Birmingham Women's NHS
NHS Foundation Trust

Menopause Service Clinical Guidelines

Policy category and number:	C
Version:	1.0
Approval committee:	Gynaecology Directorate
Date approved:	22/03/2016
Date issued:	30/03/2016
Name/Designation of Lead Officer:	Manjeet Shehmar, Clinical Director
Name/Designation of author:	Lynne Robinson, Consultant Obstetrician and Gynaecologist and Lead of Menopause Service and Subspecialist in Reproductive Medicine
Review date:	22/03/2019
Reviewer Designation Title:	Clinical Director
Target audience:	Clinical staff Gynaecology Directorate

NB. Hard copies of this policy are not permitted as they **cannot guarantee** and **risk** the content being out of date.

For assurance that the most up to date policy is being used, staff should refer to the version held on the Trust intranet policies link.

Version Control

Version	Date (DD/MM/YY)	Author (Name and Designation)	Status (Draft, Approved, Archived)	Description of Amendment
1.0	22/03/2016	Lynne Robinson, Consultant Obstetrician and Gynaecologist and Lead of Menopause Service and Subspecialist in Reproductive Medicine	Approved	New Policy.

Contents

1. Introduction

At Birmingham Women's Hospital there is a regional centre for Menopause services. The aim of the service is to lead in the provision of expert advice and management of women in the menopause, including a dedicated premature ovarian insufficiency clinic. Our practice incorporates current evidence based practice and thinking using a multidisciplinary team approach.

Following publication of Women Health Initiative Study (Rossouw et al. 2002) there has been a great deal of confusion and uncertainty regarding menopause care and therefore providing a comprehensive menopause service of great importance to both patients and doctors in primary care.

This specialist service sees all women of all ages with hormonal problems including premature ovarian insufficiency, premenstrual syndrome and post-menopausal health. Our service aims to offer the best evidence based approach along with collaborating in new research.

2. Objectives

Our objectives are:

2.1 Provide details of the clinic team members and demonstrate clear criteria for referral
2.2 Follow up and discharge
2.3 Offer information on clinical services and clinic structure
2.4 Offer guidance on assessment and investigation of patients
2.5 Offer clear guidance on management of menopausal symptoms and use of various HRT preparations
2.6 Provide evidence based guidance on the risks and benefits associated with HRT use
2.7 Provide guidance for the management of specific conditions

3. Policy Scope

This policy applies to all Trust employees, irrespective of grade, level, location or staff group, including locum and agency staff, students and staff employed on honorary contracts who are involved patients referred with post reproductive health problems.

4 Definitions

BMD: Bone Mineral Density
BTB: Break Through Bleeding
CCHRT: Continuous Combined Hormone Replacement Therapy
ET: Endometrial thickness
FSH: Follicle Stimulating Hormone
GnRH/a: Gonadotrophic Releasing Hormone /Analogue
HRT: Hormone Replacement Therapy
IMB: Intermenstrual Bleeding
LH: Luteinising hormone
PMB: Postmenopausal bleeding
POI: Premature Ovarian Insufficiency

TFT: Thyroid Function Test
USS: Ultra Sound Scan

5. Duties and Responsibilities

5.1 Clinical Director Gynaecology

- Ensure all clinical staff are aware of the guidelines.
- Ensure that patients are managed by medical staff in accordance with the guidelines.

5.2 Medical staff

All medical staff are responsible for ensuring the management of patients post reproductive problems is in accordance with these guidelines.

5.3 Nursing staff

All nursing staff involved in providing direct patient care for patients who have post reproductive problems are responsible for ensuring that care is in accordance with these guidelines.

6. Procedures

Primary / Tertiary Referral Criteria to the Menopause & PMS Service

While the majority of women can be managed in primary care, in certain situations referral may be necessary for investigation and specialist advice.

New patient referrals can be received from:

- Local GP's.
- Internal tertiary referrals from other specialties for the same condition.
- External tertiary referrals e.g. Queen Elizabeth Hospital Birmingham

6.1 Criteria for Referral

Abnormal Bleeding

Post-Menopausal Bleeding (PMB) must be referred urgently via the BWNFT PMB pathway, so that they are seen within the national two week target for suspected cancer week rule. An USS will be performed and if ET is ≥ 5mm then the patient will be seen in the PMB clinic and an endometrial biopsy or hysteroscopy will be performed. If the ET is ≤ 4mm but bleeding continues a hysteroscopy should be performed. Also the following should be considered abnormal and urgent referral within 2 weeks should be undertaken along the established PMB pathway as follows:

Sequential Combined HRT:

- Change in pattern of withdrawal bleeds or onset of intermenstrual bleeding (IMB).

