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NICE guideline – Menopause: diagnosis and management

Alternatives to hormone replacement therapy (HRT) (Sections 1 and 8)

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Introduction

Therapies offered for menopause-related symptoms include hormone replacement therapy (HRT), lifestyle advice, complementary and alternative treatments, and prescribed non-hormonal medicines. An internet survey run by www.menopausematters.co.uk in 2015 identified that 76% of women would choose alternative therapies because they consider them more natural and because of worries about safety of HRT. Women from a lower socio-economic class are less likely to use HRT. This summary deals with the recommendations from the new NICE guidelines in respect to all non-HRT alternative options.

Assess prior to starting treatment

- An individualised approach should be adopted at all stages (1.3.1, 4.1.1), and information given in ways that help women to discuss their needs. (1.3.10, 7.8.9)
- Menopausal women should be offered an explanation of the stages of the menopause. (1.3.7)
- They should know that as well as expecting a change in their menstrual cycle they might experience symptoms such as hot flushes and night sweats (vasomotor symptoms), muscle aches and pains, mood changes, vaginal dryness and sexual difficulties. (1.3.8)
- Many women will decide that no treatment is necessary as vasomotor symptoms (VMS) may resolve naturally, some do not wish to take hormones and for others HRT is contraindicated. (8.2.1.1)
- Herbal treatments, isoflavones and bioidentical hormones do not come under the regulations of the European Medicine Authority. Very few are subject to any quality control, there is lack of standardisation of strength and dose, and no requirement for evidence of effectiveness or regulation of side effects reporting. (8.2.1.1)
- Decisions about care should be made by women together with their healthcare professionals. (4)
- They should be told about lifestyle changes that would help their general health, and about the long-term health effects of the menopause. (1.3.7, 7.8.7)
- It is important to provide information about the different treatments for menopausal symptoms for those women who do not wish to take HRT (1.3.9, 7.7.2), and the benefits and risks of those treatments. (1.3.7)
- Treatment should be adapted as needed based on changing symptoms. (1.3.13)
- Women about to have medical or surgical treatment which will precipitate menopause should be advised what to expect before their treatment and should be referred to a health care professional with expertise in menopause. (1.3.12. 7.8.12)
- Similarly, menopausal women with or at high risk of breast cancer should be offered information on the different treatments available and 'offered referral to a healthcare professional with expertise in menopause'.[1] (1.3.25)

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How were the different treatment options evaluated?

A network meta-analysis (NMA) permits direct and indirect comparisons of different treatments. The NMA compared no treatment (placebo), acupuncture, sham acupuncture, estrogen plus progestogen, non-oral estrogen plus progestogen, oral Tibolone, Raloxifene, Isoflavones, Chinese herbal medicine, Black Cohosh, multi-botanicals and acupuncture, SSRIs and SNRIs. Some comparisons were directly pair-wise.

Non-hormonal prescribed treatments

- Women with a uterus with VMS had no benefit from SSRIs or SNRIs and were significantly less likely to continue compared with other treatments (specifically HRT). The group therefore discourage SSRIs and 'SNRIs as first line treatment for relief of VMS for women in menopause'.[1] (8.2.15)
- 20 mg of Citalopram was helpful in 'reducing anxiety at six weeks but no such effect was found for the other dosages of Citalopram'.[1] (8.2.5.2.6)
- Sertraline and Gabapentin were no better than no treatment in reducing low mood and anxiety. (8.2.5.2.6)

Over-the-counter alternatives

- There is a range of vaginal moisturisers and lubricants available (8.3) whose clinical effectiveness and safety were not reviewed by the CBG but they are considered safe. (8.3.7.2)
- Isoflavones and Black Cohosh had some effect on VMS when compared to no treatment but non-oral oestradiol plus progestogen had significantly greater effect. 8.2.5.1. All outcomes from Isoflavones and Black Cohosh as well as for multi-botanicals and Chinese herbal medicine are subject to caution. (8.2.5.1, 8.2.7.2)
- Similarly there was no significant difference in benefit for women with anxiety or low mood who received Black Cohosh and Estrogen plus Progestogen. (MPA)
- 'None of the herbal treatments (Ginseng, Black Cohosh, Black Cohosh plus St John's Wort, St John's Wort, Pycogneal)',[1] was any better than no treatment in reducing anxiety or poor mood.
- Promensil, Genistein, Remastril and 120 mg of Soy Isoflavones for 12 weeks were no better for anxiety than no treatment. (8.2.5.2.5)
- Genistein and Red Clover did reduce anxiety in menopausal women compared with placebo in two random controlled trials. (8.2.5.2.5)
- The GDG advise that women who try complementary therapies should be aware that because 'quality, purity and constituents of products may be unknown',[1] these treatments may not be safe. They should be aware of the traditional herbal registration schemes which have the appropriate registration certificates.
- Bioidentical formulations that are compounded are not considered safe, they are not subject to government regulations.

