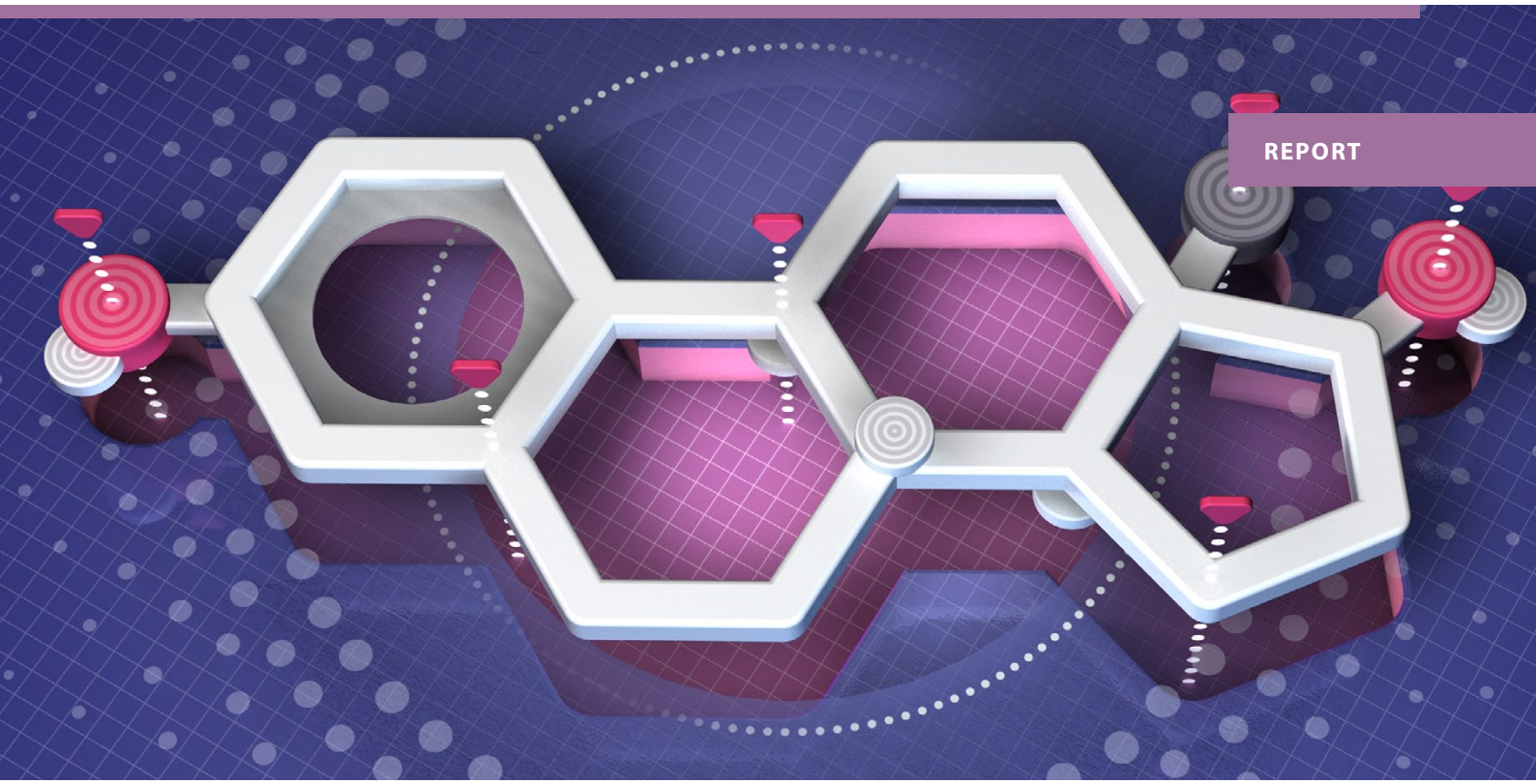


National report: **Prescribing menopausal hormone therapy**

KEY PRACTICE POINTS:

