Menopause: identification and management [NG23]

NG23

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Menopause: identification and management

Introduction

This guideline summary covers identifying and managing menopause, including in people with premature ovarian insufficiency. It covers women, trans men and non-binary people registered female at birth who currently have menopause-associated symptoms or who will experience menopause in the future. Note the guideline does not cover people who are currently taking gender-affirming therapy; for trans men and non-binary people who have taken such therapy in the past, please refer to the full guideline.

Identifying perimenopause and menopause

- Identify the following, without laboratory tests, in otherwise healthy women, trans men and non-binary people registered female at birth who are aged 45 or over and have menopause-associated symptoms:
  - perimenopause, if they have vasomotor symptoms that have recently started and any changes in their menstrual cycle
  - menopause, if they have not had a period for at least 12 months and are not using hormonal contraception
  - menopause, in those who have had a hysterectomy, based on the type and combination of symptoms they have (for example, vasomotor symptoms).
- Take into account that it can be difficult to identify menopause in people who are taking hormonal treatments, for example, for the treatment of heavy menstrual bleeding.
- Be aware that people from some ethnic minority backgrounds and people with some lifelong conditions may experience menopause at a younger age.
- Do not use a follicle-stimulating hormone (FSH) blood test to identify menopause in people using combined oestrogen and progestogen contraception or high-dose progestogen.
- Consider using the person's serum FSH level to confirm menopause only:
  - in people aged 40 to 45 with menopause-associated symptoms, including a change in their menstrual cycle
  - in people aged under 40 in whom menopause is suspected.

Discussing management options with people aged 40 or over

Hormone replacement therapy

- When discussing hormone replacement therapy (HRT) as a possible treatment for menopause-associated symptoms, talk about the benefits and risks associated with:
  - combined versus oestrogen-only HRT (see page 18 for section on starting HRT regarding which of combined or oestrogen-only HRT would be offered, and why)
  - transdermal versus oral HRT
  - types of oestrogen and progestogen
  - sequential versus continuous combined HRT
  - dose and duration.
- Tailor the information about benefits

and risks to the person's age, individual circumstances and potential risk factors.

- If a person chooses to take HRT:
  - discuss the possible duration of treatment at the outset
  - at every review, rediscuss the benefits and risks of continuing treatment
  - explain that symptoms may return when HRT is stopped and discuss the option of restarting treatment if necessary.

Cognitive behavioural therapy

- When discussing cognitive behavioural therapy (CBT) as a possible management option for symptoms associated with menopause, explain what CBT is (including menopause-specific CBT) and talk about the available options, taking into account the person's preferences and needs, for example:
  - face-to-face or remote sessions
  - individual or group sessions
  - self-help options.

Complementary therapies and unregulated preparations

- Explain to people with menopause-associated symptoms that the efficacy and safety of unregulated hormone preparations are unknown and also that the safety, quality and purity of constituents in unregulated preparations may be unknown.
- Explain to people that there is some evidence that isoflavones or black cohosh may relieve vasomotor symptoms associated with menopause. However, explain that:
  - multiple preparations are available, and their safety is uncertain
  - different preparations may vary
  - interactions with other medicines have been reported.
- Advise people with a personal history of, or at high risk of, breast cancer that, although there is some evidence that St John's wort may help relieve vasomotor

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symptoms associated with menopause, there is uncertainty about:
- appropriate dosage
- persistence of effect
- variation in the nature and potency of preparations
- potential serious interactions with other medicines (including tamoxifen, anticoagulants and anticonvulsants).

Managing symptoms associated with menopause in people aged 40 or over

Vasomotor symptoms

- Offer HRT to people with vasomotor symptoms associated with menopause.
- Consider menopause-specific CBT as an option for vasomotor symptoms associated with menopause:
  - in addition to HRT **or**
  - for people for whom HRT is contraindicated **or**
  - for those who prefer not to take HRT.
- Do not routinely offer selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) or clonidine as first-line treatment for vasomotor symptoms alone.

