Prescribing MHT in General Practice: Practical Considerations

Renowned Australian menopause specialist, Prof Rod Baber, summarises important considerations when prescribing menopause hormone therapy (MHT).

Professor Rod Baber

Rod Baber AM is Clinical Professor of Obstetrics and Gynaecology at the University of Sydney. He is a past president and life member of both the Australasian and International Menopause Societies and for over 30 years led the menopause clinic at the Royal North Shore Hospital in Sydney.

When is menopause hormone therapy (MHT) indicated?

MHT has been designed to alleviate menopausal symptoms, which affect around 75–80% of women. Most symptoms are caused by the decline in and eventual loss of endogenous oestrogen.

- The most common symptoms are the vasomotor symptoms of hot flushes, night sweats and sleep disturbances.
- Mood changes, myalgia and arthralgia follow close behind.
- Over time, most women will also develop symptoms of vulvovaginal atrophy and will be at increased risk of cardiometabolic disease, bone loss and osteoporotic fracture.

It is recommended that, where possible, body identical estradiol and progesterone be used to maximise benefits and minimise risks.

What types of oestrogen are available for MHT?

For most healthy, recently postmenopausal women, either oral or transdermal MHT are appropriate. However, as women age and thromboembolic risk rises, it is wise to consider switching from oral to transdermal therapy.

Transdermal estradiol therapy – either in the form of a gel or patches – is considered the safest route of oestrogen administration as it is not associated with an increase in thromboembolic risk and is associated with a more stable serum level of estradiol, which is advantageous for women experiencing mood changes or migraine.

Women who are initially at increased risk, including those who are hypertensive, diabetic, overweight, have increased thromboembolic risk or are migraineurs, should be advised to use transdermal therapy.

What is the best way to change from an oral to a transdermal oestrogen?

Changing from oral to transdermal oestrogen is usually simply a matter of ceasing oral oestrogen one day and commencing transdermal therapy the next.

What factors do you take into account when deciding on a progestogen regimen?

Women who have an intact uterus will require progestogen in addition to oestrogen:

- Perimenopausal women are usually prescribed continuous oestrogen plus a sequential progestogen for 12–14 days per month to minimise unplanned bleeding
- Postmenopausal women are usually prescribed continuous oestrogen and progestogen to avoid any bleeding.

The dose of progestogen should be linked to the dose of oestrogen and sufficient to provide endometrial protection. For example, options for low-to-medium dose therapy include:

- Progesterone 200mg for 12–14 days per cycle or 100mg daily
- Dydrogesterone 10mg daily for 12–14 days or 5mg continuously
- MPA 10mg for 12–14 days per month or 2.5–5mg continuously
- Norethisterone 2.5mg for 12–14 days per month or 1–2mg daily.

Changing regimens from sequential to continuous progestogen usually occurs after 1 year of regular withdrawal bleeds:

- At the end of the progestogen phase of the last sequential cycle, both oestrogen and progestogen should be ceased until a withdrawal bleed has occurred and then continuous combined oestrogen and progestogen commenced
- Some bleeding or spotting is common in the first 4–6 months of treatment.

What are the differences between transdermal estradiol treatments?

Transdermal estradiol treatments are available as gel or patches.

Estradiol gel is available in a sachet (Sandrena gel) or a pump pack (Estrogel), both of which are applied daily but in different ways:

- Sandrena gel is applied to the lower trunk or thigh, over an area one to two times the size of the hand
- Estrogel is applied all over the arm, from shoulder to wrist, or the inner thigh can also be used.

Estradiol patches are available in low (25µg and 37.5µg), medium (50µg) and high (75µg and 100µg) doses. Most women will respond satisfactorily to the low and medium doses.

Estradiol patches are applied twice weekly (Estradot, Estraderm, Estraderm MX).

How should patients be switched from a patch to a gel?

It is important to note that there will be individual variation in absorption of transdermal estradiol in many cases and sometimes a change from patch to gel (or reverse) may be appropriate.

- To switch from a patch to a gel, apply an equivalent dose of gel daily from the day after removal of the patch.
- To switch from a gel to a patch, apply an equivalent dose patch from the day after cessation of the gel.

For more detailed information about dose equivalence of patches and gels, see page 6.

Are there differences in PBS availability?

Some of the MHT choices in Australia are not available on the subsidised medicines (PBS) list. For a non-PBS listed product, the average monthly cost for a patient is $50–60.

- Both brands of transdermal estradiol gels, Sandrena® and Estrogel®, and all estradiol patches are PBS listed.
- Several oral preparations are available on the PBS including estradiol 2mg tablets, estradiol valerate 1mg and 2mg tablets, and combinations of estradiol with dydrogesterone.
- TGA approved body identical progesterone is on the PBS. The use of compounded alternatives is strongly discouraged.

For more detailed information about MHT formulations available on the PBS, see page 6.

References:

North American Menopause Society. 2022 Position Statement on hormone therapy. Menopause 2022; 29:767–794.

Baber R, Panay N, Fenton A *et al.* 2016 IMS recommendations on menopause and midlife women's health. Climacteric 2016; 19:109–150.

Davis SR, Baber R. Treating menopause: MHT and beyond. Nature Rev Endocrinol 2022; 18:490–502.

Davis SR *et al.* Menopause–Biology, Consequences, Supportive care, and Therapeutic options. Cell 2023. https://doi.org/10.1016/j.cell.2023.08.016.

