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HRT
A position statement of a scientific advisory panel to the North American Menopause Society

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HRT Update: 2007

* All women should receive a comprehensive individual assessment of their risk profiles before deciding on HRT, including mammography and bone densitometry, according to clinical guidelines.
* The primary indication of HRT remains the treatment of vasomotor symptoms, and systemic estrogen and combined HRT are approved for this indication for 1-2 years. However it is advisable to use general methods first: good nutrition, exercising, smoking cessation and avoiding warm environment, stress, alcohol, caffeine, and spicy foods.
* The lowest doses of estrogen/ combined HRT and the shortest duration of therapy should be considered. Extended use of the lowest effective dose is acceptable, provided the benefits of relief outweigh the risks
* When estrogen therapy is considered solely for vaginal dryness, topical (not systemic) therapy should be considered first-line therapy.
* Women without a uterus should not be prescribed a progestogen with estrogen, and progestogen is not generally indicated for low-dose estrogen therapy administered locally for vaginal atrophy for a limited period (See BNF).
* There is insufficient evidence regarding the non-licensed use of long-cycle progestogen (eg, every 3 - 6 months for 12 - 14 days) and vaginal administration as an alternative to combined HRT.
* Data do not currently support combined HRT use for secondary Cardiovascular Heart Disease (CHD) prevention. Combined HRT use for primary CHD prevention in relation to timing of menopause needs further evaluation. The available data indicate a reduction in CHD in women 50 to 59 years old who initiate combined HRT within 10 years of menopause, and an increased risk in women who initiate after 10 years.
* The risk for Venous Thrombosis and Embolism (VTE) is highest within 1 to 2 years after initiation of systemic HRT, and VTE risk is estimated at 11 additional cases for combined HRT and 2 additional cases per 10,000 per year for estrogen therapy in women 50 to 59 years old.
* Both estrogen and combined HRT increase stroke risk, with 8 additional strokes for combined HRT and 12 additional cases per 10,000 per year for estrogen therapy.
* Large randomised trials suggest a reduction of diabetes risk with HRT, with a 21% to 35% relative risk reduction (RRR) for combined HRT (15 fewer cases per 10,000 per year) and a 12% RRR (14 fewer cases per 10,000 per year) for estrogen therapy.
* Breast cancer risk is slightly increased with combined HRT use beyond 5 years leading to 4 to 6 additional invasive cases per 10,000 per year.
* Estrogen and combined HRT reduce risk for osteoporotic fractures and should be considered an option for women at high risk for fractures within 5 to 10 year when alternative therapies are contraindicated
* Evidence is insufficient to support the use of estrogen/ combined HRT for depression.
* Initiating combined HRT after age 65 years is not recommended for the primary prevention of dementia or cognitive decline because risk can be increased during the ensuing 5 years.
* Patients on HRT because their ovaries prematurely failed or surgically removed can continue HRT until the age 50
* Women should be very cautious about the use of herbal and natural alternatives to HRT, as there is no scientific proof of their safety.