MENOPAUSE

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Topics to be covered:

- Definitions
- Symptoms of menopause
- The role of MHT
- Benefits and risks of MHT
- How to prescribe MHT
- Non-hormonal treatments
- NSW Health Menopause Network, Referral service, PBS additions, resources

Definitions

Menopause

- Date of the final menstrual period (FMP)
- Permanent loss of menses due to loss of ovarian follicular activity
- Normal Age 45 – late 50's
- Early menopause 40-45
- Premature Ovarian Insufficiency (POI) before age 40

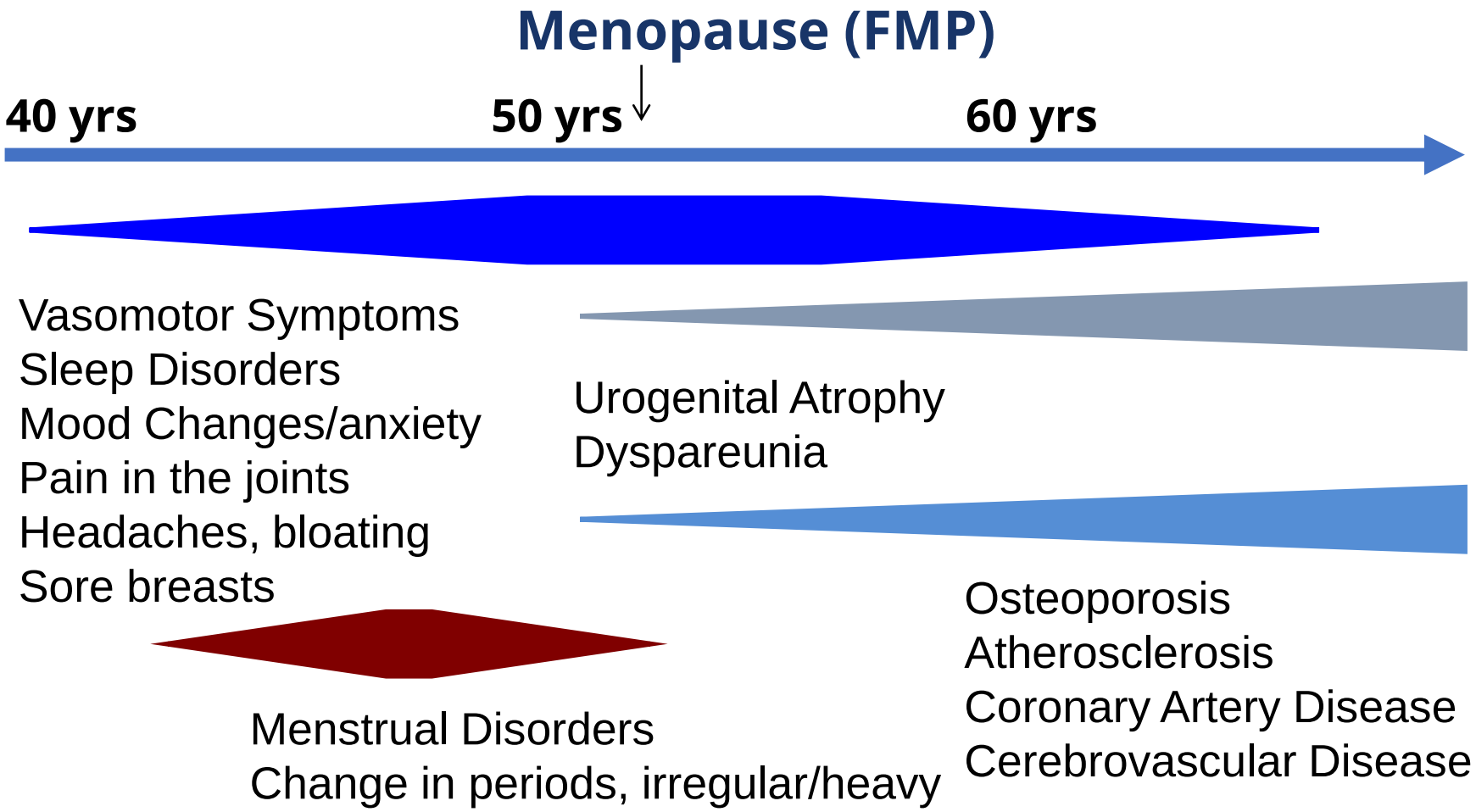
Perimenopause

- Begins when menses are consistently irregular
- Ends 1 year after FMP
- Fluctuating sex hormones and symptoms
- Menses irregular, often heavy and prolonged, eventually cease
- 3-5 years but may be longer

Postmenopause

- The rest of life.
- Starts 1 year after FMP
- Adverse effects on bone, CVD and mental health

Signs and symptoms during the menopause transition



Source: Bungay GT, Vessey MP, McPherson CK. Study of symptoms in middle life with special reference to the menopause. Br Med J. 1980 Jul 19;281(6234):181-3. van Keep PA. The history and rationale of hormone replacement therapy. Maturitas. 1990 Sep;12(3):163-70. *Bromberger JT, Kravitz HM. Mood and menopause: findings from the Study of Women's Health Across the Nation (SWAN) over 10 years. Obstet Gynecol Clin North Am. 2011 Sep;38(3):609-25.*

Premature Ovarian Insufficiency

- Incidence 3-4:100 by age 40, 1:1000 by age 30
- Due to decreased number of follicles during development or an accelerated rate of follicular loss
- Diagnosis is often delayed: Any woman younger than age 40 with more than 4 months of amenorrhoea or oligomenorrhoea for 6 months should be investigated, initially, with **FSH repeated**, if elevated, **4-6 weeks apart**
- **POI is associated with increased osteoporosis, CHD, cognitive impairment and premature death**
- **Unless contraindicated, treatment should include MHT until at least average age of menopause**

Source: Lambrinoudaki I, Paschou SA, Lumsden MA, Faubion S, Makrakis E, Kalantaridou S, Panay N. Premature ovarian insufficiency: a toolkit for the primary care physician. Climacteric. 2021 Oct;24(5):425-437

Menopause is natural, but symptoms could be debilitating….