- In the 12 months from July, 2018, to June, 2019, dispensing rates of menopausal hormone therapy (MHT) nationally were highest in women aged 50–59 years (5% of this age group), followed by those aged 40–49 years (3.5%) and 60–69 years (2%). Dispensing rates were lowest in women aged ≥ 70 years (< 1%).
  - Women of European ethnicity were approximately 1.5 times more likely to be dispensed MHT than Māori women and approximately twice as likely as Pacific or Asian women
  - Transdermal estradiol was dispensed at a rate of five to seven times higher than oral estradiol, irrespective of ethnicity
- MHT is the most effective treatment for the vasomotor symptoms and urogenital atrophy associated with menopause, but given that treatment is not without risk, e.g. breast cancer, venous thromboembolism and stroke, it should only be used if symptoms are affecting a woman's quality of life
- The benefit-risk ratio for MHT to treat menopause symptoms is most favourable for women aged < 60 years or within ten years of menopause
- Review treatment annually, taking into account any changes in the patient's risk factors, adverse effects and extent of benefit

Overview of MHT

Menopausal hormone therapy (MHT) is the most effective treatment for the vasomotor symptoms (i.e. hot flushes and night sweats) and urogenital atrophy associated with menopause, and may also reduce other symptoms, e.g. mood changes, sleep disturbances and changes in libido.[1] Adverse outcomes associated with MHT include breast cancer, stroke and venous thromboembolism (VTE).[2] The risk of these outcomes depends on factors such as the age or time since menopause when MHT is initiated, MHT type, dose, duration of use,* route of administration, and whether a progestogen is used.[2] For women initiating treatment aged < 60 years or within ten years of menopause, MHT is likely to provide overall benefit if they have symptoms affecting their quality of life, provided they have no contraindications to treatment.[2]

* Stroke and VTE risk do not appear to be affected by duration of treatment, but are influenced by woman's age.[2]

MHT prescribing in primary care

This report provides an overview of MHT prescribing in New Zealand by presenting the national dispensing data. Personalised data have not been included because a considerable number of prescribers and practices have only small numbers of patients dispensed MHT. In the 12 months

from July, 2018, to June, 2019, 22% of practices and 66% of prescribers had fewer than ten patients dispensed MHT; 1242 prescribers had no dispensing data for MHT. Having a small number of patients dispensed a medicine can result in marked differences between the personalised data and comparator or national data when it is extrapolated to a rate per 1000 patients, making meaningful interpretation of the data difficult.

If you are a prescriber consider how you prescribe MHT, if at all. Points for reflection are available at the end of the report, along with a clinical audit.

MHT dispensing by age

Dispensing data shows that 5% of women in New Zealand aged 50–59 years received MHT in the 12 months from July, 2018, to June, 2019 (Figure 1). Women aged 40–49 years (3.5%) had the next highest dispensing rate, followed by women aged 60–69 years (2%). Dispensing rates were lowest in women aged ≥ 70 years (0.9%).

Most women reach the age of natural menopause between 45–55 years, with the average around age 50 years.[3] Symptoms last for an average of approximately seven years, however, some women may have symptoms for more than ten years.[3] The pattern of MHT dispensing nationally, i.e. highest in women aged 50–59 years (the group who are most likely to be experiencing symptoms) and lowest in those aged > 70 years, reflects this. MHT dispensed to women aged 40–49 years may include those with primary ovarian insufficiency* (i.e. loss of ovarian function before age 40 years) or who have undergone menopause early (age 40–45 years).

* High-dose MHT is recommended in these women until the age of natural menopause to alleviate symptoms and reduce the risk of long-term consequences associated with oestrogen deficiency, e.g. fracture, cardiovascular disease and premature mortality.[2]

The benefit-risk ratio is less favourable when initiating MHT in women aged > 60 years due to the greater absolute risks of stroke, VTE and dementia.[2] However, MHT initiated at a younger age may be continued beyond age > 60 years if it is beneficial and no new contraindications or significant risk factors develop.[2]

MHT dispensing by ethnicity

Most women close to the age of menopause in New Zealand report they have menopausal symptoms when asked, but little data is available on preferred treatment approaches or ethnic or cultural differences. National dispensing data shows that women of European/Other ethnicity were 1.6 times more likely to receive MHT than Māori women and 2.2 times and 2.3 times as likely as Pacific and Asian women, respectively (Figure 2).