Genitourinary symptoms associated with menopause

People with no history of breast cancer

- Offer vaginal oestrogen to people with genitourinary symptoms associated with menopause (including those using systemic HRT) and review regularly.
- When discussing the option of vaginal oestrogen, explain that:
  - serious adverse effects are very rare
  - their treatment should be reviewed at three months and then annually (see final section on reviewing treatment)
  - symptoms often return when vaginal oestrogen is stopped but treatment can be restarted if necessary
  - vaginal oestrogen is absorbed locally – a minimal amount is absorbed into the bloodstream (when compared with systemic HRT), but this is unlikely to have a significant effect throughout the body.
- When someone chooses vaginal oestrogen, make a shared decision with the person about whether to use an oestrogen cream, gel, tablet, pessary or ring.
- Advise people with genitourinary symptoms associated with menopause that vaginal oestrogen can be used on its own or in combination with non-hormonal moisturisers or lubricants.
- For people with genitourinary symptoms in whom vaginal oestrogen preparations are contraindicated, or for people who would prefer not to use vaginal oestrogen, consider non-hormonal vaginal moisturisers or lubricants.
- Consider vaginal prasterone for genitourinary symptoms if vaginal oestrogen, or non-hormonal moisturisers or lubricants have been ineffective or are not tolerated.
- Consider ospemifene as an oral treatment for genitourinary symptoms if the use of locally applied treatments is impractical, for example, because of disability.

People with a personal history of breast cancer

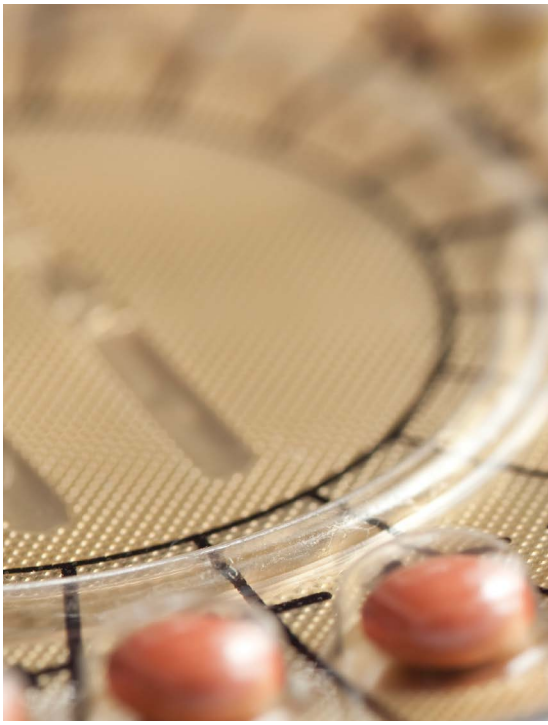
- Offer non-hormonal moisturisers or lubricants to people with a personal history of breast cancer who have genitourinary symptoms associated with menopause.
- Consider vaginal oestrogen for people with a personal history of breast cancer whose genitourinary symptoms have continued despite trying non-hormonal treatments (see point below regarding those receiving adjuvant aromatase inhibitor treatment for breast cancer). Vaginal oestrogen may be used in combination with a non-hormonal moisturiser or a lubricant. Note that in

November 2024, this was an off-label use of vaginal oestrogen.

- For people currently having aromatase inhibitors as adjuvant treatment for breast cancer, work with a breast cancer specialist to identify treatment options for genitourinary symptoms that have continued despite trying non-hormonal treatments.
- When assessing the safety of vaginal oestrogens for someone in relation to breast cancer recurrence, take into account all of the following:
  - the person's general risk factors for breast cancer recurrence
  - it is unknown whether vaginal oestrogen affects the risks of breast cancer recurrence
  - vaginal oestrogen is absorbed locally, and some of it is absorbed into the bloodstream but compared with oestrogen from systemic HRT, the amount is minimal.
- For people with a personal history of oestrogen receptor-negative breast cancer, recognise that any oestrogen systemically absorbed from taking vaginal oestrogen is unlikely to increase the risk of breast cancer recurrence, and so it is likely to be safe.
- For people with a personal history of oestrogen receptor-positive breast cancer, recognise that:
  - it is unknown whether any oestrogen systemically absorbed from taking vaginal oestrogen could increase the risk of breast cancer recurrence **and**
  - adjuvants that block oestrogen receptors in cancer cells (for example, tamoxifen) would reduce any such potential impact.
- In people given treatment for genitourinary symptoms associated with menopause, see recommendations on reviewing treatment in final section.

Depressive symptoms

- Consider HRT to alleviate depressive symptoms (not meeting the criteria for a diagnosis of depression) with onset around the same time as other symptoms associated with menopause.
- Consider CBT as an option for people who have depressive symptoms (not meeting the criteria for a diagnosis of depression) in association with vasomotor symptoms:
  - in addition to other management options **or**
  - for people in whom other options are contraindicated **or**
  - for those who prefer not to try other options.