Continuous Combined HRT or long cycle regimens:

- BTB persisting for more than 3-6 months after starting CCHRT or bleeding which is not lessening.
- A bleed after 6 months of amenorrhoea on a CCHRT regimen.
- Endometrial thickness >4mm on ultrasound +/- reported intra-uterine pathology (see section 2.3).

Note that it is important that a vaginal and speculum examination is always performed even if the scan is normal to exclude genital tract abnormalities.

Multiple Treatment Failure

- Several regimens tried. List types of HRT attempted and detail problems experienced.

Venous Thromboembolism

- Personal history**,** family history: in a first degree relative age <50 years old.
- GP to include history of event including: venogram**,** ultrasound, V/Q scan, anticoagulation history, circumstance of event, thrombophilia screen.

Premature Ovarian Insufficiency (POI)

- Menopause <40 years old.
- Reason for ovarian insufficiency if known (idiopathic, iatrogenic).
- Included results for LH/FSH, , Estradiol , TFTs, BMD.

Osteoporosis/high risk of fracture

- Confirmed or high risk e.g. early menopause, glucocorticoid use
- Family history of osteoporosis, especially first degree relative
- BMD by DEXA scan if available
- Parental history of hip fracture

Previous or High Risk of Hormone Dependent Malignancy

- E.g. breast +/- ovarian/ endometrial cancer. Details of disease: stage, treatment, family history

Other

E.g. patient or GP preference
History of risk factors or contraindications for HRT

6.2 Follow-up Appointments and Discharge

Criteria for follow-up

Follow-up visits will be judged against clinical need but aim to discharge patients once established on a preparation unless they have specific needs or have POI.

- **1st follow-up** should be conducted after **4 months** in patients starting a new menopausal preparation.
- **2nd follow-up** – consider discharge if established on effective treatment, not requiring further intervention or patient declines intervention. If required, subsequent follow-up should be conducted six monthly unless special review is required.

Criteria for discharge

Aim to achieve within 2 appointment visits

- Patients stabilised on their Management plan and need no active monitoring.
- Patient declines treatment or intervention

Exception to discharge criteria

Women falling within one of these categories:

- Premature Ovarian Insufficiency
- Severe osteoporosis (managed with HRT)
- Estrogen or testosterone implants
- Long term GnRHa + BMD

- Not stabilised on medication / HRT
- Complex co-morbidities

6.3 Clinical Services

		Miss Robinson	Mr Toozs-Hobson	Mrs Stephens
Tuesday	**AM**	**Weekly menopause POI monthly**	**Alternate weeks**	**Alternate weeks Implant clinic**
Wednesday	**AM**			**Weekly**

Timetable subject to change

Menopause Clinic
Clinical Lead: Lynne Robinson
The clinic offers management of women in the menopause from the age of 40+. This includes:

- Lifestyle changes
- HRT prescription including advice on risks/benefits
- Non-hormonal approaches to management of symptoms
- Contraceptive advice in the perimenopause
- Management of osteoporosis with HRT

Premature Ovarian Insufficiency

Clinical Lead: Lynne Robinson
For women under the age of 40. This clinic aims to sensitively support women with POI who are at long term health risks. The clinic has a multidisciplinary approach with collaborative links to:

- Fertility services at Birmingham Women's Fertility Centre for women wishing to seek a pregnancy. Egg donation IVF is offered and we have a donor egg bank women can access.
- Endocrinology services at UHB: quarterly MDT with physicians

We are in the process of registering with an international collaborative POI database to aid research, understanding and effective management of POI www.poiregistry.net . We offer bio banking of serum for POI patients to aid research in this area. We also see a cohort of patients from the epilepsy service whom require management of their catamenial epilepsy with hormonal manipulation.

6.4 Assessment in Secondary Care

Menopause patients required a concise gynaecology assessment. This should include history of presenting complaint, investigations, identification of risks, choice for treatment and management plan.

General Assessment

Assess the stage of the menopause:

- Ask the woman if she is still having periods, i.e. whether perimenopausal or postmenopausal:
    - Record last menstrual period (LMP).
    - Note frequency, heaviness, and duration.
    - Amenorrhoea < 40 years of age = POI.

Assess the symptoms and their severity:

- Identify the significance and severity of symptoms affecting quality of life e.g. hot flushes, night sweats, vaginal dryness

Assess cardiovascular disease and VTE risk:

- A full cardiovascular history should be taken and any VTE risk factors noted.

