Dr AnnaBurrows
medical specialist in gynaecology

MHT (menopausal hormone treatment) and alternatives

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medical specialist in gynaecology

- **MENOPAUSAL HORMONE THERAPY (MHT)**

- This presentation is for a general informative read and should **never** be a substitute for a consultation with your general practitioner or Dr Burrows.

- Much of the information on this document is based upon the best world knowledge, past literature and the latest research from around the globe. I attended the Intenational Menopause Society 19th World Congress – nearly 3000 gynaecologists, endocrinologists, primary health care doctors, scientists and allied health professsionals presented or attended.

THE MENOPAUSE TRANSITION

- Vasomotor
- Irregular Bleeding
- Urinary Incontinence
- Sleep disturbance
- Dyspareunia
- Depression
- Anxiety
- Labile Mood
- Fatigue
- Headache
- Myalgias
- Arthralgias
- Weight gain
- Poor memory
- Dry Skin
- Dry eyes
- Vaginal Dryness
- Thin scalp hair
- Hirsutism

Perimenopause/ Menopausal Transition

MENOPAUSE is a diagnosis made in retrospect after 12 consecutive months without a menstrual bleeding (in the absence of other causes) and is caused by the loss of ovarian function with permanent decline in the reproductive hormones.

THE MENOPAUSE TRANSITION is a major milestone for women and is an adaptive process to lowering hormone levels. Women need time to accommodate lowering of oestrogen levels. Frequently the levels can change abruptly which can be problematic due to individual factors (adaptability, genetic, environmental and psychologic).

EARLY PERIMENOPAUSE commences with clinically silent reduced ovarian reserve with less AMH (antimullerian hormone) and inhibin A. This leads to (1) less restraint on FSH (follicle stimulating hormone) (2) 'rapid cycles', short follicular phases with the follicle containing the egg maturing early before the next menstrual period (3) more frequent menses (4) longer luteal phases and (4) wider hormone fluctuations

LATE MENOPAUSE TRANSITION is when the periods can be 60 -364 days apart, there are long stretches of low oestradiol , failure to produce progesterone due to anovulation (not releasing an egg). THIS LEADS TO ACCELERATED 'TYPICAL' SYMPTOMS (hot flushing, vaginal dryness, mood changes and sleep changes).

Understanding the Perimenopause Journey

Typical menopause symptoms include irregular menses; vasomotor: hot flusing, night sweats; mood; sleep; and weight changes.

Mood: The good news is that this is not a significant predictor of a major depressive illness and it can be managed mainly by addressing the symptoms.

Weight: The metabolic syndrome increases dramatically over the menopause transition. There is a constellation of related factors eg insulin resistance, abdominal obesity, lipids changes and hypertension. The loss of the protective role of oestrogen alters body fat distribution and leads to abdominal obesity.

The good news is that many of these processes have a short curve of worsening then restabilize.

OESTROGEN

- Oral tablet -oestrogen -for symptoms
- Gels or patches (oestrogen absorbed through the skin)
- creams and tablets (oestrogen) placed in the vagina (60-80% improvement for the genitourinary syndrome of menopause)

PROGESTERONE

- a hormonal intrauterine device (IUD)(Mirena). Minimal systemic progesterone effects, a contraceptive for the perimenopause as well as a treatment for bleeding.
- Micronised progesterone (Prometrium) natural- body identical,preferred over androgenic progesterone agents. Better risk profile for coronary disease, venous clotting and breast cancer risk.
- Synthetic androgenic progestogens.

TESTOSTERONE

Androfeme has approval in Australia for hypoactive sexual desire disorder – in other words, decreased libido.

The 19th Annual International Menopause Society IMS World Congress was held in Melbourne, Oct 2024.

The presentations confirmed unequivocal evidence that Androfeme improves female sexual function. Hormone levels confirm accurate safe dosing, and avoids dose related androgenic (male type) side effects.

Anecdotally, there are other benefits, but this requires caution - the literature does not support testosterone for other indications. Large randomized controlled trials found no changes for mood disorders, wellbeing, cognitive (‘brain fog’ – *Climacteric 2023 vol 26),* dementia, muscle mass and bone density over placebo.

INTRAROSA…for the genitourinary syndrome of menopause

INTRAROSA (DHEAS or prasterone) daily insertion, 6.5 mg pessary blister pack was approved by the TGA in 2023. It provides a 40-80% improvement in symptom severity.

DHEAS is produced in the adrenal glands, gonads and brain and is converted intracellularly into active metabolites of estrogens and androgens (male type hormones).

The 19th Annual International Menopause Society World Congress had demonstrated the Canadian extensive experience with Intrarosa. The studies showed a 36% improvement in elastin density (improved elasticity for sexual comfort), 152% increase in nerve ending density to the vaginal mucosa(increased sensation and communication to the brain), improved nitous oxide mediated increase of cGMP responsible for relaxation of smooth muscle vessels – to improve lubrication).

The literature also cofirms improved bladder symptoms- it decreased frequency of bladder uti symptoms, and overactive bladder symptoms.

Daily vaginal administration

This is to treat the genitourinary syndrome of menopause. It is an alternative to vaginal oestrogen.

REF- ***Med Lett Drugs Ther. 2017 (1529. 149-150); Maseroli, El et al Sex Med Rev 2020, 8:379; Mattarazo, 2021 (European J Obs Gynae and reproductive Biology).***

MHT (Menopausal Hormone Treatment) – Some of the benefits include…

MHT/HRT is usually helpful if you experience problems with hot flushes and night sweats. Mood, sleep and sex drive may also improve. Oestrogen with natural progesterone early after the menopause will be protective for cardiac disease. Women can find improvements in joint and muscle aches, vaginal dryness and urine incontinence. There is long term protection of the heart, bones and vaginal mucosa.

MHT - Some of the risks include…

Oestrogen

- Oral (not transdermal) could increase thrombosis (blood clots in the legs or lungs).

Progestogen

- Androgenic progesterone (used rarely) may lead to a slightly increased risk of developing breast cancer.
- Prometrium (body identical) or micronized progesterone is preferred.
- The Mirena intrauterine device is neutral with respect to systemic progesterone effects.