Sleep

- Consider menopause-specific CBT as an option for people who have sleep problems (such as night-time awakening) in association

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with vasomotor symptoms:
- in addition to other management options (including HRT) **or**
- for people in whom other options are contraindicated **or**
- for people who prefer not to try other options.

Altered sexual function
- Consider testosterone supplementation for people with low sexual desire associated with menopause if HRT alone is not effective.

Taking medical history into account before offering treatment for menopause associated symptoms
Type 2 diabetes
- Consider HRT for menopause-associated symptoms in people with type 2 diabetes after taking comorbidities into account and seeking specialist advice if needed.

Increased risk of venous thromboembolism
- Consider transdermal rather than oral HRT for people with menopause-associated symptoms who are at increased risk of venous thromboembolism (VTE), including those with a body mass index (BMI) over 30 kg/m^2.
- Consider referring people with menopause-associated symptoms who are at high risk of VTE (for example, those with a strong family history of VTE or a hereditary thrombophilia) to a haematologist for assessment before considering HRT.

Table 1 Combined HRT versus no HRT: effect on specific health outcomes

Use the discussion aid on HRT, available at nice.org.uk/guidance/ng23/resources, for the number of cases per 1,000 people for each health outcome, with or without combined HRT, over given time periods.

–	Baseline risk	How does taking combined HRT impact the risks related to this outcome?
All-cause mortality (life expectancy)	–	Overall, life expectancy is unlikely to change with the use of combined HRT.
Cancer: breast (for people with no personal history of breast cancer)	Breast cancer risk varies depending on a person's modifiable and non-modifiable risk factors.	Breast cancer risk increases with combined HRT and the increase: • rises with duration of use • is higher in people currently taking HRT than in those who have taken it in the past • declines after stopping HRT but persists for at least 10 years after stopping use. There is a very small increase in risk of death from breast cancer with combined HRT.
Cancer: endometrial (for people with no personal history of endometrial cancer)	–	–
Cancer: ovarian (for people with no personal history of ovarian cancer)	The baseline population risk of ovarian cancer in women aged under 60 is very low.	In people with ovaries, there is a very slight increase in ovarian cancer risk with combined HRT.
Coronary heart disease (for people with no personal history of coronary heart disease)	–	Coronary heart disease risk does not increase with combined HRT. Mortality from cardiovascular disease does not increase with combined HRT.

	Does the way combined HRT is taken affect these risks?	**Does the type of hormone affect these risks?**
	–	–
	Breast cancer risk with sequential combined HRT is: • lower than with continuous combined HRT **but** • higher than without HRT.	There is insufficient evidence to establish whether the increase in risk of breast cancer is different with preparations containing micronised progesterone or dydrogesterone from what it is with preparations containing other progestogens.
	Endometrial cancer risk decreases with continuous combined HRT. Endometrial cancer risk may slightly increase with sequential combined HRT, and the increase may be greater with: • longer duration of use • fewer days of progestogen per cycle • increased dosage of oestrogen.	–
	–	–
	–	–

Table continued ▶

Table 1 (Continued)

–	Baseline risk	How does taking combined HRT impact the risks related to this outcome?
Dementia	–	Dementia risk might increase with combined HRT if it is started at age 65 or over.
Muscle mass and strength	–	There is limited evidence suggesting that HRT may improve muscle mass and strength.
Osteoporosis	The baseline population risk of fragility fracture: • is low in the UK for women, trans men and non-binary people registered female at birth who are around the age of menopause, and • varies from one person to another.	Fragility fracture risk is decreased while taking HRT and this benefit: • is maintained during treatment but decreases once treatment stops • may continue for longer in people who take HRT for longer.
Stroke (for people with no personal history of stroke)	The baseline population risk of stroke in women aged under 60 is very low.	–
Type 2 diabetes	–	The risk of developing type 2 diabetes does not increase with HRT. Generally, no adverse effect on blood glucose control is reported when taking HRT.
VTE	–	VTE risk is not increased with transdermal HRT.

