

Menopause in questions and answers

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Can hormone replacement therapy be used in a patient with polycystic liver disease and normal aminotransferase levels?

Cystic liver disease is a heterogeneous group of conditions of varied etiology. There are currently no strict standards of optimal treatment options in these patients. The assessment of liver function solely on the basis of aminotransferase levels is not sufficient to assess the feasibility of using hormone replacement therapy (HRT). This is because HRT is now contraindicated in patients with liver disease regardless of aminotransferase levels. A patient in whom HRT is considered because of severe perimenopausal symptoms needs to be consulted by a hepatologist.

Can low-dose hormone replacement therapy reduce the risk of stroke and venous thromboembolism? If so, can it be used as prophylaxis? Is this also true for women with a history of ischemic stroke or thromboembolism? What doses can be considered low?

HRT does not prevent stroke or venous thromboembolism (VTE) regardless of the doses. A history of stroke or pulmonary thromboembolism is an absolute contraindication to HRT.

Studies indicate that HRT at specific doses may decrease the risk of coronary disease (and also, for example, osteoporosis) in a specific group of women, that is, younger women who have recently ended their menopausal transition. However, it should be strongly emphasized that HRT is not recommended for prophylaxis either in this or in any other groups of women. This is because HRT is associated with a risk of serious adverse effects, including stroke, invasive breast cancer, dementia, gallbladder disease, deep venous thrombosis, and pulmonary embolism. Furthermore, it was proved that women who started HRT about 10 years after the menopause have an increased risk of coronary artery disease. Therefore, in the majority of postmenopausal women, the benefits of using HRT to prevent chronic diseases do not outweigh the risks associated with this therapy.

It is important to note that HRT is a medical intervention that is justified only in patients with indications to use it, with no contraindications,

and who have given their informed consent to start the therapy after reviewing its risks and benefits with their physician. The results of studies do not support prevention of cardiovascular disease as an indication to HRT, even in the early postmenopausal period. Nevertheless, benefits of HRT may be the highest if the therapy is started earlier, optimally in the perimenopausal period. HRT should not be started in women over 60 years of age, as it was shown to be associated with higher risk and fewer benefits. Experts from the U.S. Preventive Services Task Force or the North American Menopause Society do not recommend using HRT for prevention of cardiovascular disease.

As for the doses, low-dose HRT is defined as using a half of the replacement dose.

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Is coronary artery spasm (with no abnormalities on coronary angiography) a contraindication to hormone replacement therapy?

I assume this question regards so called cardiac syndrome X or Prinzmetal angina. In my opinion, HRT is not contraindicated in this case. However, before instituting the therapy the patient should be consulted by a cardiologist.

Can hormone replacement therapy be used in a 55-year-old woman with a history of myocardial infarction, stent implantation, and with severe perimenopausal hormone deficiency symptoms?

HRT is contraindicated in such a patient. A nonhormonal treatment targeting specific symptoms should be used.

In the case of vasomotor symptoms (flushing, diaphoresis, rash, anxiety, and palpitations), the use of agents other than estrogens (eg, bioidentical hormones, herbal remedies, vitamins) has been proved ineffective in patients with perimenopausal symptoms. The recommended non-hormonal treatment options include cognitive-behavioral therapy and use of selective serotonin reuptake inhibitors, mainly paroxetine. Paroxetine is the only nonhormonal drug approved by the U.S. Food and Drug Administration for the treatment of perimenopausal symptoms.

In the case of local perimenopausal symptoms in the vagina or the perineum (dryness, pruritus, vaginal discharge, dyspareunia), experts recommend the use of nonhormonal, long-acting emollients, using lubricants before a sexual intercourse, and regular sexual activity, as the first-line options. Herbal or soy preparations proved to be ineffective. Short-term treatment with topical estrogens may be used in the case of exacerbation of symptoms.

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Does hormone replacement therapy increase the risk of breast cancer?

An association between the risk of breast cancer and the duration of HRT has been reported. Studies have shown that when dual therapy (estrogen + progestogen) was used for more than 5 years, the risk of breast cancer was higher in women who started the therapy shortly after the menopause compared with women who started the therapy 5 years after the menopause. In women after hysterectomy no increase in the risk of breast cancer was seen after a mean of 7.5 years of estrogen monotherapy. Therefore, the duration of HRT should be reduced to approximately 4 years in the case of dual therapy and approximately 7 years in the case of estrogen monotherapy.

HRT is also not recommended in women with a history of breast cancer, because available data indicate that HRT may be associated with a higher risk of relapse.

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