Interpreting these data are difficult as the ideal level of prescribing is not known. The age of menopause is similar for Māori and non-Māori women, therefore, this is unlikely to explain the difference in dispensing rates.[4] Possible explanations for these differences include:

- Variability in how menopause is perceived across cultures, e.g. some cultures may not medicalise menopause
- Cultural differences in the acceptability of hormonal treatment
- Accessibility and affordability of healthcare services
- Inadvertent disparity in care, e.g. by not asking all women if they are experiencing symptoms

All women who are near the age of menopause should be asked routinely if they have any symptoms and if these are affecting their quality of life. If so, non-pharmacological and pharmacological interventions (non-hormonal and hormonal) should be discussed as appropriate.

Figure 1. Number of female patients (per 1,000 registered female patients) who were dispensed MHT from community pharmacies in New Zealand in the 12 months from July, 2018 to June, 2019, by age.

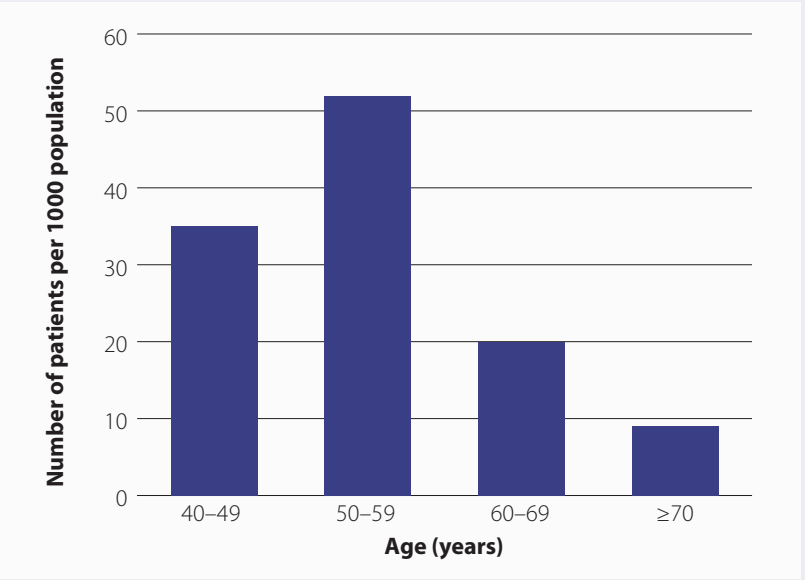
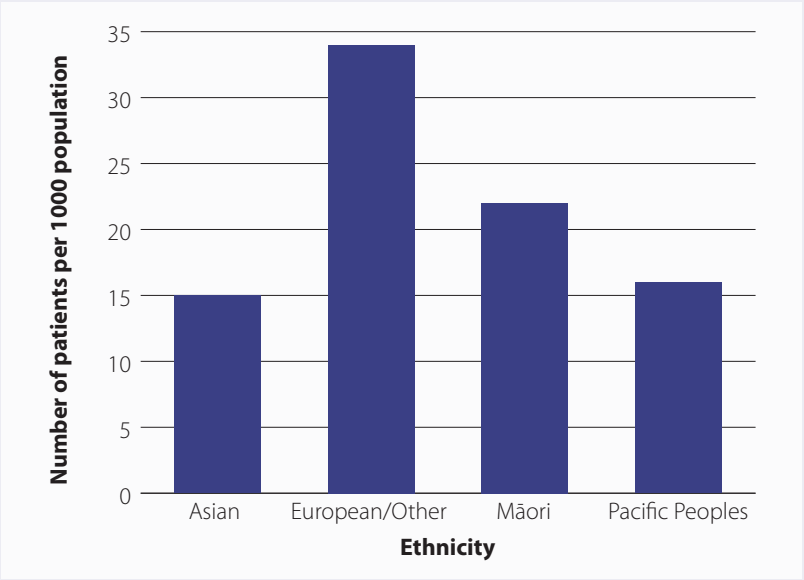


Figure 2. Number of female patients (per 1,000 registered female patients) aged ≥ 40 years who were dispensed MHT from community pharmacies in New Zealand in the 12 months from July, 2018 to June, 2019, by ethnicity.



What MHT regimens are being used?

Women prescribed MHT who have a uterus must take progestogen* in addition to oestrogen to avoid an increased risk of endometrial hyperplasia and cancer. Women who have had a hysterectomy can take oestrogen alone.