	Does the way combined HRT is taken affect these risks?	Does the type of hormone affect these risks?
	–	–
	–	–
	–	–
	Stroke risk is unlikely to increase with the use of combined HRT that includes transdermal oestrogen. Stroke risk increases with combined HRT containing oral oestrogen and the increase: • rises with higher oestrogen dosage and longer duration of treatment, for example, if used for more than 5 years • is greater with increasing age at first starting HRT • differs between ethnic groups and may be greater in Black people.	–
	The risk is not affected whether HRT is taken orally or transdermally.	–
	VTE risk is increased with oral HRT. VTE risk is greater with oral than transdermal HRT.	–

Table 2 Oestrogen-only HRT versus no HRT: effect on specific health outcomes

Use the discussion aid on HRT, available at nice.org.uk/guidance/ng23/resources, for the number of cases per 1,000 people for each health outcome, with and without oestrogen-only HRT, over given time periods.

–	Baseline risk	How does taking oestrogen-only HRT impact the risks related to this outcome?
All-cause mortality (life expectancy)	–	Overall, life expectancy is unlikely to change with use of oestrogen-only HRT.
Cancer: breast (for people with no personal history of breast cancer)	Breast cancer risk varies depending on a person's modifiable and non-modifiable risk factors.	There is very little or no increase in risk of breast cancer with oestrogen-only HRT. There is little or no increase in the risk of breast cancer mortality with oestrogen-only HRT.
Cancer: endometrial (for people with no personal history of endometrial cancer)	–	In people with a uterus, endometrial cancer risk increases with oestrogen-only HRT. See section on starting HRT (page 18) for recommendation regarding which type of HRT to offer depending on whether people have a uterus or not.
Cancer: ovarian (for people with no personal history of ovarian cancer)	The baseline population risk of ovarian cancer in women aged under 60 is very low.	In people with ovaries, ovarian cancer risk increases very slightly after 5 years of using oestrogen-only HRT and this risk increases with duration of use.
Coronary heart disease (for people with no personal history of coronary heart disease)	–	Coronary heart disease risk does not increase with oestrogen-only HRT. Mortality from cardiovascular disease does not increase with oestrogen-only HRT.
Dementia	–	Dementia risk is unlikely to increase with oestrogen-only HRT.
Muscle mass and strength	–	There is limited evidence suggesting that HRT may improve muscle mass and strength.

	Does the way oestrogen-only HRT is taken affect these risks?	Does the type of hormone taken affect these risks?
	–	–
	–	Breast cancer risk is similar with oestradiol and with conjugated equine oestrogen.
	In people with a uterus, endometrial cancer risk increases with both oral and transdermal oestrogen-only HRT.	–
	Ovarian cancer risk increases with both transdermal and oral oestrogen-only HRT.	–
	–	–
	–	–
	–	–

Table continued ▶

Table 2 (Continued)

–	Baseline risk	How does taking oestrogen-only HRT impact the risks related to this outcome?
Osteoporosis	The baseline population risk of fragility fracture: • is low in the UK for women, trans men and non-binary people registered female at birth who are around the age of menopause, and • varies from one person to another.	Fragility fracture risk is decreased while taking HRT and this benefit: • is maintained during treatment but decreases once treatment stops • may continue for longer in people who take HRT for longer.
Stroke (for people with no personal history of stroke)	The baseline population risk of stroke in women aged under 60 is very low.	–
Type 2 diabetes	–	The risk of developing type 2 diabetes does not increase with HRT. Generally, no adverse effect on blood glucose control is reported when taking HRT.
VTE	–	VTE risk is not increased with transdermal HRT.

Personal history of coronary heart disease or stroke

- For people with a personal history of coronary heart disease or stroke, ensure that combined or oestrogen-only HRT is discussed with and offered, if appropriate, by a healthcare professional with expertise in menopause. Note that, in November 2024, use of combined or oestrogen-only HRT in people with active or recent arterial thromboembolic disease was off-label.

Personal history of breast cancer or high risk of breast cancer

- Offer people with menopause-associated symptoms and who have a personal history, or are at high risk, of breast cancer:
  - information on all management options available to them

	Does the way oestrogen-only HRT is taken affect these risks?	Does the type of hormone taken affect these risks?
	–	–
	Stroke risk increases with oral oestrogen-only HRT and the increase: • rises with the dosage of oestrogen • is greater if HRT is started after the age of 60. Stroke risk is unlikely to increase with transdermal oestrogen-only HRT.	–
	The risk is not affected whether HRT is taken orally or transdermally.	–
	VTE risk is increased with oral HRT. VTE risk is greater with oral than transdermal HRT.	–

• referral to a healthcare professional with expertise in menopause.