20% of women have few symptoms

60% of women have 4 - 8 years of symptoms which diminish quality of life

20% of women experience persistent symptoms into their 60’s and 70’s

How to assess

Menopause and Midlife Appointment Guide

Find Information Videos and Fact Sheets at:
the Australasian Menopause Society-menopause.org.au

CHECKLIST	Y/N	Write your information in blank spaces & WHERE TO FIND MORE INFORMATION
Are you taking regular medications? Please List		
Are you allergic to anything?		
Any significant illnesses or operations?		
Family History of significant illnesses?		
Do you drink alcohol? If yes how much?		
Are you a smoker? How much?		
Have you ever had a DVT or blood clot?		
Is your Cervical Screening (smear) up to date? When did you have it?		National Cervical Screening program https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program
Have you had a mammogram? When was your last?		Breastscreen: free call 132050
When was your last period? Did your period finish before age 45?		Menopause means your last period was over 12 months ago; Perimenopause means you have had one within 12 months
Have you had a bone density		Healthy Bones Australia for information about bone health

https://www.menopause.org.au/images/members/Appointment_guide_Menopause_and_midlife.pdf

How to assess

Medical History

Relevant gyn history
Major medical illnesses

Family History:
Cardio/cerebrovascular disease
Dementia
Cancer

Smoking/alcohol use
Current medications
Social History
Sexual wellbeing

Examination

Height and weight
Blood pressure
Breast exam(if required)

Midlife general health assessment
CST
Mammogram
Lipid profile
FBG
TSH
Renal and liver function
FBE/Ferritin
FOBT
Vit D at-risk women

How to assess

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EMPOWERING MENOPAUSAL WOMEN

SYMPTOM SCORE (Modified Greene Scale)[1]

This symptom score can be used to document symptoms and monitor response to treatments. It should NOT be used to diagnose perimenopause or menopause.

Perimenopause commences when menstrual cycle changes occur, with differences in length of consecutive cycles.

Menstrual cycle changes cannot be used to diagnose perimenopause or menopause for people using hormonal contraception, or who have had an endometrial ablation or hysterectomy.

	Score before MHT	3 months after starting MHT	6 months after starting MHT
Hot flushes			
Light headed feelings			
Headaches			
Brain fog			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			

<u>Score</u>
Mild: one
Moderate: two
Severe: three

https://www.menopause.org.au/images/members/Appointment_guide_Menopause_and_midlife.pdf

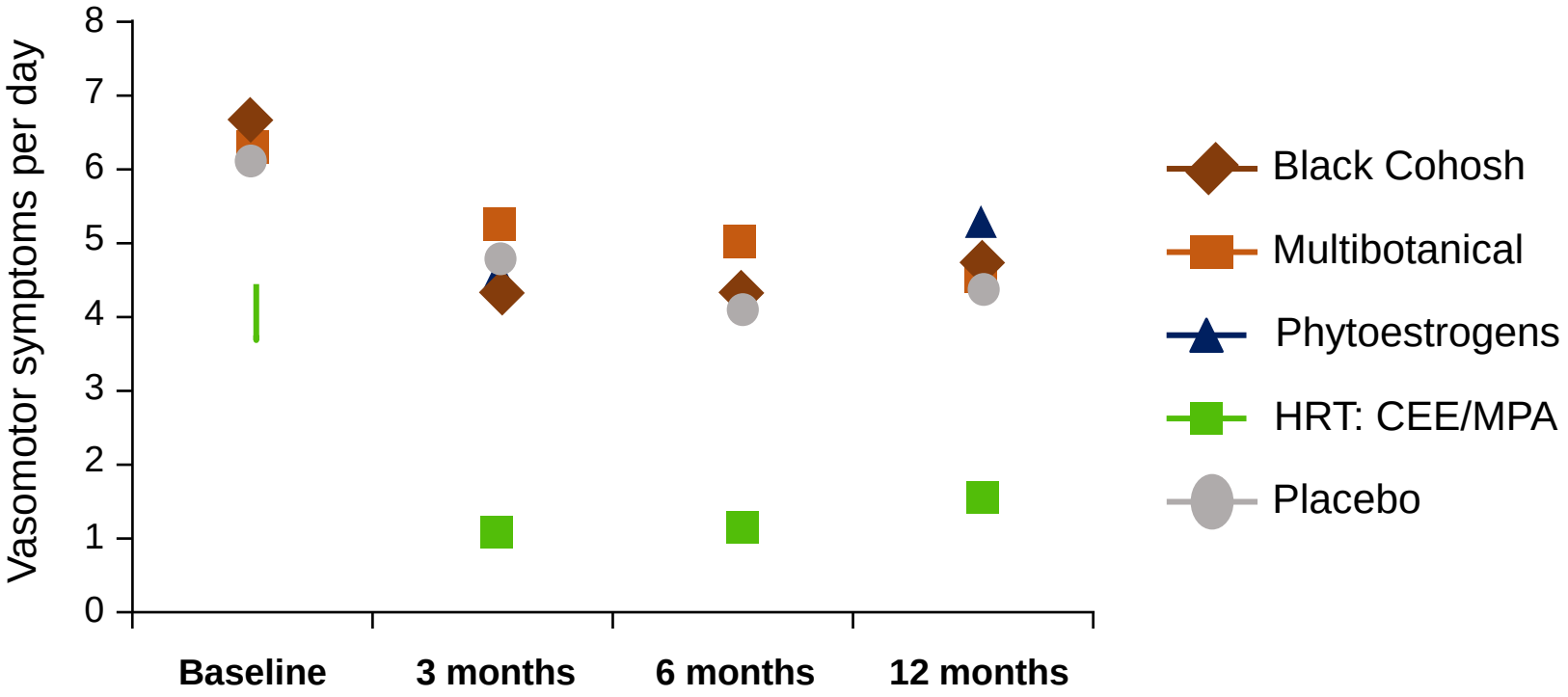
Why use MHT?