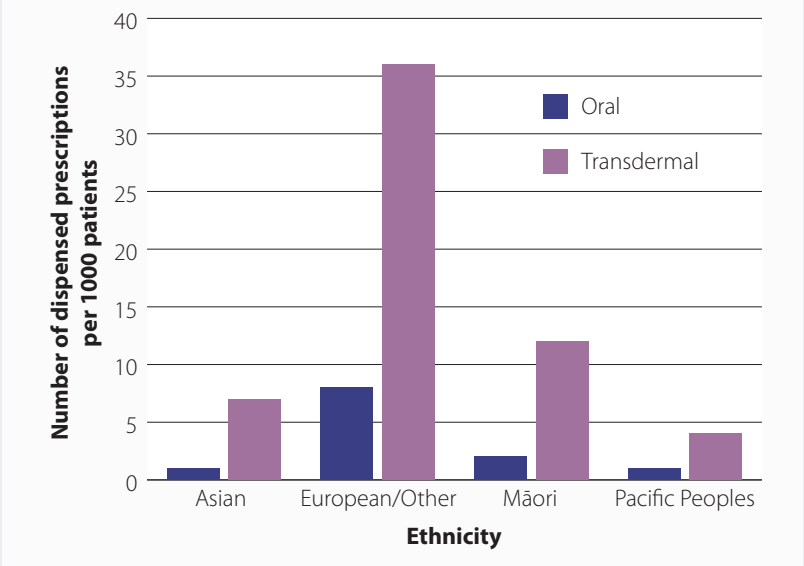
Various MHT formulations, doses and regimens are available. For women who have increased cardiovascular or venous thromboembolism risk, hypertension, type 2 diabetes or obesity, transdermal estradiol is the recommended oestrogen. Transdermal administration avoids first-pass metabolism and results in fewer effects on markers of cardiovascular risk than oral oestrogen, particularly in older women.

* Unless they are taking oestrogen + bazedoxifene (not funded)

Transdermal estradiol is the most commonly dispensed oestrogen

National dispensing data for the 12 months from July, 2018, to June, 2019 shows that transdermal estradiol was preferred to oral estradiol (Figure 3). Despite lower use of MHT in non-European ethnic groups, the proportion receiving transdermal estradiol was similar (five to seven times higher than oral estradiol) across all ethnic groups.

Figure 3. Number of dispensed prescriptions for oral and transdermal estradiol to females aged ≥ 40 years (per 1,000 registered female patients) from community pharmacies in New Zealand in the 12 months from July, 2018 to June, 2019, by ethnicity.



Points for reflection

- Do you routinely ask all women near the age of menopause if they have menopause symptoms and if these are affecting their quality of life? Have you noticed any cultural or ethnic differences in the expression of menopausal symptoms or willingness to seek treatment?
- What non-pharmacological and/or non-hormonal pharmacological treatment options do you recommend to women with menopausal symptoms? Do you find these to be effective?
- The overall dispensing of MHT is low; how comfortable do you feel prescribing MHT? Do you find that women are open to being prescribed MHT or is there still reluctance due to perceived risks?
- What is the typical duration you would prescribe MHT for? Do you carry out an annual risk assessment to determine whether ongoing treatment is indicated?
- Do you prescribe transdermal estradiol first-line? What factors do you consider when choosing an oral versus a transdermal formulation?

A clinical audit of MHT prescribing is available from: **www.bpac.org.nz/audits/mht.aspx**

References

1. Baber RJ, Panay N, Fenton A, et al. 2016 IMS Recommendations on women's midlife health and menopause hormone therapy. Climacteric 2016;19:109–50. doi:10.3109/13697137.2015.1129166
2. North American Menopause Society. The 2017 hormone therapy position statement of The North American Menopause Society. 2017. Available from: https://www.menopause.org/docs/default-source/2017/nams-2017-hormone-therapy-position-statement.pdf (Accessed Nov, 2019).
3. Australasian Menopause Society. What is menopause? 2016. Available from: https://www.menopause.org.au/images/stories/infosheets/docs/AMS_What_is_menopause.pdf (Accessed Nov, 2019).
4. Lawton BA, Rose SB, Cormack DM, et al. The menopause symptom profile of Maori and non-Maori women in New Zealand. Climacteric 2008;11:467–74. doi:10.1080/13697130802351094

This article is available online at: **www.bpac.org.nz/2019/mht-report.aspx**