

# GYNAECOLOGY & OBSTETRICS UPDATE

Website for Doctors [MarkMalak.com](http://MarkMalak.com)

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Author

**Mark Malak**

MB, BCh., M.Sc.,  
Ph.D., DFFP,  
MRCOG, FRCOG

Lead Urogynaecologist  
East Sussex NHS  
Hospitals Trust

Tel: 01323 413735

**HOSPITAL  
DOCTOR**

**AWARD**

1st runner up

**UK best  
Continence Team**

**Eastbourne  
Urogynecology  
Team**

M Malak, A Grimston,  
J Andrews, N Lawton,  
A Spirou, W Fletcher

Integrated management of pelvic floor disorders: Prolapse, urinary incontinence (1ry & recurrent), frequency, urgency and recurrent cystitis

**NHS Clinical  
Excellence  
Award  
2005 2006 2007  
2008 2009  
(achieving the highest  
local Award)**

## “MHT” rather than “HRT”!

A “Position Statement” of the “ American Endocrine Society” has been recently published in the Journal of clinical endocrinology and metabolism (July 2010). The work was led by 12-member of the Scientific Statement Task Force of The Endocrine Society who worked with 25 lead authors and 14 peer reviewers!.

They used the term Menopausal Hormonal Therapy (MHT) rather than Hormone Replacement Therapy (HRT). Although no explanation to using MHT this may have a major impact on avoiding the confusion of using Hormonal Therapy (HT) before and after the menopause. A problem which was highlighted in previous “Update Issues” [*Issue 34, 2004*].

The HT is essential for women before the menopause who had premature menopause (natural or surgical). They need to continue on the HT until the age of menopause (50/51) whatever the duration of the therapy as it is a true Hormone Replacement Therapy (HRT) which is needed due to a premature failure of an endocrine gland. This is similar to other cases of endocrine gland failure or hypofunction e.g. hypothyroidism, etc. The risks associated with HRT use before the age of the menopause is similar to that associated with normally functioning ovaries.

The HT after the menopause i.e. MHT is the therapy that associated with some risks as the level of hormones achieved is higher than what is naturally exist after the menopause. It is not a true replacement therapy and therefore the risks and the benefits should be assessed prior to initiating the MHT [*Issues 54& 92*]. This is contrary to initiating HRT before the menopause due to premature menopause as benefits outweigh the risks except in rare situations e.g. we induce premature menopause in some cases of breast cancer.

The “Position Statement” has included the following advice (for more comprehensive advice on HT please refer to [*Issues 54& 92*].

- "Standard-dose", and for many women lower doses, of MHT is associated with marked reduction in frequency and severity of hot flashes.
  - An alternative MHT for postmenopausal vasomotor symptoms is Tibolone
  - For symptoms of vaginal atrophy, very low doses of vaginal oestradiol are effective.
  - Use of MHT containing oestrogen plus a progestogen is linked to a lower risk for colon cancer.
  - Mammographic density is increased in women taking oestrogen alone or with a progestogen.
  - Use of Tibolone is associated with a greater risk for breast cancer recurrence.
  - Sexual function is improved by physiologic amounts of transdermal testosterone
  - Risk for venothrombotic episodes is approximately doubled in women using MHT, and this risk is multiplicative with baseline risk factors such as age, increased body mass index, thrombophilias, surgery, and immobilization.
  - In older, but not younger, women, Tibolone is associated with an increased risk for stroke.
  - In older women with pre-existing vascular disease, hormone use does not reduce stroke incidence.
  - Tibolone is not associated with an increased incidence of endometrial hyperplasia or carcinoma.
  - Risk for gallbladder disease is increased in women using oestrogen alone or with a progestogen.
- MHT started after age 60 years does not improve memory.

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