Assess osteoporosis and fracture risk:

- FRAX risk assessment should be considered in high risk patients www.shef.ac.uk/FRAX/

Further discussion:

- Determine treatment expectations e.g. HRT, non-hormonal, alternative or complimentary therapies (complimentary therapies not offered by BWH).Consider EGGS for patients (expectations, goal setting, goal achievement, satisfaction).
- Offering referral for psycho sexual counselling, dietary advice, physiotherapy or bladder assessment if indicated
- Encourage participation in the national cervical / mammogram screening programme where age relevant
- Give clarification / additional written information (document that this has been provided within the notes)
- The following are contraindications to starting hormone replacement therapy and specialist advice should be sought if HRT is considered:
    - Hormone-dependent cancer (e.g. endometrial cancer, current or past breast cancer).
    - Active or recent arterial or venous thromboembolic disease (e.g. DVT, angina or myocardial infarction).
    - SLE with renal involvement

NB: advice, risk assessments, consent to treatment and information leaflets given should be recorded in the notes

We aim to provide an evidence based approach to menopause management and empower women to making informed choices for the management of their menopause, be it with HRT or non-hormonal therapies. There are important potential risks which need to be individualised and discussed with all women given their first prescription of HRT and informed consent should be documented.

Investigations

New or follow-up patients

- All new patients require full gynaecological, medical, social and drug history.
- Weight, BP and BMI will be recorded for screening purposes.
- Physical examination, including breasts and pelvic examination are only performed when clinically indicated.

Baseline investigations may include:

Investigations are dependent upon presenting clinical history and risk assessment

- Pathology.
    - E2, FSH/LH – where menopausal status is uncertain or to monitor response to therapy if the patient remains symptomatic on transdermal estrogen HRT. Do not perform FSH/LH/E2 routinely in women >45 yrs. No value in performing AMH, inhibin A, Inhibin B, antral follicle count and ovarian volume in these women. Do not measure FSH/LH if the patient is using the combined contraceptive pill.
    - FBC, LFTs, U&Es, TFT's, 24 hr urine for VMA if unexplained flushing
    - Request cardiovascular disease risk markers from GP e.g. lipids, lipoproteins, insulin resistance etc: according to personal and family risk factors.
    - Thrombophilia screen after discussion with haematologist: if personal or significant family history of thromboembolic disorder oral estrogen would be contraindicated due to hepatic first pass effect. *Note this must first be referred to haematology prior to doing screen.*

- Radiology
    - Vaginal ultrasound scans – if there is a history of bleeding irregularities or indicated from clinical examination.
    - DEXA scans – if a significant risk of fracture is identified. FRAX assessment tool aids identification patients at future risk of fracture. www.shef.ac.uk/FRAX/.

- Endometrial sampling (Pipelle) – if TV USS fails to adequately visualise the endometrium or shows the endometrium to be irregular or thickened (>3mm CC HRT or >5mm sequential HRT) in conjunction with unscheduled bleeding. www.sign.ac.uk/
- Hysteroscopy –will normally be undertaken in combination with an endometrial biopsy in symptomatic women where:
    - Endometrial biopsy fails or is non-diagnostic
    - the index of clinical suspicion of endometrial disease is higher
    - Focal abnormalities within the uterine cavity are suspected on ultrasound scan
    - Note that in symptomatic women referral should be along the rapid access PMB pathway on a 2 week rule. A routine referral can be made for hysteroscopy in asymptomatic women (i.e. those women without bleeding or vaginal discharge) with suspected focal pathologies within the uterus.

Mammograms

Women between the ages of 50-74 will be screened as part of the national screening programme. Women remaining on HRT beyond 70 should self-refer for 3 yearly screening until discontinuation of their HRT. www.cancerscreening.nhs.uk/breastscreening/

Those women considered at increased risk of breast cancer should be given a family history form to fill out for genetics. A clinic letter can also be copied to the genetics department but it is the patient's responsibility to complete and return the form. If the patient is found to be above background risk a recommendation for screening will be made to them by the genetics department and/or they will be sent an appointment for genetics counselling.

Cervical Smears

Women between 25 and 64 will be on the national recall for cervical screening. Cervical screening does not need to continue after the age of 64 for women on HRT who have a normal smear history. www.cancerscreening.nhs.uk/cervical/

Research Patients

Examinations and investigations are performed according to research clinical protocol. Information on current studies upon request.

6.5 Management of Vasomotor Symptoms with HRT

Prescribing of menopause products will be carried out according to the needs of the individual patient. Patients not already on HRT should be counselled regarding the full range of available products along with the known risks and benefits. Verbal consent should be obtained and information should be provided, which should be recorded within the notes.

In keeping with the International Menopause Society Guidance (Brown 2013), Hormone replacement therapy should be ***individualised using the lowest effective dose to treat symptoms.***
Younger women may require higher start doses both for symptom relief and bone conservation

Systemic HRT

Choice of type and route of HRT is dependent upon menopausal status and uterine status. (See algorithm, Chart 1).