SLEEP DISTURBANCES

POOR SLEEP

- **45% Perimenopausal Women**
- **Increased awakening, poor quality sleep, waking up alert**
- **Insufficent sleep, difficulty falling asleep, waking up early.**
- **Common – In 2024, the National Health and Wellness Survey of 27,621 women across the globe found up to 56% of post-menopausal and up to 60.1% of perimenopausal women reported sleep issues.**

CAUSES

- **Hot Flushes night sweats from menopausal oestrogen loss** (in 2024, Dr Makim, a neuroscientist from Chicago USA showed 78% of women will wake with a night flush, even if not subjectively aware of the flush -
- **Nocturia (waking to pass urine)**
- **Anxiety/Depresson/Mood**
- **Life stressors**
- **Primary Sleep Disorders/ restless leg syndrome/obstructive sleep apnoea/partner disturbance**

SLEEP DISTURBANCES

POOR SLEEP – CONSEQUENCES

Sleep Disturbances, Hot Flusing and Moods are interrelated.

-Depressed Mood is a risk for sleep disturbance & vice versa

-Sleep disturbance is suggested to be a potential mediator of the relationship between hot flusing and mood

-Mood can impact women's experience of menopause – those with depressive symptoms are more likely to report flushing, and negative mood can lead to more severe symptom severity**.**

Poor sleep impacts many aspects of health as well as overall quality of life.

(1)Cognitive, (2) Bone Health (3) immune function (4) metabolic health (5) mental health (6) cardiovascular health (7) dementia risk

Menopause Brain Fog and Sleep

'Constellation of cognitive symptoms experienced by women around the menopause which most frequently manifest in memory and attention difficulties'. (Maki et al, Menopause 2024; 31 – 724-33).

SLEEP DISTURBANCES - Management Strategies

Menopausal Hormone Treament (Oestrogen) has a favourable effects on the Circadian Rhythm **(Citron et al, Endocrine 2017, reprinted IMS 2024)**

- Improved sleep quality
- Improved length of REM sleep
- Improved latency (time from awake to sleep – the lightest of the non –REM sleep)
- Improved sleep quality

Other – Cognitive Behavioural Therapy has been helpful in randomized controlled trials.

Your family doctor or specialist will exclude other conditions- eg thyroid, autoimmune conditions, iron deficiency, stress, sleep apnoea, restless legs, anxiety and depression, reflux, alcohol, caffeine, chronic pain etc.

DEPRESSION

Harvard Study of Moods – depression during the menopausal transition- women entering the perimenopause had a 2 fold increased risk for the first onset of depression or depressive symtoms :

Premenopausal 5.1%, perimenopausal 9.1%, postmenopausal 9.8%

SWAN (Study of Women's Health Across the Nation) – increased psychologic distress

DEPRESSION more likely:

1. Latter phases of perimenopause
2. History of postnatal depression and PMDD
3. Sleep disorders and hot flushes
4. Chronic health conditions
5. Life stressors

DEPRESSION

- Treatment with transdermal oestradiol success -KEEPS (Krono Early Prevention Study) :
- HRT can improve
  1. Depression
  2. Anxiety
  3. Sexual function
- Your gp/ psychiatrist might also consider
- Consider Cognitive behavioural therapies
- SSRI’s (fluoxetine, sertraline, escitalopram, citalopram, vortioxetine)
- SNRI’s (venlafaxine, desvenlafaxine, duloxetine)
- Others –mirtazapine, quetiapine

GENITOURINARY SYNDROME OF MENOPAUSE

Consensus of 2 medical societies ISSWSH (Int society for the Study of Women's Sexual Health) and NAMS(North American Menopause Society).

Effect of sex steroids on the female genitourinary tract, including the vaginal, labia, urethra and bladder.
The term includes vulvovaginal atrophy (VVA), lower urinary tract symptoms and sexual symptoms.
At least 50% of women have symptoms, starting at the perimenopause and progressing after menstural cessation.

HORMONAL

***Vaginal Oestrogen Creams or pessary**

***DHEA**

Intrarosa vaginal pessary

NON-HORMONAL

***Strata MGT – silicone gel (available USA, soon Aus)**

***Olive and Bee or other natural oils/moisturisers**

OSTEOPOROSIS

- Oestrogen deficit results in increased osteoclast activity & bone resorption.

- Bone mass peaks third decade of life; then accelerated loss starts 2 years before menopause and can continue for 2-4 years after cessation of menses

- Oestrogen will reduce fractures by 65% with a statistically proven reduction of RR (relative risk) of fractures: HRT vs placebo
    - RR 0.66 hip fracture
    - RR 0.66 vertebral fracture
    - RR 0.77 fragility fractures any site

- Consider alternatives to HRT if no other indication than primary prevention of osteoporosis (specialist Endocrinology assessment for bisphosphonates, parathyroid hormone, anabolic bone medications).

-Calcium and Vit D;weight bearing and resistance exercises; work on balance and flexibility to avoid falls;moderate alcohol intake and cease smoking.

CARDIOVASCULAR DISEASE

- Accounts for 30.7% of female deaths
- The lifetime risk of dying from ischaemic heart disease is 10 times that of risk of dying from:
  - Breast cancer
  - Reproductive cancer
  - Osteoporotic fracture
- American Heart Association does not recommend HRT to be used for primary prevention of heart disease- but with early menopause –menopausal hormone treatment can protect from cardiovascular disease.
- Observational and randomized studies suggest younger women starting HRT at menopause are **not** at increased risk. T
- Cardiovascular benefits of oestrogen is a vasodilator (to protect from heart disease), increases HDL cholesterol, improves insulin resistance, reduces atheroma formation
- KEEPS Study 2012;DOPS Study 2012 (BMJ);Elite Study 2014 (younger women attenuation carotid intima-media thickness)

BREAST CANCER

- Oestrogen may promote **pre-existing** breast cancer – it is unknown if it will induce the growth of **new** cancers.
- Prometrium (modern progesterone which is body identical) is preferred to the older prescribing of androgenic progesterone.