- The principal indication for the use of MHT is alleviation of troublesome VMS
- MHT is the most effective treatment for menopausal vasomotor symptoms
- MHT reduces the risk of postmenopausal osteoporosis and related fractures
- MHT (topical or systemic) is effective in alleviating symptoms of VVA / GSM
- MHT should always be accompanied by appropriate life-style advice
- MHT is not for every woman and a range of other therapies including CBT, hypnosis, non-hormonal prescription meds are available to assist when MHT is not used
- Complementary therapies are, mostly, no better than placebo

Source: de Villiers TJ, Hall JE, Pinkerton JV, Cerdas Pérez S, Rees M, Yang C, Pierroz DD. Revised Global Consensus Statement on Menopausal Hormone Therapy. Climacteric. 2016 Aug;19(4)

Benefits of MHT:

The principal indication for the use of MHT is alleviation of troublesome vasomotor symptoms
MHT should be part of an overall strategy to improve the health of midlife women

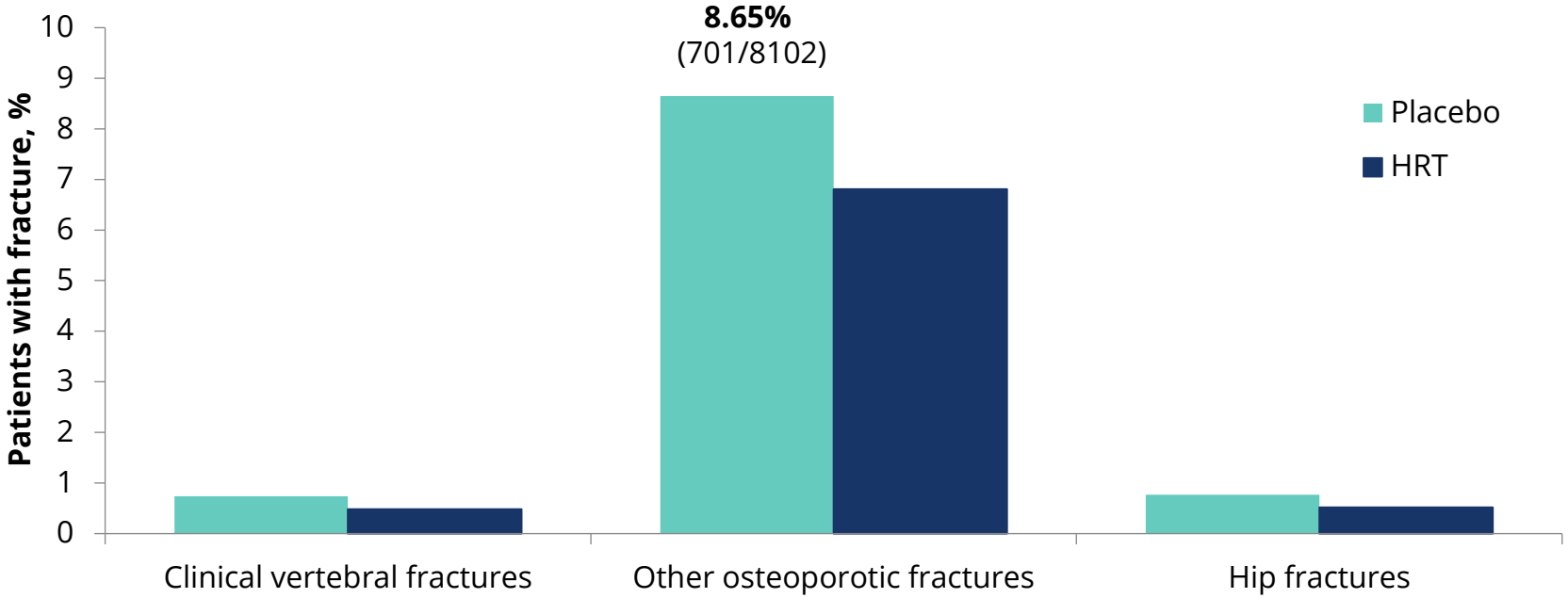


- No significant effect of botanicals on VMS.
- In a Cochrane Systematic Review MHT reduced the frequency and severity of VMS by 87%
- OR 0.13 (0.07,0.23)

Source: Newton KM, Reed SD, LaCroix AZ, Grothaus LC, Ehrlich K, Guiltinan J. Treatment of vasomotor symptoms of menopause with black cohosh, multibotanicals, soy, hormone therapy, or placebo: a randomized trial. Ann Intern Med. 2006 Dec 19;145(12):869-79. Rowe I, Baber R. Climacteric 2021; 24:57-63. MacLennan A H et al. Maclennan AH, Broadbent JL, Lester S, Moore V. Oral oestrogen and combined oestrogen/progestogen therapy versus placebo for hot flushes. Cochrane Database Syst Rev. 2004 Oct 18;2004(4)

Benefits of MHT: Fracture reduction in WHI RCT

MHT prevents bone loss and lowers the risk of hip, vertebral and other osteoporotic fractures in post-menopausal women
MHT for fracture prevention is a secondary indication in Australia



Source: Rossouw JE et al. JAMA 2002;288:321–33. Pinkerton J et al. Climacteric 2016;19:313-315

Cardiovascular benefits of MHT

Cardiovascular disease increases after menopause

MHT used within 10 years of FMP has been shown not to increase the risk of cardiovascular disease

MHT is currently not recommended for primary or secondary prevention of CVD.

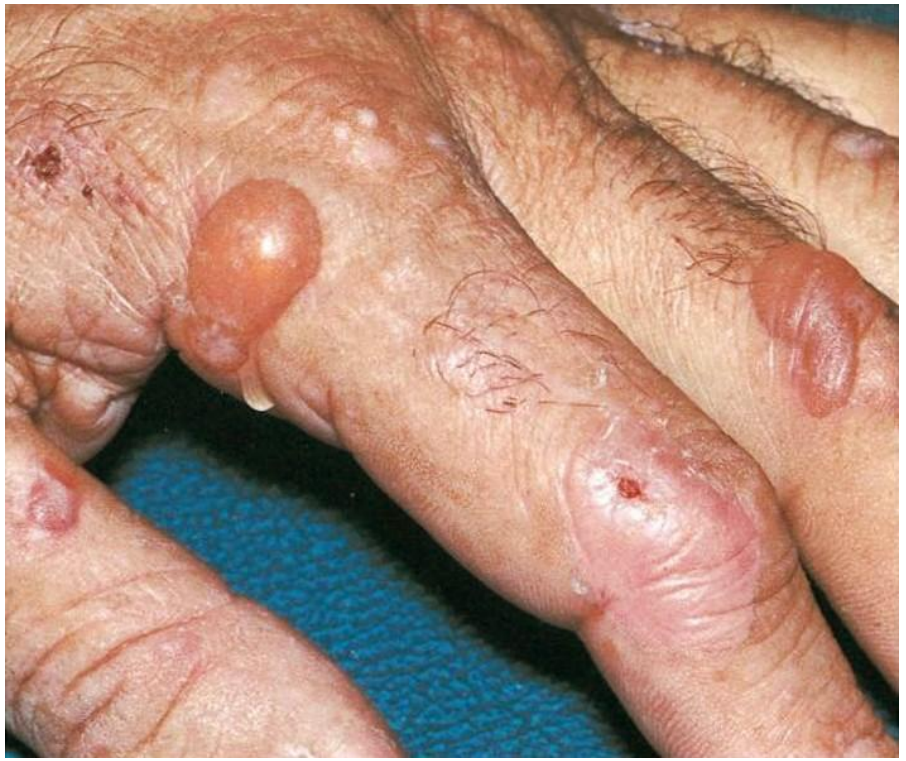
Source: Global Consensus Statement on MHT De Villiers T et al. Climacteric 2016;19:313-5