Non-pharmaceutical alternative/ complementary therapies

- Acupuncture compared with sham acupuncture found no benefit in mood changes. 8.2.5.2.5
- Cognitive behavioural therapy (CBT) is significantly more effective at reducing anxiety and low mood at 26 weeks follow-up, than what is termed 'usual care'. 8.2.5.2.7 (moderate quality evidence with 88 women)
- Low mood can be improved both by hormone replacement therapy and psychological therapy such as CBT but not by the other non-pharmacological treatments. (8.2.7.2)

Women at a high risk or history of breast cancer

- Moderate quality but sparse evidence was available when considering VMS in women with breast cancer. (8.2.5.1)
- Women with breast cancer or at a high risk of breast cancer should be referred for treatment to a menopause expert in order to provide information on all treatment options in accordance with NICE guidelines 1.13 on the early and advanced breast cancer and section 1.7 of NICE guidance on familial breast cancer.[2]
- SSRI, SNRI, Gabapentin, Isoflavones and St John's Wort were considered for women with breast cancer with VMS. None of these treatments was found to be any better than no treatment ('although St John's Wort had the highest probability of being the best treatment'.[1] (8.2.7.2)
- There are concerns about the 'interaction of St John's Wort with other drugs used commonly to treat breast cancer'[1] (specifically tamoxifen) and a there is a recommendation that we raise awareness of interactions with these drugs. (8.2.7.2)
- Paroxetine and Fluoxetine should not be offered if women are taking Tamoxifen.

Research recommendation

- Women with breast cancer might be able to use systemic HRT which if found to be so in research situations would offset the cost of SSRI, SNRI, Gabapentin and Clonidine. (8.2.9)
- Research recommendations are made to look at alternatives to systemic HRT for symptomatic women who have had breast cancer. (8.2.9)

Key points

Give information to women about hormonal, non-hormonal and non-pharmaceutical treatments.

Non-hormonal prescribed treatments

- Do not offer routinely SSRI/SNRIs or Clonidine for VMS.
- There is no evidence that SSRIs or SNRIs improve low mood in menopausal women who do not have a depressive illness. (1.3.19, 8.2.19)
- Unregulated compounded bioidentical hormones have no evidence of safety or effectiveness. (1.3.21 8.2.8.21)

Over-the-counter alternatives

- 'Moisturisers and lubricants can be used alone or in addition to vaginal estrogen'.[1] (8.3.2.30)
- Isoflavones and Black Cohosh may improve hot flushes and improve anxiety but there are concerns about safety, efficacy and purity. (1.3.16, 8.2.8.16)
- Similar concerns exist for the quality and purity of complementary therapies. (1.3.22, 8.2.22)

Non-pharmaceutical alternative/complementary therapies

- Menopausal low mood or anxiety can be treated with CBT. (8.2.8.18, 8.2.8.17, 1.3.18)

Women at high risk or history of breast cancer

- Women with breast cancer or at a high risk of breast cancer should be referred to a menopause expert who can discuss all treatment options as recommended by the NICE guidelines 1.13 on the early and locally advanced breast cancer[3] and section 1.7 of NICE guidance on familial breast cancer.[2] (8.2.8.24, 8.2.8.25)
- Although St John's Wort may be of benefit in relieving hot flushes, there are serious 'interactions with other drugs (including tamoxifen, anticoagulants and anticonvulsants),[1] and uncertainty over dosage, and strength. (1.3.23, 8.2.25)
- Women with breast cancer who are taking Tamoxifen should not be prescribed Paroxetine or Fluoxetine. (8.2.8.25)

Author's note

Many women choose to take alternative therapies for control of menopausal symptoms. This guideline did not have a scoping remit to specifically address alternative and non-hormonal treatments, and there is no chapter devoted to their use. In particular, while there is widespread use of drugs such as selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs) by healthcare professionals providing menopause care, this guideline identifies that there is a lack of evidence of safety and efficacy for many commonly used therapies. That there is common usage of such medications is assumed by those guideline recommendations which avoid or discourage their use.

Declaration of conflicting interests

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Provenance

Commissioned; internally reviewed.

References

1. National Institute for Health and Care Excellence; Menopause; Clinical Guideline – methods, evidence and recommendations (NG23), version 1.5, www.nice.org.uk/guidance/ng23/evidence/full-guideline-559549261 (accessed 12 November 2015).
2. National Institute for Health and Care Excellence; Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer (CG164), June 2013, section 1.7.10–1.7.15, www.nice.org.uk/guidance/cg164 (accessed 21 April 2016).
3. National Institute for Health and Care Excellence. Early and locally advanced breast cancer: diagnosis and treatment (CG80), February 2009, section 1.13, www.nice.org.uk/guidance/cg80/evidence/full-guideline-242201629 (accessed 21 April 2016).