Book with breast screen QLD

before and while taking MHT

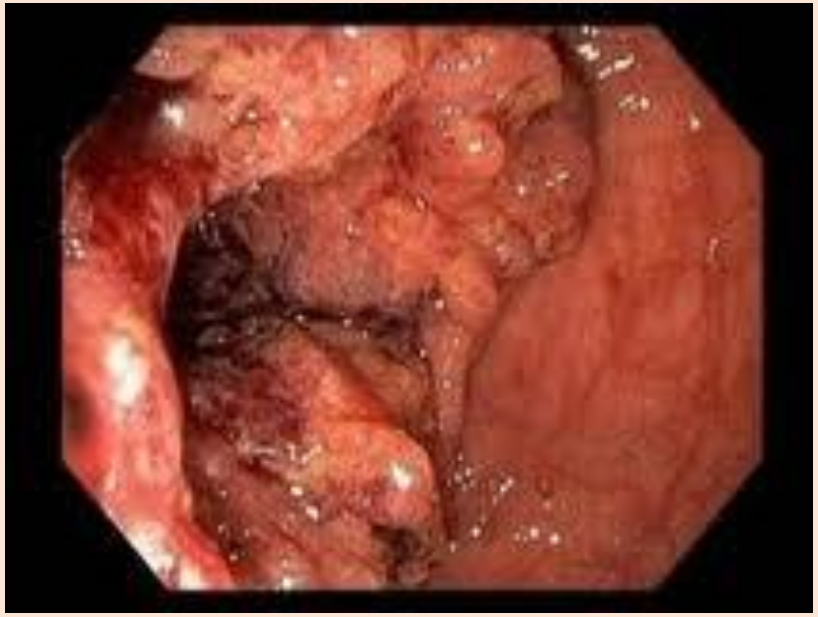
https://www.breastscreen.qld.gov.au

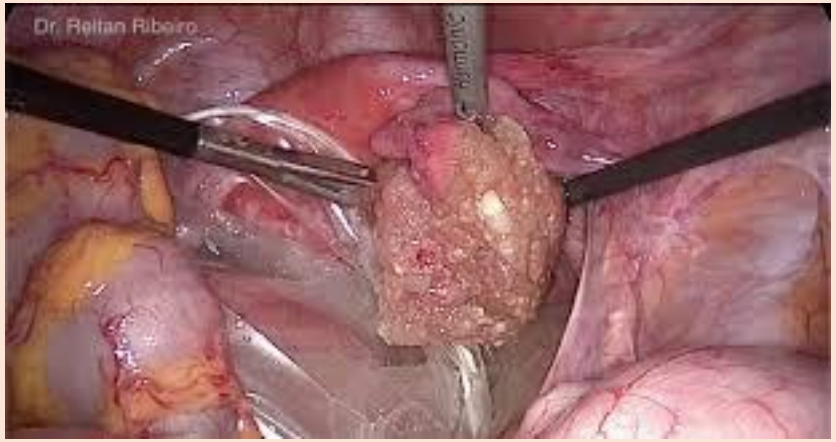
BREAST CANCER

- No randomized studies to evaluate different progestogens
- BRAC 1 and 2
  - Prophylactic oophorectomy
  - HRT improves quality of life
  - HRT does not increase risk of genetically determined breast cancer
- History of breast cancer avoid HRT
- Family history (first degree relative with pre-menopausal breast cancer)
  - HRT will not increase the risk

OVARY / COLON CANCER

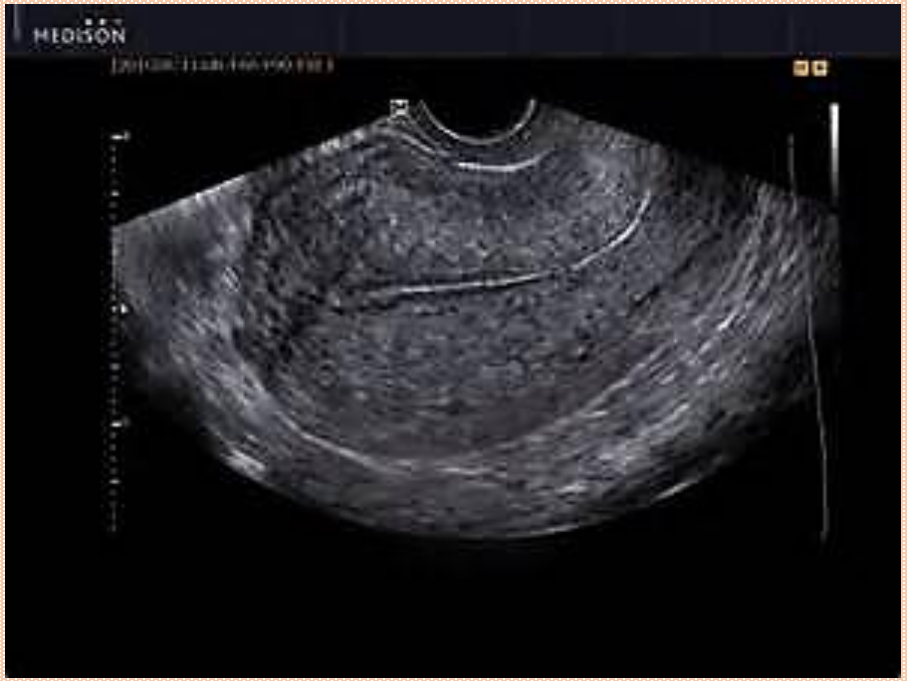
No consistent risk with HRT has been demonstrated