Contraindications & Precautions for MHT

- Undiagnosed PV Bleeding
- Estrogen-dependent cancers
- Active thromboembolic disease
- Porpyhria cutanea tarda
- Active myocardial infarction
- Active severe liver disease

Use with caution

- Gallbladder disease, hypertriglycerideamia, DM
- Past MI, stroke or TIA, hepatobiliary disease
- High risk of breast cancer
- Migraine with aura
- Age over 65 and no prior MHT



Source: Davis SR, Baber RJ. Treating menopause - MHT and beyond. Nat Rev Endocrinol. 2022 Aug;18(8)

MHT Risks?

MHT Risks

SHORT TERM:

- Vaginal bleeding and spotting
- Fluid retention, bloating
    - These are dose-related and may be minimised by starting with a low dose

MHT long-term risks

- **Thromboembolic risk**

  Increased by oral estrogens.

- **Cardiovascular risk**

  related to age.

- **Endometrial Cancer**

  Risk increased by unopposed estrogens or an inadequate dose of progestogen.

- **Breast Cancer**

  Risk may be increased by the addition of a progestogen and perhaps by duration of use.

Treating Perimenopausal women

Combined Oral Contraceptive----------→

First exclude contraindications, regulates cycles, controls HMB and contraceptive, alleviates VMS

LnG–IUCD + Estrogen----------→

Effective treatment for HMB and contraceptive, will not regulate menstrual cycle
May make moods worse (Progestin effect)

Sequential MHT ----------→

Several pre-formulated combined sequential options available, oral or transdermal.
Or: Rx transdermal estradiol plus progesterone 200mg for 12-14 days /cycle.

Try to 'match' the cycle to minimise spotting and unplanned bleeding. Change to continuous combined after 1 year of regular withdrawal bleeds. NOT contraceptive

Jane F, Davis SR Climacteric 2013;15

Prescribing MHT: Different Clinical Scenarios

Clinical Presentation	Management options
Post Hysterectomy	Estrogen only [tibolone not contraindicated]
Within 12 months of LMP	Sequential MHT, Combined OC, Lng IUS+ estrogen
Contraception required	Barriers (safe sex), COC, Lng IUS, Bilateral Salpingectomy
Low risk women	Both oral and transdermal route of delivery should be offered based on patient preferences and risk assessment.
Higher risk women e.g. older, smokers, diabetics, obese, prior VTE, hypertensive, migraines	Discuss measures to minimize pre-existing risks. Discuss with other care givers. Transdermal delivery, micronized progesterone, lowest dose

Genitourinary Syndrome of the Menopause (GSM)
previously vulvovaginal atrophy (VVA)

- Vaginal dryness, dyspareunia and urinary symptoms
- Affects at least 50% of women. Due to low E2 and changes in vaginal flora & pH
- Non hormonal moisturisers and lubricants are widely used despite limited evidence of efficacy. Should be first line in breast cancer patients
- Topical hormonal options where symptoms are confined to lower genital tract
- Women on MHT may still need topical therapy
- Ovestin cream (1mg estriol per G); Vagifem tablets (10ug estradiol)
- Progestogens are not required when used according to directions
- Vaginal DHEA ovules (Prasterone) 6.5mg daily
- Vaginal laser therapy - insufficient long-term data available

Source: NAMS 2020 position statement on GSM Menopause 2020;27:976-992Li F.G et al JAMA 2021;326:1381-1389

Bleeding in women using MHT

- Women taking continuous combined MHT will commonly bleed during the first 6 months of therapy.
- **Bleeding after that time must be investigated.**
- Women taking sequential MHT should bleed around the end of the progestogen phase.
- **Bleeding that is out of cycle, too long or too heavy must be investigated.**

- Endometrial thickness on TV Ultrasound should be 5mm or less.
- Office biopsy may be inaccurate in cases where pathology occupies less than 50% of cavity.
- When biopsy is inadequate or when bleeding persists or recurs Hysteroscopy is mandatory.

Source: Brand AH Australian family Physician 2007.

Is it wrong to prescribe MHT after age 60 ?

- IMS Guidelines say ‘no reason to place mandatory limits on duration of MHT… whether or not to continue should be decided at the discretion of the well-informed woman and her HCP depending on the specific goals and objective estimation of ongoing risks and benefits’.

- Global Consensus Statement says ‘duration of treatment should be consistent with treatment goals and the benefit : risk profile of individual women. This should be reviewed annually.’

- North American Menopause Society (NAMS) says ‘periodic assessment of the need for ongoing use of MHT should be individualized on the basis of the woman’s symptoms, general health and underlying risks and personal preferences.

Baber R et al Climacteric 2016 , DeVilliers T et al Climacteric 2016, NAMS position statement. Menopause 2022

Practice tip: Continuing MHT

- The principal indication for the use of MHT is alleviation of vasomotor symptoms.
- Benefits on musculoskeletal health, cardiac health and quality of life are acknowledged.
- The need to continue MHT should be assessed annually, taking into account persistence of symptoms and individual risks and benefits.
- Formal calculation of risk of cardiovascular disease, metabolic disease and cancer may be helpful and should be considered for all women as they age.