Effects of HRT on specific health outcomes in people aged 40 or over

People aged 45 or over

• When discussing HRT as a treatment option for menopause-associated symptoms, explain that, overall, taking either combined HRT or oestrogen-only HRT is unlikely to affect life expectancy.

Combined HRT

This recommendation is for people with a uterus.

• When talking about combined HRT as a treatment option:

• discuss different combined HRT options

to identify the one that best balances benefits and risks for the person
- share information from Table 1 on page 8
- refer to the discussion aid on HRT and the likelihood of some medical conditions, to provide information on the extent of benefits and risks associated with HRT (nice.org.uk/guidance/ng23/resources).

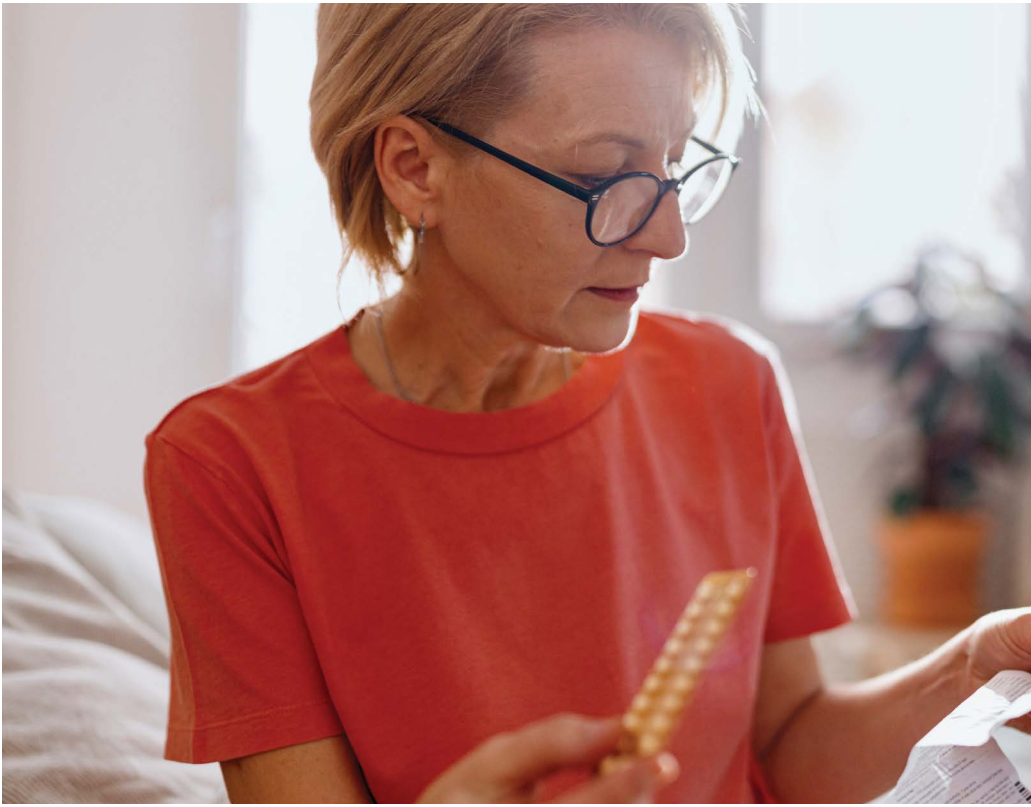
Oestrogen-only HRT

This recommendation is for people who have had a total hysterectomy.

- When talking about oestrogen-only HRT as a treatment option:
  - discuss different oestrogen-only HRT options to identify the one that best balances benefits and risks for the person
  - share information from Table 2 on page 12
  - refer to the discussion aid on HRT and the likelihood of some medical conditions for information on the extent of benefits and risks associated with HRT (nice.org.uk/guidance/ng23/resources).

Cardiovascular disease prevention

- Do not offer combined or oestrogen-only HRT for primary or secondary prevention of



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cardiovascular disease. For guidance on ways to reduce the risk of cardiovascular disease (for example, lifestyle changes), refer to NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification (NG238).

Dementia prevention

- Do not offer combined or oestrogen-only HRT for the purpose of dementia prevention. For dementia prevention, see NICE's guideline on dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (NG16).

People in early menopause (ages 40 to 44)

- When discussing HRT as a treatment option, explain to people experiencing early menopause that, for them, the benefits and risks of either taking or not taking HRT are likely to lie between those for people with premature ovarian insufficiency and those for people aged 45 or over.