Australasian Menopause Society Information Sheets. Accessed at menopause.org.au

Australian Menopause Society Guide to MHT/HRT Doses in Australia

Scan the above QR code for:

- Information about dose equivalence of patches and gels
- Information about MHT formulations available on the PBS

Sandrena Product Explainer

Scan the above QR code to learn more about Sandrena from Prof Baber

Applying Sandrena Gel

Scan the above QR code to watch 'How to apply Sandrena gel' video

Prescriber and patient resources

Scan the above QR code to request prescribing and patient resources, or email contactusaustralia@orionpharma.com

This educational material is proudly supported by Orion Pharma, manufacturers and distributors of Sandrena Gel

Sandrena is indicated for the short-term treatment of climacteric symptoms after natural or surgical menopause. Wherever possible the lowest effective dose should be used.

Review the need for continuation of treatment after 6 months, taking into account the risk-benefit ratio for the individual user at that moment (including cardiovascular disease and breast cancer). Sandrena should only be continued for as long as the benefit outweighs the risks.[1]

PBS Information: Sandrena 1.0g and 0.5g sachets – General Benefit for short-term treatment of oestrogen deficiency.

Please review the Product Information before prescribing, available on request from Orion Pharma or by scanning the QR code.

References: 1. Sandrena® Product Information, 24 February 2025.

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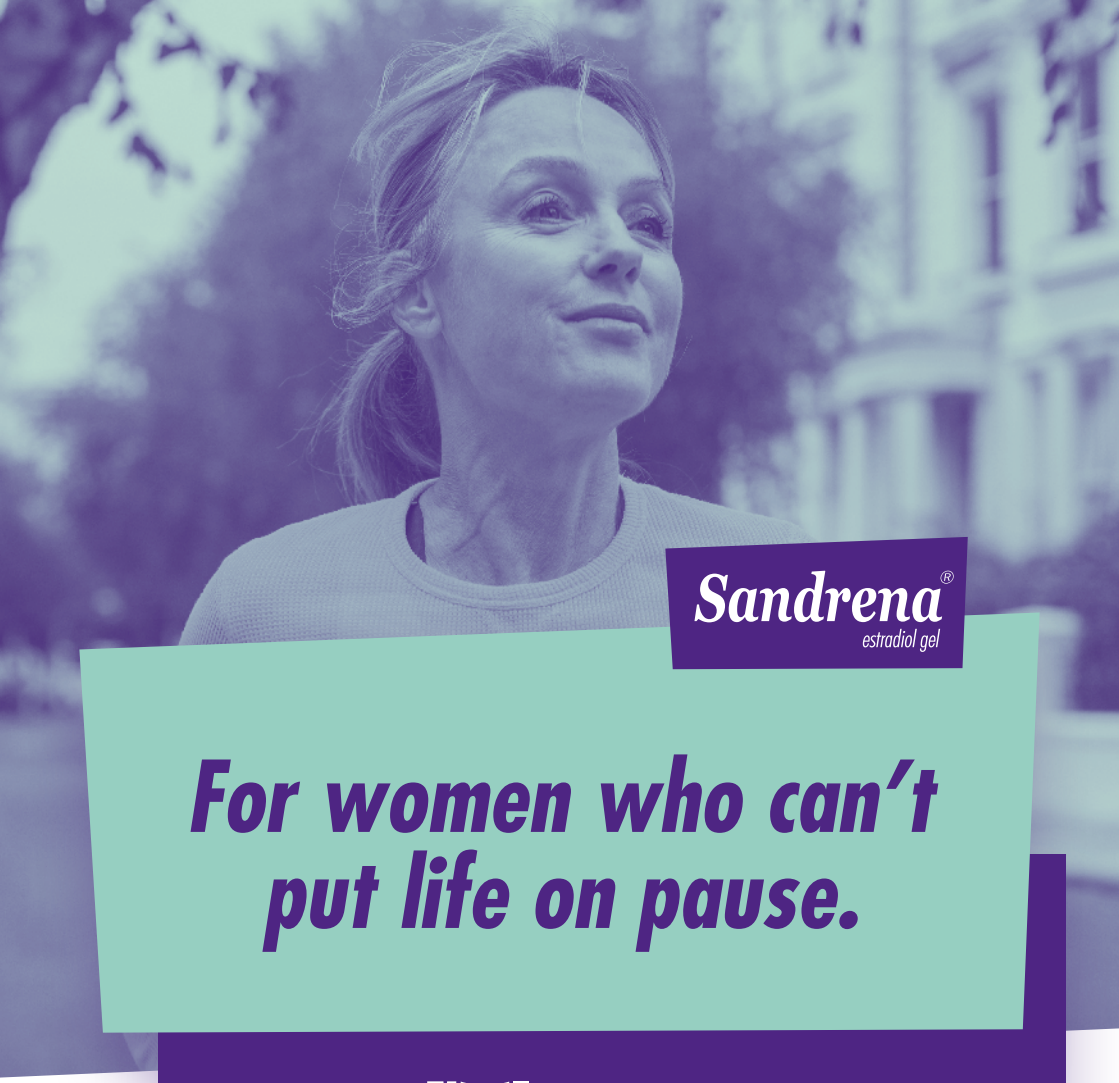

Sandrena®
estradiol gel

For women who can't put life on pause.

0.5g Sachets

1.0g Sachets

PBS Listed

High-concentration, low-volume, body-identical estradiol transdermal gel[1]

For Prescribing and PBS Information see previous page.