasting glucose level;
                  | mammography                                                   |
| As indicated       | Bone mineral density studies                                          |
all women with a uterus. Compliance with treatment symptom control, side effects (if any), and the bleeding pattern of those receiving combined treatment should be noted at each visit. The examinations and investigations shown in Table 2 are commonly performed, but there is no universal agreement as to which of them are essential.

(4.2) Management of irregular bleeding during hormone replacement therapy
(4.2.1) Bleeding during combined cyclical hormone replacement therapy
Some women will be amenorrhoeic during this course of therapy and a biopsy is not necessary. Bleeding should occur around the time of progestogen withdrawal. If bleeding occurs at times other than this or if it is persistently irregular, endometrial biopsy is recommended.

(4.2.2) Bleeding during continuous combined hormone replacement therapy
Women using continuous combined HRT should achieve amenorrhoea within about 4 months of starting treatment. Spotting in the first few months is common. Endometrial biopsy should be considered in women who develop irregular bleeding but who were previously amenorrhoeic when using this regimen.

References