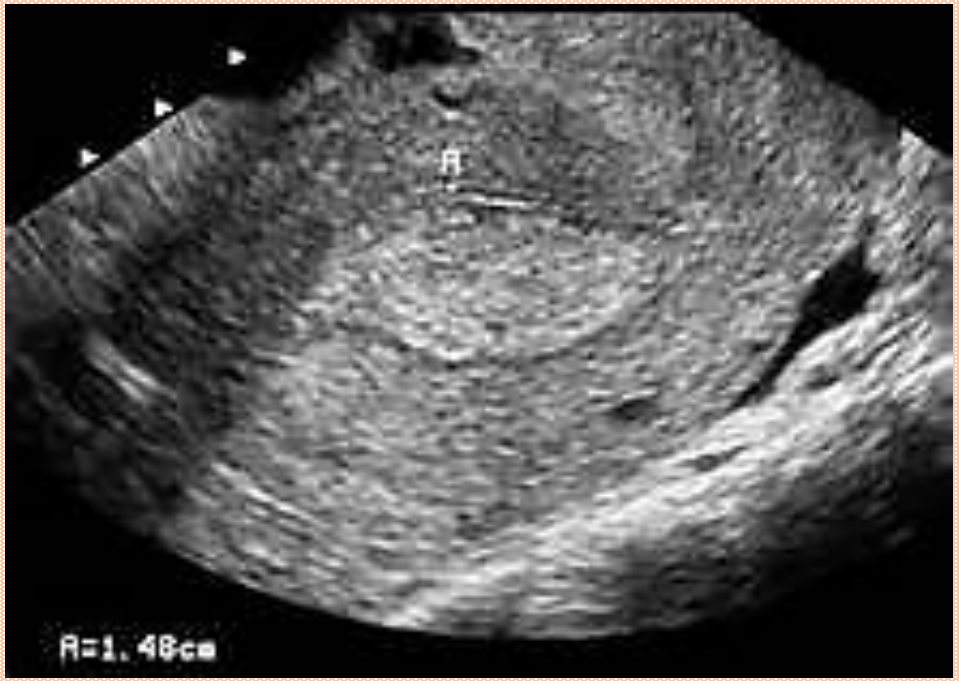


ENDOMETRIAL CANCER

The lining should be suppressed (thin). Any thickening of the lining or bleeding must be investigated.
Dr Burrows will discuss your circumstances and ways to take hormones in a safe manner.
This is the main reason why progesterone is added to oestrogen regimes in women with a uterus on hormone therapy.



THIN ENDOMETRIUM



ABNORMAL ENDOMETRIUM

NEUROLOGICAL FUNCTION

VASCULAR DEMENTIA

- Endostage repetitive minor or major vascular incidents in diseased vessels – leading to repetitive minor or major thrombosis or haemorrhage in brain vessels – leading to loss of neurons and ultimately dementia

ALZHEIMERS DISEASE

- Loss of neurons due to toxicity of amyloid and Ptau accumulation – leads to repetitive damage of susceptibe brain neurons-leading to dementia

The effects of hormones on cognitive function varies enormously between trials with inconsistent outcomes. It is agreed that early treatment with menopausal hormones is protective due to the vasodilatory effect of oestrogen.

Nerattini (*Frontiers in neuroscience 2023)* reviewed hormones on 21 065 treated and 20 997 placebo patients).

- **Oestrogen use in midlife is associated with a 32% reduced risk of Alzheimers and oestrogen use in late life has a smaller reduced risk.**
- **Combined oestrogen progesterone use in midlife leads to a non-statistically significant risk reduction . Commencing combined MHT in late life leads to a non-statistically significant risk increase.**

- **NEUROLOGICAL FUNCTION (dementia), ALZEHIMER'S DISEASE**

- **<u>How oestogen works on the brain</u>**
  - Synaptic plasticity –Oestrogen stimulates an increase of dendritic synapses in hippocampus
  - Free radicals - Oestrogen provides neuroprotection against oxidative stress by antioxidant effect
  - Cholinergic Neurotranmitter system –Oestrogen stimulate the enzyme that produces acetylcholine (a neurotransmitter important for memory functions and whose levels are reduced in Alzheimers)
  - Cellular maintenance and survival-Oestrogen enhances the survival of neurons via modulation of neurotrophins (growth factors responsible for survival and maintenance of neurons
  - Amyloid beta protein – is decreased by oestrogen to protect against amyoid mediate cell death
  - Tau protein – estrogen prevents hyperphosphorylation of this protein which would have caused decreased neurofibrillary tangles.
- (*Depypere H et al, Maturitas 2016 – BELGIUM)*

VENOUS THROMBOEMBOLISM

- Evidence demonstrates ORAL oestrogen can increase the

risk of a venous clot (deep venous thrombosis) which can

travel eg to the lungs and cause a potentially serious pulmonary embolism.

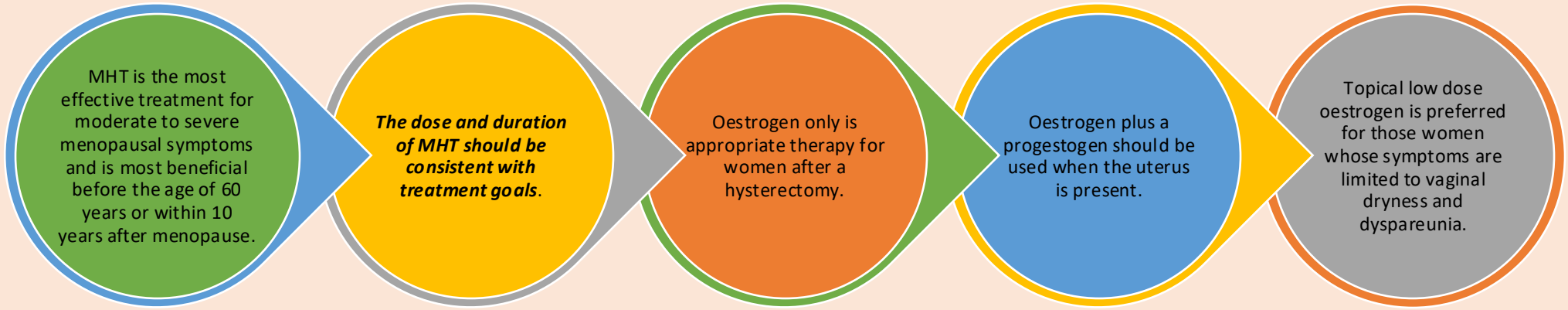
- National Collaborating Centre for Women's and Children's Health concluded Guidelines:

1. Oral HRT increases VTE risk and can occur immediately
2. Risk increases substantially with age, immobilization, surgery, family history etc
3. Risk discontinues when HRT stopped

SAFEST OPTION IS TO AVOID ORAL OESTROGEN and use TRANSDERMAL (SKIN)

TRANSDERMAL GELS or PATCHES don't significantly increase this risk

MENOPAUSAL HORMONE THERAPY



IMS Recommendations. Baber et al Climacteric ;19: 109-150

Global Consensus Statement. De Villiers et al Climacteric 19:313-315)

Global Consensus Statement

RCT and observational data provide strong evidence that oestrogen only MHT may decrease coronary disease and all-cause mortality in women younger than 60 years of age and within 10 years of menopause