- ***There is no mandatory stopping time for menopausal hormone therapy although dose and regimen may require modification.***

Baber R et al Climacteric 2016 , DeVilliers T et al Climacteric 2016, NAMS position statement. Menopause 2022

When to consider non-hormonal treatments for menopausal symptoms?

When to consider non-hormonal treatments?

Personal history of breast cancer

- Even estrogen receptor negative

Medical history

- Previous VTE
- Severe liver disease
- Acute cardiovascular event
- Undiagnosed PV bleed

Relative contraindications

- Age over 65
- High risk breast cancer
- High risk of CVD
- Personal preference

Source: Eeles, RA et al, JCO Dec 2015, Hickey et al 2012, Chelebowski et al 2015 Davis SR, Baber RJ Nature Reviews 2022

How effective are non-hormonal treatments?

Less effective than medium dose estrogen for vasomotor symptoms

Average 40-60% reduction compared to MHT around 80%

- Less effective for genitourinary symptoms
- Do not prevent bone loss
- Less likely to cause vaginal bleeding or breast tenderness
- May improve mood and sleep

Source: Hickey et al, 2017

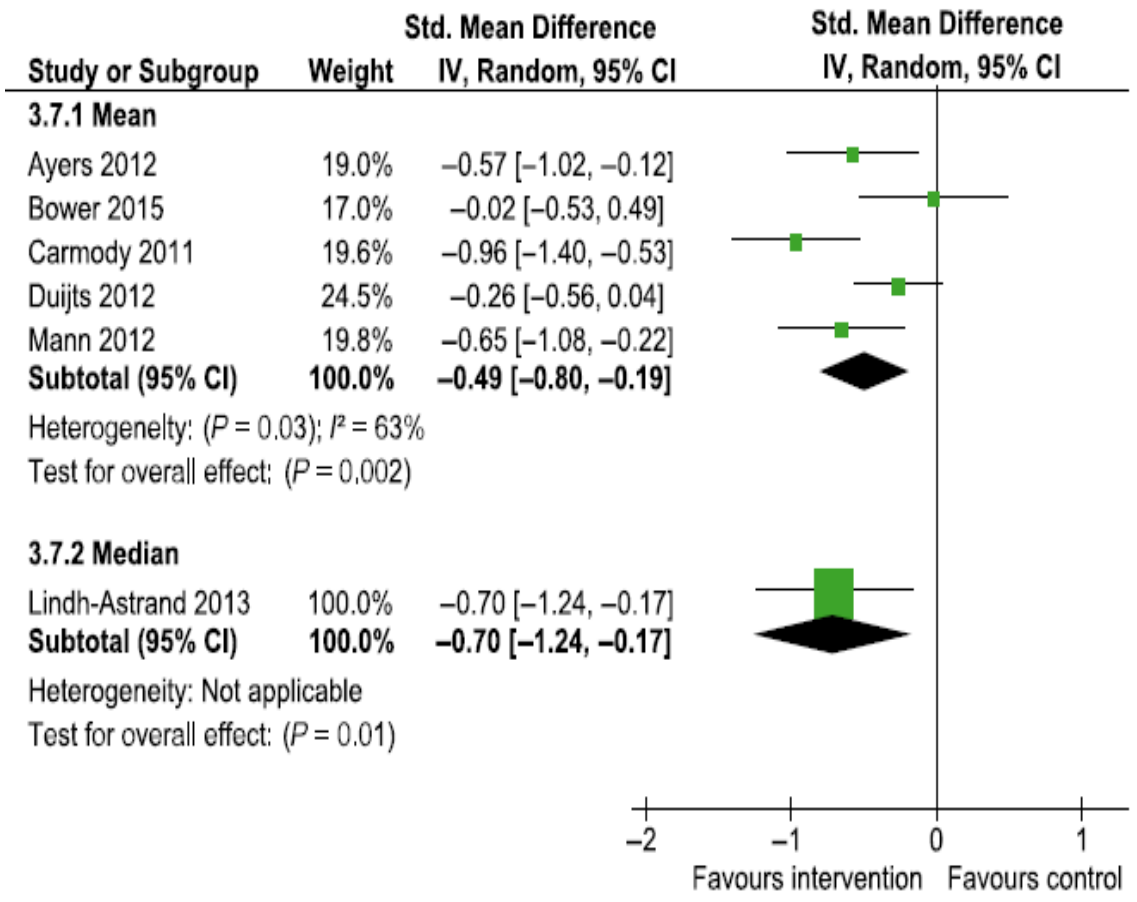
Cognitive behaviour therapy

CBT reduces the 'bother' of VMS in:

- Healthy symptomatic women
- After breast cancer
- Working women

"Side effects" include improved mood, less anxiety, improved sleep and improved sexual function