Diagnosing and managing premature ovarian insufficiency in people under 40

Diagnosing premature ovarian insufficiency

- Take into account the person's clinical history (for example, previous medical or surgical treatment) and family history.
- Diagnose premature ovarian insufficiency in women, trans men and non-binary people registered female at birth who are under 40 based on:
  - menopause-associated symptoms, including no or infrequent periods (taking into account whether the person has had a hysterectomy) **and**
  - elevated follicle stimulating hormone (FSH) levels on 2 blood samples taken 4 to 6 weeks apart.
- Do not diagnose premature ovarian insufficiency on the basis of a single blood test.
- Do not routinely use anti-Müllerian hormone testing to diagnose premature ovarian insufficiency.
- If there is doubt about the diagnosis of premature ovarian insufficiency, refer the person to a specialist with expertise in menopause or reproductive medicine.

Managing premature ovarian insufficiency

- Offer sex steroid replacement with a choice of HRT or a combined hormonal contraceptive to people with premature ovarian insufficiency, unless

contraindicated (for example, in people with hormone-sensitive cancer).
- Explain to people with premature ovarian insufficiency:
  - the importance of starting hormonal treatment either with HRT or a combined hormonal contraceptive and continuing treatment until at least the age of natural menopause (unless contraindicated)
  - that the baseline population risk of diseases such as breast cancer and cardiovascular disease increases with age and is very low in people under the age of 40
  - that HRT may have a beneficial effect on blood pressure when compared with a combined oral contraceptive
  - that both HRT and combined oral contraceptives offer bone protection
  - that HRT is not a contraceptive.
- Give advice to people with premature ovarian insufficiency and contraindications to hormonal treatments, including on bone and cardiovascular health, and on symptom management
- Consider referring people with premature ovarian insufficiency to healthcare professionals with the relevant experience to help them manage all aspects of physical and psychosocial health related to their condition.

Starting and stopping hormone replacement therapy for anyone

Starting HRT

- For people who wish to take HRT for symptoms associated with menopause:
  - offer combined HRT to people with a uterus
  - offer oestrogen-only HRT to people who have had a total hysterectomy.
- For people with a condition that may be affected by HRT, consider seeking advice on the choice of HRT from a healthcare professional with specialist knowledge of that condition.
- If a person chooses to take HRT, use the lowest effective dosage.
- Explain to people with a uterus that vaginal bleeding is a common side effect of systemic HRT within the first 3 months of treatment, and they will be asked about this during their three-month review. Advise them to seek medical help promptly if they experience vaginal bleeding after 3 months.

Stopping HRT

- Offer people who are stopping HRT a choice of gradually reducing or immediately stopping treatment.
- Explain to people that:
  - gradually reducing HRT may limit recurrence of symptoms in the short term
  - gradually reducing or immediately stopping HRT makes no difference to their symptoms in the longer term.
- Stop systemic HRT in people who are diagnosed with breast cancer in line with the recommendations on menopause symptoms in NICE's guideline on early and locally advanced breast cancer.

Reviewing treatment for anyone

- Discuss importance of keeping up to date with nationally recommended health screening
- Review each treatment for symptoms associated with menopause:
  - at 3 months to assess efficacy and tolerability
  - annually thereafter, unless there are clinical indications for an earlier review.

Mirena®

52 mg levonorgestrel
intrauterine delivery system

Mirena® is indicated for:

- Contraception for up to 8 years
- Idiopathic menorrhagia for up to 5 years
  Should symptoms not return after 5 years of use, Mirena® can be considered for continued use for up to 8 years
- Protection from endometrial hyperplasia during oestrogen replacement therapy for up to 4 years

- Broadest range of licensed indications for an intrauterine system (IUS) in the UK[1]
- Can significantly reduce menstrual blood loss by up to 90% ($p<0.005$) within just 3 cycles in the treatment of heavy menstrual bleeding (HMB)[1,2]
- The only IUS licensed for endometrial protection (EP) during oestrogen replacement therapy in the UK[1]

When making individualised treatment decisions, please refer to the Mirena® Summary of Product Characteristics for more information including other important clinical considerations.

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For direct access to this prescribing information, please ensure your device's browser settings have automatic PDF download enabled.

This resource has been created and funded by Bayer plc | PP-MIR-GB-0249 February 2025

References: 1.Mirena® Summary of Product Characteristics 2.Reid C. and Virtanen-Kari S. BJOG 2005; 112:1121-1125