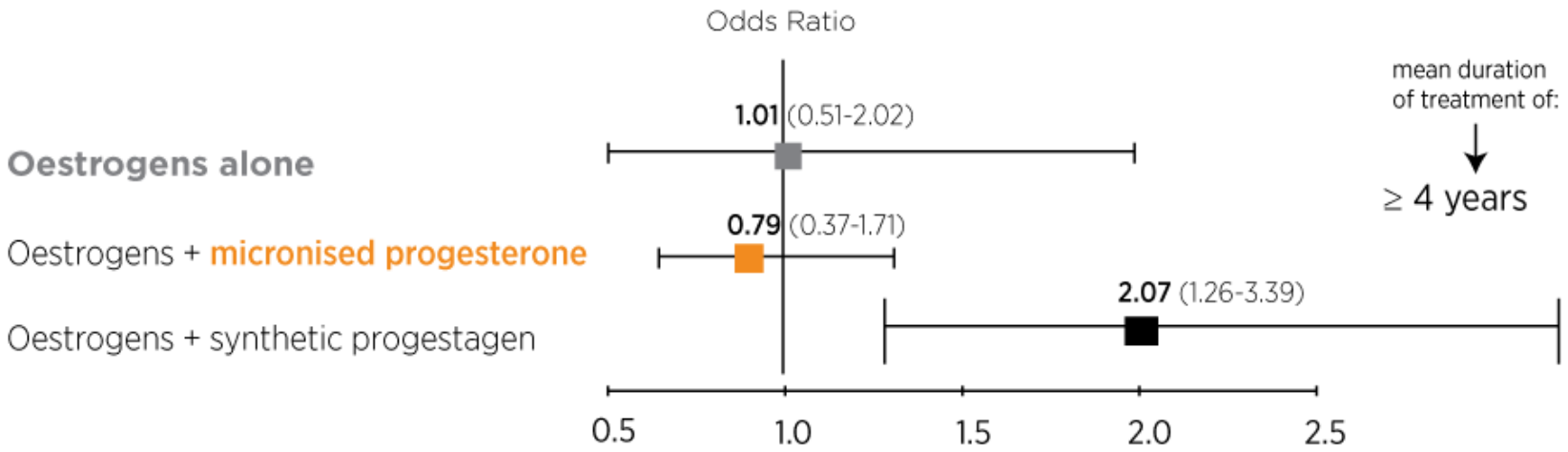
The risk of breast cancer in women over 50 years associated with MHT is a complex issue but *is primarily associated with the addition of a progestogen to estrogen therapy and to the duration of use*

(Global Consensus Statement. De Villiers et al Climacteric 2016;19:313-315)

UPDATE ON THE USE OF Micronised Progesterone: Hormone Replacement

Breast Cancer Risk and HRT – CECILE Study

Odds ratios for breast cancer among current users of menopausal hormone therapy with treatment duration ≥4 years

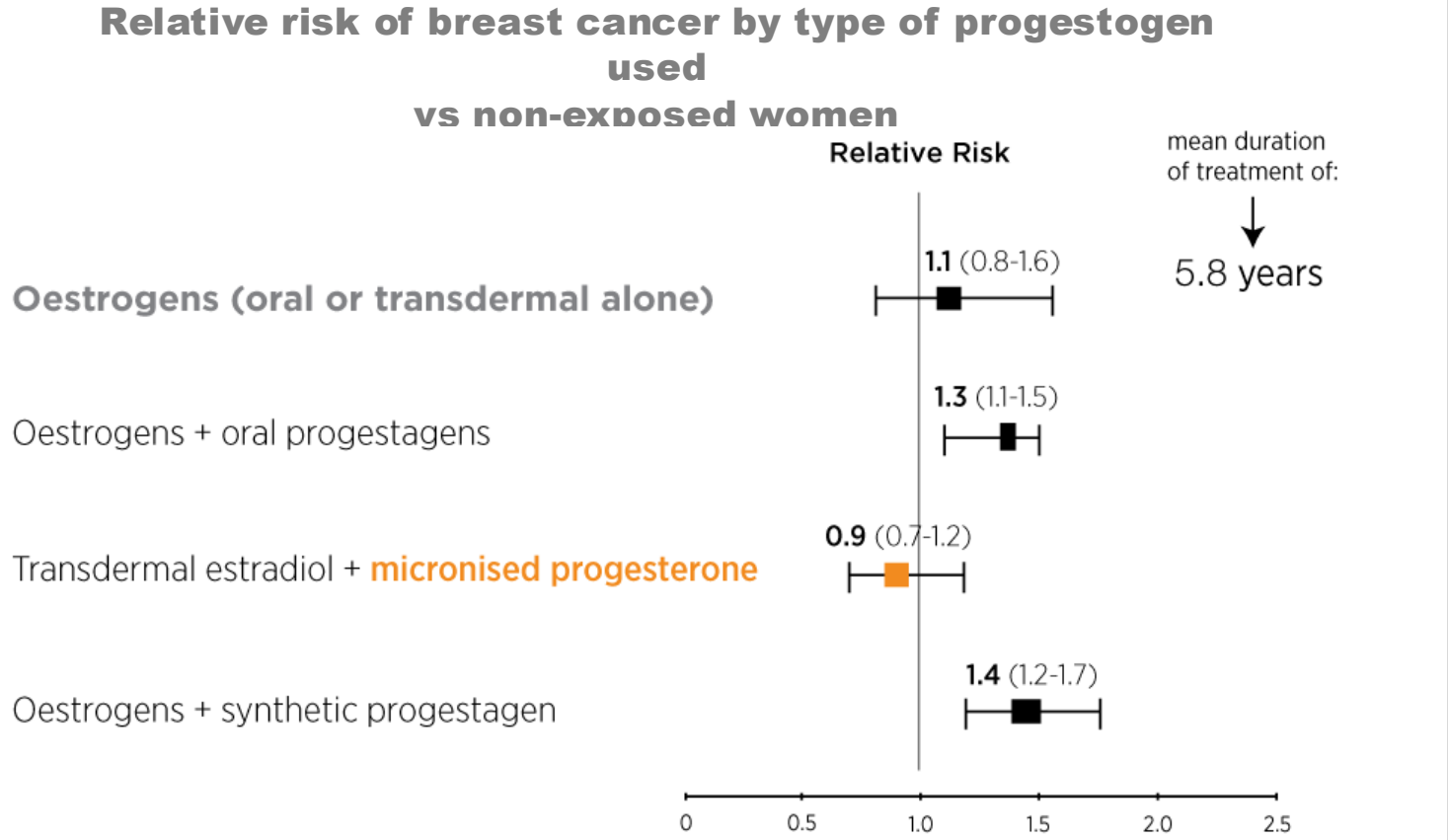


Adapted from Cordina-Duverger E, PLoS One 2013

Odds ratios adjusted for study area/ age at reference date / age at menarche / parity / age at first full-term pregnancy / breast feeding /history of benign breast disease / family history of breast cancer in first-degree relatives / BMI / oral contraceptive use