Recommended in international guidelines

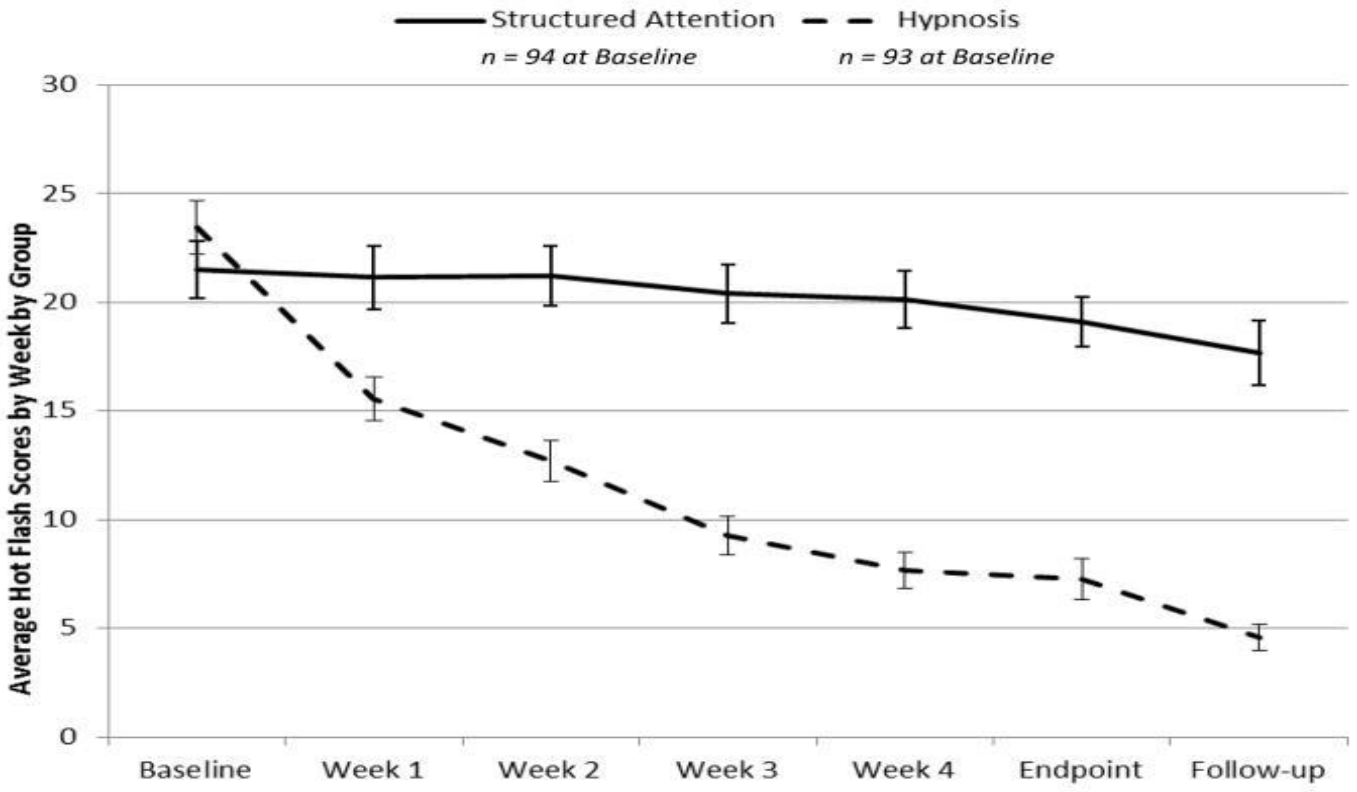


Source: Spector A et al. J Affective Disorders 2024;352:460-472, Mann et al, 2012, Hunter et al, 2016, Green et al, 2019, Van Driel et al, 2018

Hypnosis

187 women, single blind RCT, 12 weeks duration, 5 sessions per week

- Reduced frequency of VMS by 74% vs. 17% for controls
- Physiologically measured VMS reduced by 57% (vs 10% controls)
- May also be effective in women treated for breast cancer



Source: Elkins G et al Menopause 2013;20:291-8

Pharmacotherapy for vasomotor symptoms

Pharmacotherapy	Dose/day	Reduction in hot flush frequency compared with baseline	Additional Benefits	Adverse Effects
SSRI				
Citalopram	10-20mg	**43-50%**	Decreased anxiety	Drowsiness, dry mouth, palpitations
Escitalopram	10-20mg	**50-60%**	Improved QOL and sleep	Sexual dysfunction, dry mouth, GIT upset
Paroxetine	10-20mg	**40-60%**	Improved sleep	Sexual dysfunction, dry mouth, GIT upset – **avoid in tamoxifen users**
SNRI				
Venlafaxine (ER)	37.5mg-75mg	**22-66%**	Improved sleep, QOL & mood	Sexual dysfunction, dry mouth, GIT upset
Desvenlafaxine	100-150mg	**64%**	Reduced night time awakenings	Sexual dysfunction, dry mouth, GIT upset

Source: Witten T et al DOI :10.7759/cureus.52467, Madsen T et al Int J Womens health 2023;15:825-836, NAMS Position statement Menopause 2023;30:573-590

Pharmacotherapy for vasomotor symptoms

Pharmacotherapy	Dose/day	Reduction in hot flush frequency compared with baseline	Additional Benefits	Adverse Effects
Anticonvulsants & centrally acting agents				
Gabapentin	300-900mg in divided doses	**44-80%**	Improved QOL & sleep, reduced pain	Dizziness, drowsiness, weight gain
Pregabalin	150-300mg in divided doses	**60%**		Dizziness, drowsiness, weight gain
Clonidine	0.1-0.15mg	**26-49%**	Improved QOL	Dry mouth, tiredness, sleep disturbance
Other agents				
Oxybutynin	2.5mg bd	**70%**	Reduces urinary urgency	anti-cholinergic effects e.g. dry mouth. C/I in women with glaucoma
Neurokinin receptor antagonist Fezolinetant	45mg daily	**60% reduction in frequency and severity**	Nil	Abdominal disorders 3-4% Raised LFT 4-5% C/I with CYP1A2 inhibitors

Source: Witten T et al DOI :10.7759/cureus.52467, Madsen T et al Int J Womens health 2023;15:825-836, NAMS Position statement Menopause 2023;30:573-590

Shortages of MHT: AMS website

https://www.menopause.org.au/about-ams/news/mht-discontinuation-and-shortages-may-2025

HOME | ABOUT AMS | MEMBERS | HEALTH PROFESSIONALS | CONSUMER INFORMATION | WORKPLACES

Home · About AMS · News · Menopausal Hormone Therapy (MHT) discontinuation and shortages May 2025

Menopausal Hormone Therapy (MHT) discontinuation and shortages May 2025

Australia

Patch Shortages

There are a number of MHTs that are currently unavailable. Please note that the TGA has approved some unregistered products under Section 19A and some substitute doses are currently in supply in Australia. Pharmacists are encouraged to contact suppliers Medsurge Healthcare Pty Ltd on 1300 788 261 for orders of Estramon and Sandoz on 1800 726 369 for orders of Estradiol Transdermal System.

Oestradiol patches

	Availability and expected supply due		Alternative supply under Section 19A	
Dose	Estradot	Estraderm	Estramon	Estradiol Transdermal System
25 mcg	Unavailable - 31 Dec 2025	Available	Available	
37.5 mcg	Unavailable - 30 Jun		Unavailable	Available

Due to manufacturing issues and unexpected increase in demand

Shortages of MHT- TGA website

Pharmaceutical companies Sandoz and Juno Pharmaceuticals have notified us of shortages of their estradiol and combination estradiol/norethisterone (norethindrone) transdermal patch products. These medicines are used as hormone replacement therapy (HRT) in the management of perimenopause and menopause.