Cordina-Duverger E et al. PLoS One 2013;8(11) e78016

Breast Cancer Risk and HRT – E3N Study

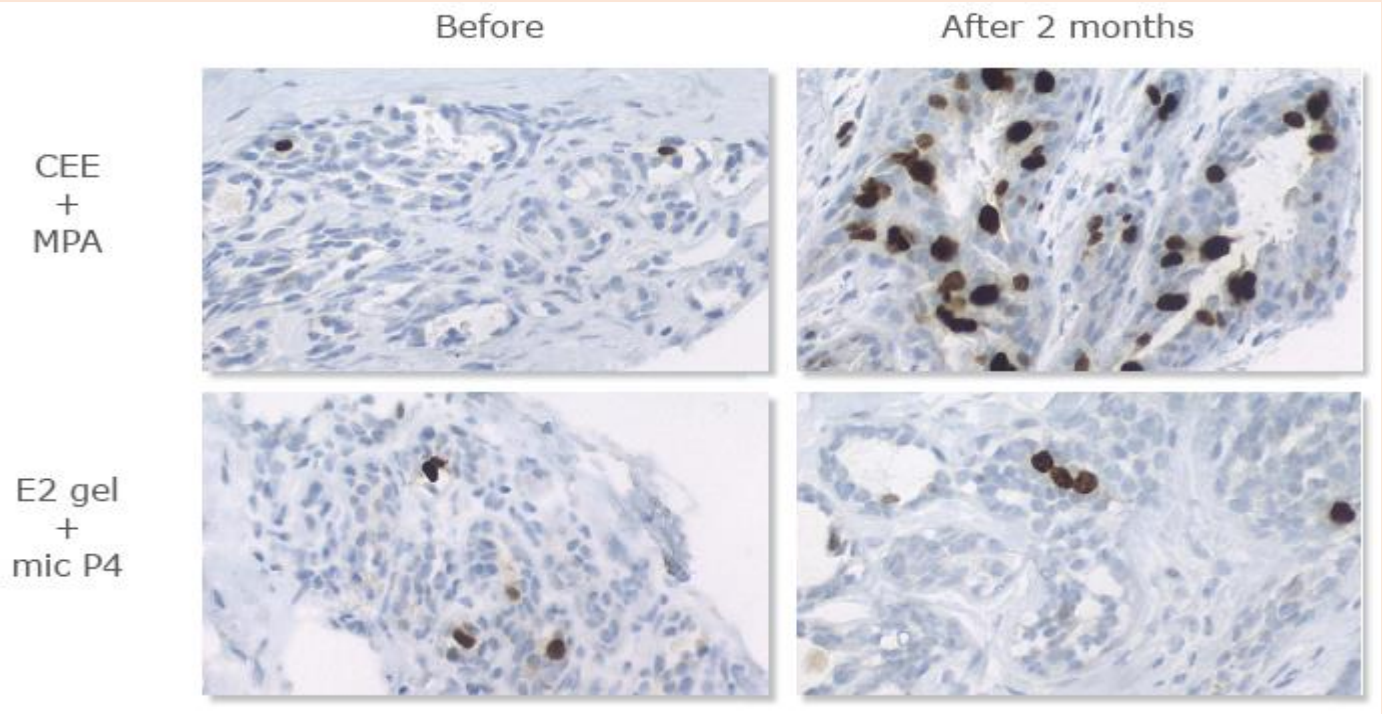


The test for heterogeneity between micronised progesterone and synthetic progestins was significant ($p < 0.001$).

Adapted from Fournier A et al. 2005

Fournier A et al. Int. J. Cancer: 2005;114:448–454

Effects of percutaneous E2 - oral mic.P4 versus oral CEE + MPA on breast cell proliferation and bcl-2 protein in healthy women



Breast histologic findings from two individual women before (left) and after (right) 2 months of sequential treatment with either oral conjugated equine oestrogens–MPA (top) or percutaneous E2–oral micronised P (bottom). Nuclei of proliferating cells staining brown by Ki-67 MIB-1 antibody. (Original magnification X200)

Murkes D et al. Gynaecol Endocrinol 2012;28(S2):12-15

Breast cancer and progestogen: Guidelines

- "…It is not clear whether there is a class effect from the progestogen or whether the specific agent used influences breast cancer risk. Data from a large observational study suggest that **EPT with micronised progesterone carries a low risk of breast cancer with short-term use** *(meaning up to 5 years)* but carries an increased risk of breast cancer with all EPT formulations with long-term use."[1]

- "Emerging data …..report that **progesterone** (and perhaps **dydrogesterone**) in combination with oestrogen does **not increase breast cancer risk** if given for 5 years or less." (Level of Evidence C)[2]

- **A large European observational study** suggested that **micronised progesterone** or dydrogesterone used in association with oral or percutaneous estradiol may be associated with **a better risk profile** for breast cancer than synthetic progestogens.[3]

- The risk may be lower with micronised progesterone or dydrogesterone than with a synthetic progestogen.

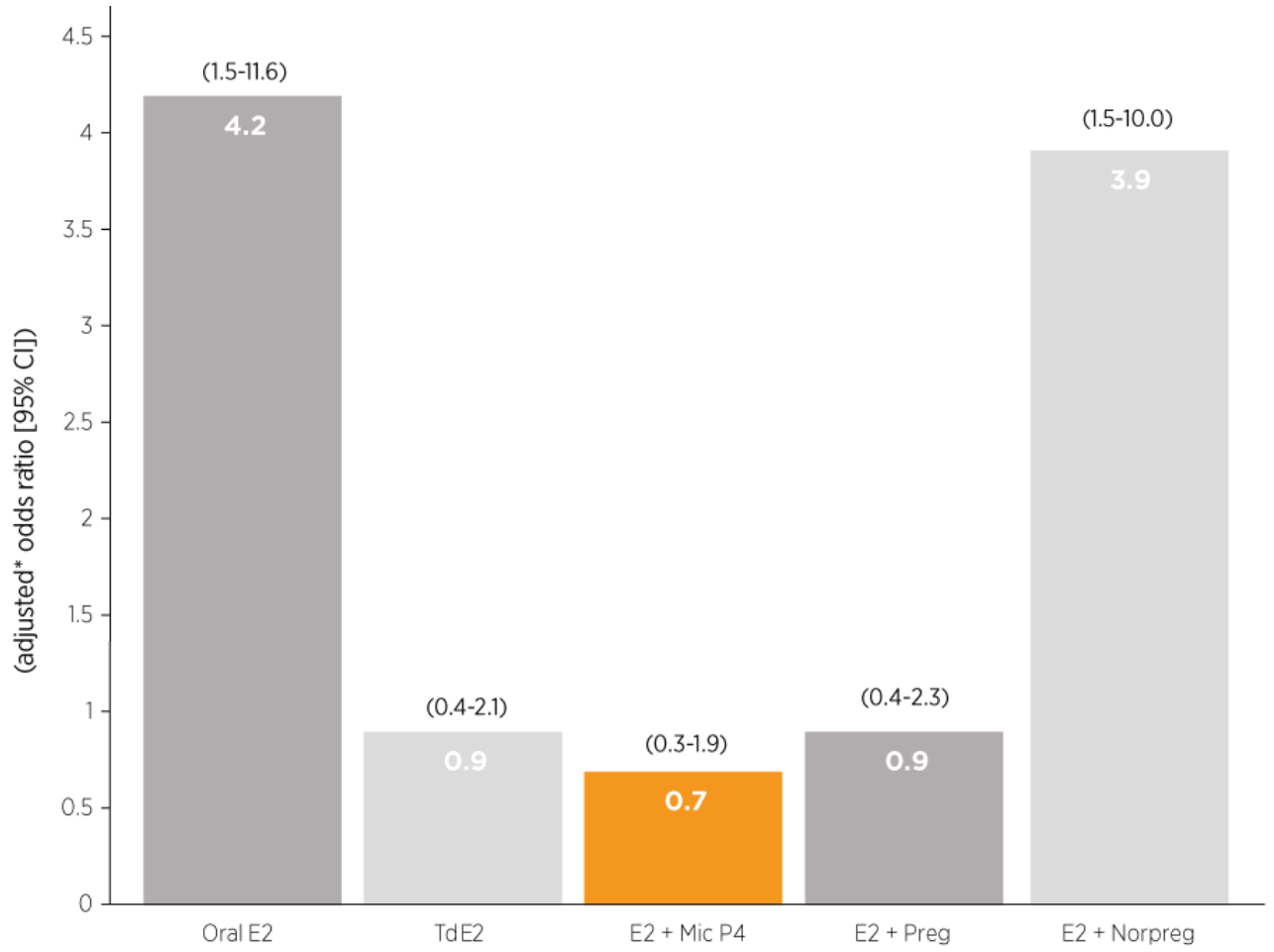
1. Schmidt P. Menopause. 2012; 19(3): 257-271
2. Santen RJ. JCEM.2010:95,(1):S1-S66
3. De Villiers TJ et al. Climacteric 2013;16:316–337

Micronised Progesterone on VTE risk

BESINS HEALTHCARE
Innovating for Wellbeing

Prometrium®
micronised progesterone

Impact of Hormone Therapy on VTE Risk by Route of Oestrogen Administration and Type of Progestogens **(ESTHER study)**



*Adjusted for obesity status, familial history of VTE, history of varicose veins, education, age at menopause, hysterectomy and cigarette smoking. Td E2 (Transdermal estradiol), Mic P4 (micronised progesterone), Preg (Pregnane derivatives), Norpreg (Norpregnanes derivatives)

Adapted from **Canonico M, et al.** *Circulation 2007*

Canonico M, et al. *Circulation 2007;**115**:840-845*

BIJUVA 1/100 – oral estradiol and progesterone

The first and only fixed dose ccMHT treatment with micronised progesterone, like other combinations are helpful for many menopausal symptoms. As a combined continuous bleed free regime, it is usually commenced one year after the last period.

BENEFITS – Symptom Relief

Hot flushes, night sweats, vaginal dryness, sleep/mood disturbances, muscle aches , vaginal and bladder problems

BENEFITS – Bone Health

MHT helps maintain bone density and reduces the risk of osteoporosis and fractures

BENEFITS – Quality of Life

MHT can improve menopause specific quality of life in women experiencing menopausal symptoms

BIJUVA 1/100 – oral estradiol and progesterone

The first and only fixed dose ccMHT treatment with micronised progesterone

BENEFITS

BREAST CANCER RISK

- **Risk of breast cancer is slightly increased (figures Iprevent July 2023, Theramex data)**
- **Lifetime risk of breast cancer is 86 in 1000 (55 year old never used MHT)**
- **Risk after using ccMHT for 5years – lifetime risk of breast cancer is 91 in 1000 (5 extra cases per 1000 women)**
- **This data can be compared to other risk factors which include but are not limited to**

  i) Drinking 3 x alcohol units daily (7 extra cases per 1000)

  ii) Body Mass Index over 30 (12 extra cases per 1000)

  iii) Family history

The use of body identical estradiol and micronised progesterone will reduce these numbers (*Baber et al Climacteric 2016 19(2) pp109; Fournier et al Breast Ca Res Treat 2008*)

BIJUVA 1/100 – oral estradiol and progesterone

VENOUS THROMBOEMBOLISM RISK (VTE)

Both oral oestrogen-only and combined oestrogen-progestogen therapy can slightly increase the risk of VTE. The risk is highest in the first year of use.