The shortages, which are due to manufacturing issues and an unexpected increase in demand, are affecting multiple brands as follows:

Product	Estimated return to normal supply
Estradot 25	31 December 2025
Estradot 37.5	30 June 2025
Estradot 50	31 December 2025
Estradot 75	31 December 2025
Estradot 100	31 December 2025
Estraderm MX 25	Shortage resolved
Estraderm MX 50	Shortage resolved
Estraderm MX 75	30 June 2025
Estraderm MX 100	Shortage resolved
Estalis Sequi 50/140	30 June 2025
Estalis Sequi 50/250	30 June 2025
Estalis Continuous 50/140	30 June 2025
Estalis Continuous 50/250	21 July 2025

Serious Scarcity Substitution Instrument SSSI- allows dispensing alternative brand/strength without new prescription

Available preparations

AMS Guide to MHT/HRT Doses

AUSTRALIA ONLY

This Information Sheet has been developed as a guideline only to MHT/HRT products available in Australia in November 2024. Hormone Replacement Therapy (HRT) is now referred to as Menopausal Hormone Therapy (MHT). The intention of this sheet is to help clinicians change their patients to higher or lower approximate doses of MHT if needing to tailor therapy, or remain within the same approximate dose if needing to change brands of MHT. Private/non-PBS script products are marked with an * .

CYCLIC MENOPAUSAL HORMONE THERAPY (MHT)

Use continuous oestrogen and cyclic progestogen combinations at peri-menopause or if less than 12 months amenorrhoea

PRODUCT	PRESENTATION	COMPOSITION
Low Dose		
Femoston	Tablet	1mg oestradiol/10mg dydrogesterone
Estrogel Pro	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle
Medium dose		
Trisequens*	Tablet	1 and 2mg oestradiol hemihydrate/1mg norethisterone acetate
Femoston	Tablet	2mg oestradiol/10mg dydrogesterone
Estalis sequi 50/140)	Transdermal patch	50mcg 17β oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis sequi 50/250 (same oestrogen, more progestogen than Estalis sequi 50/140)	Transdermal patch	50mcg 17β oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules	2 pumps (1.5mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle

Available preparations

CONTINUOUS COMBINED MENOPAUSAL HORMONE THERAPY (MHT)

Should be used if 12 months since LMP or after 12 months cyclical MHT

PRODUCT	PRESENTATION	COMPOSITION
LOW DOSE		
Angeliq1/2*	Tablet	1mg oestradiol hemihydrate/2mg drospirenone
Femoston-conti*	Tablet	1mg oestradiol/5mg dydrogesterone
Kliovance*	Tablet	1mg oestradiol hemihydrate/0.5mg norethistrone
Bijuva*	Capsule	1mg oestradiol/100mg micronised progesterone
Estrogel Pro	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol hemihydrate) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle[1]
OTHER LOW DOSE HORMONAL OPTIONS		
Livial*, Xyvion*	Tablet	2.5mg tibolone
Duavive* (oestrogen/ SERM combination)	Tablet	0.45mg conjugated equine oestrogens / 20mg bazedoxifene acetate
MEDIUM DOSE		
Kliogest*	Tablet	2mg oestradiol hemihydrate/1mg norethistrone
Estalis continuous 50/140	Transdermal patch	50mcg 17β oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis continuous 50/250 (same oestrogen, more progestogen than Estalis continuous 50/140)	Transdermal patch	50mcg 17β oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol hemihydrate) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle[1]

[1]Can be given daily if adherence is an issue

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www.menopause.org.au

Available preparations

OESTROGEN ONLY THERAPY:

Only use these if patient has had a hysterectomy or in combination with a progestogen or Mirena if intact uterus

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Estrofem*	Tablet	1mg oestradiol hemihydrate
Progynova	Tablet	1mg oestradiol valerate
Premarin*	Tablet	0.3mg conjugated equine oestrogens
Estradot 25, 37.5	Transdermal patch	25mcg or 37.5mcg oestradiol (twice weekly application)
Estraderm 25 MX	Transdermal patch	25mcg oestradiol hemihydrate (twice weekly application)
Estrogel	Gel	0.75mg oestradiol hemihydrate = 1 pump daily
Sandrena	Gel	0.5mg oestradiol daily
MEDIUM DOSE		
Estrofem*, Zumenon	Tablet	2mg oestradiol hemihydrate
Progynova	Tablet	2mg oestradiol
Premarin*	Tablet	0.625mg conjugated equine oestrogens
Estradot 50	Transdermal patch	50mcg oestradiol (twice weekly application)
Estraderm 50 MX	Transdermal patch	50mcg oestradiol hemihydrate (twice weekly application)
Sandrena	Gel	1mg oestradiol daily
Estrogel	Gel	1.5mg oestradiol hemihydrate = 2 pumps daily
HIGH DOSE		
Estradot 75, 100	Transdermal patch	75 or 100mcg oestradiol (twice weekly application)
Estraderm 75, 100 MX	Transdermal patch	75 or 100mcg oestradiol hemihydrate (twice weekly application)
Sandrena	Gel	1.5mg oestradiol = 1mg + 0.5mg sachets daily
Estrogel	Gel	2.25mg oestradiol hemihydrate = 3 pumps daily or 3.0mg oestradiol = 4 pumps daily

VAGINAL THERAPY

If prescribing vaginal oestrogen rather than systemic hormone therapy, a progestogen is not required.

PRODUCT	PRESENTATION	COMPOSITION
Ovestin	Cream	0.5mg oestriol = 1 application; daily for first 14 days, then twice weekly ongoing
Ovestin	Pessary	0.5mg oestriol; daily for first 14 days, then twice weekly ongoing
Vagifem Low	Pessary	10mcg oestradiol hemihydrate; daily for first 14 days, then twice weekly ongoing
Intrarosa*	Pessary	6.5mg dehydroepiandrosterone (DHEA) daily (prasterone)

PBS listing

Effective March 1st 2025, the following three MHT brands are listed on the PBS

Estrogel® Pro (estradiol / micronised progesterone)

Estrogel® (estradiol)

Prometrium® (micronised progesterone)

All products are available for 60 day prescriptions

Gynaecology clinic at Nepean Hospital- referrals for menopause management, initiation or review of MHT in various clinical scenarios /POI/ BTB with HRT

Agency for Clinical Innovation
The Menopause Initiative

Aim: To provide escalation pathways for people experiencing **severe and/or complex** menopause & perimenopause symptoms and access to specialist menopause MDT care.