(figures Iprevent July 2023, Theramex data)

Risk of VTE in a 55 year old woman who has never used MHT is 1 in 1000

Risk after using oral MHT is 2 in 1000 (1 extra cases per 1000 women)

(Baber et al 2016 International Menopause Society Recommendations, Climacteric 2016; Vinogradova British Medical Journal, 2019; Thermex data)

The above level of VTE risk is defined as rare, and can be reduced by the use of body identical estradiol and micronised progesterone, or vaginal and transdermal MHT ***(2022 Position Statement North American Menopause Society Advisory Panel; Vinogradova BMJ 2019; Canonico et al Thromb Vas Biol 2010).***

WEIGHT MANAGEMENT

WEIGHT MANAGEMENT

Physiological responses oppose weight loss

Appetite hormones, CNS activation of mesolimbic reward pathways, energy expenditure

Medications are indicated

In conjunction with lifestyle interventions – eating changes, physical activity, sleep and stress management

BMI over 30 kg/m2 or over 27 kg/m2 with weight related complication

Semaglutide and Tirzepatide has the ability to achieve the goal – 10% weight loss at 1 year (New England J Medicine)

Glp1 Agonists also have secondary health benefits

improved blood pressure

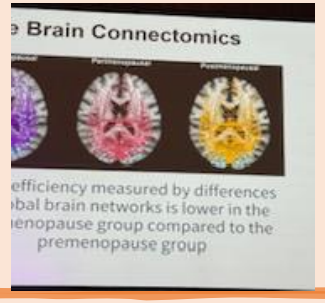
improved triglycerides and LDL-cholesterol

improved physical function score

improved HbA1C

improved fasting glucose

Semaglutide reduces cardiovascular events in non-diabetics with obesity, and has FDA approval for this



- **COGNITIVE ISSUES 'BRAIN FOG' AT THE PERIMENOPAUSE**

Cognitive performance is maintained in the normal range for most women. About 10% will have a clinically significant change that can persist into the post-menopause *(Maki et al, Menopause 2021, April)*

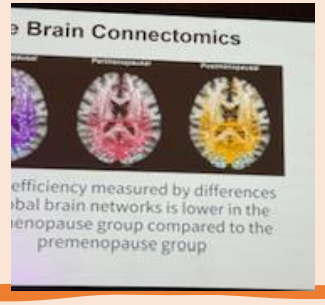
To maintain memory function, the perimenopausal brain may compensate for low oestradiol levels by increasing hippocampus connectivity across the hemispheres.

BRAIN FOG: symptoms include memory loss, clouding of thinking processes, word finding difficulties and losing ones' train of thought

Altered cognition and brain fog is also very closely linked to (1) Mood changes (2) Sleep issues – it is not surprising that clinical trials show declines in verbal learing and memory with poor sleep (3) Vasomotor flushing – hot flushes are associated with memory decline- correction of this symptom has been proven to improve memory

OESTROGEN/COGNITION AND PERIMENOPAUSE

The greater changes and fluctuations in oestrogen levels increase risk of depression. Oestrogen treatment will lessen this effect and improve brain function.



COGNITIVE ISSUES 'BRAIN FOG' AT THE PERIMENOPAUSE

Cognitive performance - Strategies for Brain Health *Maki et al, 'Brain Fog in Menopause: a healthcare practitioners' guide for decision making and counselling for cognition.'*

- Heart health is brain health – aim to normalise blood pressure, lipids, blood sugars
- Train the body to boost the brain – an exercise regime of at least 150 minutes of moderate intensity aerobic exercise weekly
- Slow mid life weight gain – follow a balanced mediterranean type diet -
- 2) and 3) combined – weight management and physical exercise will lower your dementia risk
- Don't smoke
- Stay connected – maintain your social connections
- Exercise your brain – eg reading, learn a new language, volunteer, learn a new skill

https://www.imsociety.org/wp-content/uploads/2022/09/ENGLISH-WMD-Leaflet.pdf

VEOZA (FEZOLINETANT 45 mg) NON-HORMONAL TREATMENT

- Veoza is not a hormone. It works at the body's natural temperature control centre to control hot flushing. During menopause/perimenopause, declining oestrogen effects the thermostat. Veoza rebalances the thermostat. It is a daily tablet taken with or without food.

- In clinical trials Veoza resulted in a 60% reduction in the number of vasomotor symptoms (hot flushing, night sweats, better sleep) but also the episodes were of less intensity resulting in better comfort. As of May 2025, over 11,300 Australian women have been treated with VEOZA

- Very few patients not suited to commence this treatment (liver disease, renal impairment). There is a body of safety evidence. A blood liver function test to check at 3, 6 and 9 months is needed (new recommendations Sept 2025). No other special management is required. Less than 5% discontinue the treatment and there were no serious adverse effects related to the treatment in trials.

- Note Veoza is only for flushes; it does not treat vaginal symptoms, nor improve bone health.

- NEW PATIENT BOOKLET
- https://hcpveoza.com.au

StrataMGT (Stratpharma, Switzerland). Non-hormonal

- **A new silicone based lubricant (non hormonal) for the treatment of menopausal vaginal dryness and lichen sclerosus. – Therapeutic Goods Australia approval is pending.**

- **Unlike traditional hormones, Strata MGT does not absorb and has no systemic hormonal risks. It is inert, has no measurable pH, contains no steroids, hormones, alcohol, parabens or fragrance, for long term use.**

- **Mucosal healing –apply direct to dry, wet, cracked and sensitive mucosal tissue.**
- **Faster healing – provides a moist healing environment – for re-epithelialization, reduction in acute inflammation with a barrier restoration**
- **Early studies showed Strata MGT relieves itch, tenderness, dryness, buring, dyspareunia, dysuria.**

NON-HORMONAL OPTIONS

Hot Flushing and Vasomotor Symptoms

- **Lifestyle** - weight loss, (cooling techiques, exercise, yoga, diet – less proven but helps)
- **Mind Body Techniques**-Cognitive Behavioural Therapy, Clinical Hypnosis
- **Prescription therapies –** Fezolinetant (Veoza),
- SSRIs/SNRIs, gabapentin, oxybutynin (moderate effect and limited by side effects)
- **Other –** herbal, soy and over the counter supplements are of limited benefit in trials. Purity and safety can be an issue due to lack of regulation.

Herbal

- Promensil PERI For perimenopause - plant based *Rheum rhaponticum* (Siberian Rhubarb)- once daily tablet
- Promensil 0 Standardised herbal extract for of red clover for menopause (*Trifolium pratense*)
- Olive and Bee
- 100% natural intimate cream(*Olea Europa and Cera Alba* – olive oil and pure Australian beeswax) suitable to use internally and externally – made in the Adelaide Hills

Olive & Bee

Intimate Cream

100% NATURAL

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Dr AnnaBurrows

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This presentation is for a general informative read and should **never** be a substitute for a consultation with your general practitioner or Dr Burrows