4x Hubs in NSW:

- Northern Sydney LHD
- South Eastern Sydney LHD
- Hunter New England LHD
- **South Western Sydney LHD**
    - **Nepean Blue Mountains LHD**
    - Western NSW LHD
    - Murrumbidgee LHD

NSW GOVERNMENT

Nepean Blue Mountains Local Health District

Specialist Menopause Service

NBMLHD Specialist Menopause Service

'The Hub' located at SWSLHD

- Medical Team
  - Gynaecologist
  - Endocrinologist
  - Hematologist
  - Psychiatrist
- Clinical Nurse Consultant
- Allied health
  - Physiotherapist x2
  - Dietitian
  - Clinical Psychologist – TBA

Cluster sites

- NBMLHD Coordinators:
  - Physiotherapist
  - Clinical Nurse Consultant
- MLHD- Murrumbridgee
  - 1x Coordinator
- WNSWLHD
  - 1x Coordinator

NSW GOVERNMENT

Nepean Blue Mountains Local Health District

Specialist Menopause Service

Patient Journey

Referral: GP, Specialist, Family Planning, Nurse Practitioner, Nurses, AMS, Allied Health & self-referral

- How: phone or email: nbmlhd-menopause@health.nsw.gov.au
- Patient contacted by coordinator & triaged

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Initial assessment booked (hybrid service)

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Referral to Allied Health e.g. Pelvic Health Physio (part of service) dietitian, psychology etc

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Client discussed at weekly MDT

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Patient is accepted for care by Specialists at SWSLHD

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Referral Criteria

Eligibility criteria Referral MUST meet one or more of the following criteria and reside within NBMLHD to be accepted by the Specialist Menopause Team			
☐	Is client's menopause onset under age 40?	☐	Has client undergone or currently undergoing cancer treatments?
☐	Is client at increased risk of VTE or has a history of stroke or CV disease?	☐	Is client at genetic risk of breast or gynaecological malignancies?
☐	Does client have a high risk of fracture or history of minimal trauma fracture?	☐	Has client been unresponsive to Menopause Hormone Therapy over a 6-week period with GP follow up?
☐	Does client suffer from Migraine with aura?	☐	Does this client have complex health issues making commencement of MHT difficult?

NB: Referral form is on Health Pathways and links to GP software

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Contact Information

Get in contact

For more information contact our Menopause Referral Service Coordinators

Phone: 0456 625 150 or 0437 176 764

Email: nbmlhd-menopause@health.nsw.gov.au

Referral form:

- Located on NBM Service directory web page
- Located on Health Pathways

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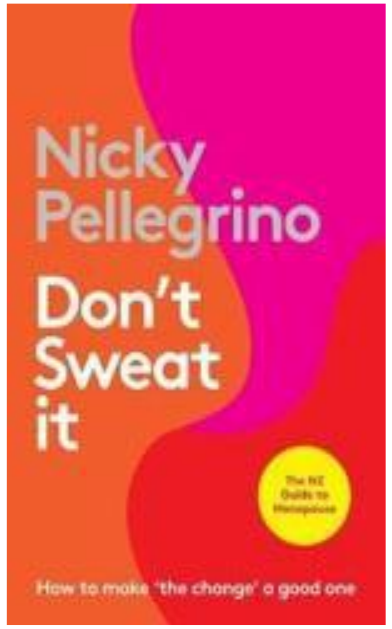
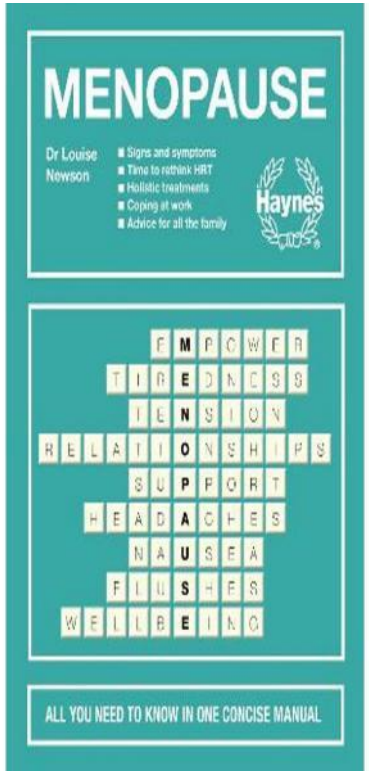
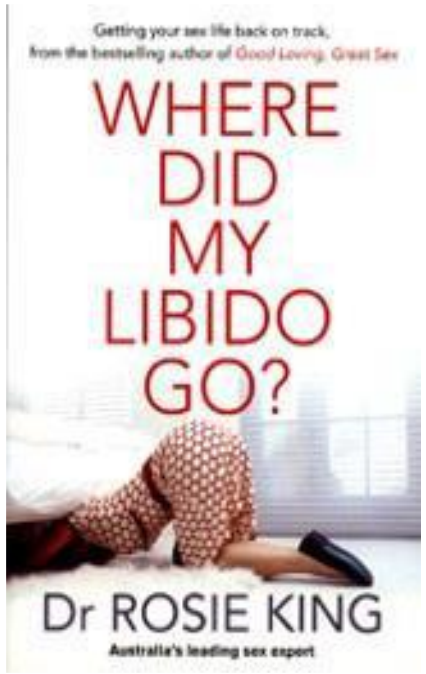
Take Home Messages

- Always start with a low-dose regimen and titrate up as necessary.
- The principal indication for prescribing MHT is the alleviation of vasomotor symptoms.
- MHT has additional benefits for QoL, mental health, bone and cardiovascular health.
- Risks are few and may be minimised by using the lowest effective dose of body-identical estradiol and progesterone.
- The need to continue treatment should be reviewed annually, but there is no mandatory stopping time.
- Choice of intervention will depend on each woman's medical history, concurrent illness, symptoms and preferences.







Resources:

AUSTRALASIAN MENOPAUSE SOCIETY
EMPOWERING MENOPAUSAL WOMEN

www.menopause.org.au/

Jean Hailes for Women's Health

www.jeanhailes.org.au/health-a-z/menopause

MONASH University

https://www.monash.edu/__data/assets/pdf_file/0011/3476072/menopause-toolkit-update.pdf