Oral Estrogen

- Generally cheaper. Usually first line choice in primary care
- Often has higher incidence of side effects due to first past effect
    - May increase SHBG – results in loss of libido and increase tiredness
    - May increase triglycerides – caution when cardiac risk factors evident
    - Neutral effect on lipids/HDL
    - Increased risk of VTE in first year of use. Not recommended as first line in patients at risk of VTE

Transdermal Estrogen

- Generally more expensive. Usually first line choice in in patients with migraine, epilepsy, diabetes, existing gallbladder disease, obesity and varicose veins
- Preferred route for those with CVD risk factors
- Patch or gel - down to patient preference.
    - Avoids first pass metabolic effects
    - Neutral impact on SHBG
    - Neutral impact on Lipids
    - Lowers Triglycerides
    - VTE risk less than with oral (High dose patches can increase VTE risk)
    - Provides steady levels of E2 and therefore better for migraines & epilepsy

Subcutaneous Estrogen

- Estrogen +/- Testosterone implant.
- Implants are not readily reversible, therefore they are not recommended in POI or women seeking a pregnancy
- Estrogen implants are *unlicensed*. Informed verbal consent must be obtained and recorded.

Tibolone: a selective tissue estrogenic activity regulator (STEAR)

- A novel compound that acts on estrogen, progesterone and androgen receptors. Offers CCHRT. It is suitable for use in post menopausal patients.
- Grade 1 evidence for benefit in climacteric symptoms, bone density and mood/libido (androgenic effect). (Biglia et al. 2010)
- 10-15% incidence of breakthrough bleeding little evidence of endometrial hyperplasia. (Kane & Quinn 2009)
- **Not recommended in women with a past history of breast cancer although may be considered for those with estrogen negative tumours.** (Bundred et al. 2012)
- **Progestogens**
- Addition of Progestogen with Estrogen attenuates increases in HDL2 cholesterol, but lowers triglycerides. The WHI trial and Million Women Study suggested that the addition of progestogens to HRT conferred an increased risk of breast cancer (Rosseau et al 2002; Beral et al 2002) and women using estrogen only HRT actually had a lower risk of breast cancer than the controls.
- **Progestogens** must be added in women with a uterus to prevent hyperplasia and subsequent cancer

Complementary and Alternative Therapies

'Natural Alternatives' (Pitkin 2012)

- **Progesterone cream/ gel** – Grade A RCT data for symptom relief only (not skeletal protection) with uncertain endometrial protection. (Elshafie & Ewies 2007) (Wren et al. 2000). Not licensed for use with estrogen
- **Soya, Tofu, Red Clover, St John's Wort and Isoflavones**. These are naturally occurring weak phytoestrogens and may help with hot flushes and PMS. They can be recommended as a dietary supplement. No conclusive data for benefit on climacteric symptoms and bone markers. Caution in history of breast cancer. (Fritz et al. 2013)
- **Black Cohosh** – Has estrogenic effects but its mode of action unclear. May benefit breast cancer and liver dysfunction. (Leach & Moore 2012)
- **Reflexology, aromatherapy and acupuncture** – limited clinical data for vasomotor symptoms but useful for some patients.
- **SSRI/SNRI, clonidine, Gabapentin and Venlafaxine** – Selected licence for use in hot flushes. Useful for vasomotor symptoms especially for breast cancer patients who may not want to/be able to have estrogen. (Pinkerton et al. 2013)(Rada et al. 2010) (Shams et al. 2013). Do not offer SSRI/SNRI and clonidine to women without contraindications to HRT.
- Bioidentical hormones are considered unregulated and their safety is uncertain and therefore they are not recommended for use.

NB: Soy (isoflavones), red clover, black cohosh, vitamin E and magnetic devices are not recommended by NICE for the management of menopause symptoms in women with breast

cancer. www.nice.org.uk. St John's Wort can interact with several drugs such as Tamoxifen. The constituents, quality and purity of complimentary therapies are unknown.

Comparative estrogen doses

Preparation	Ultra low dose	Low dose	Standard dose	-	High dose
Oral estradiol	0.5mg	1.0mg	2.0mg	3.0mg	4.0mg
Premarin	-	0.3mg	0.625mg	-	1.25mg
Sandrena gel	½ sachet (0.25mg)	0.5mg	1.0mg	1.5mg (1.0&0.5mg)	2.0mg (2 x1.0mg)
Oestrogel	½ app	1app	2apps	3apps	4.0apps
Estradot	12.5mcg (1/2 patch)	25mcg or 37.5 mcg	50mcg	75mcg	100mcg

Selective Estrogen Receptor Modulators (SERMS)
SERMs have been designed to maintain the benefits of HRT and minimise the side effects. They are selective estrogen-type molecules in the same class as Tamoxifen and Raloxifene. Their actions depend on which receptors they bind to and whether they switch the receptor on or off. They have a similar risk of VTE as oral HRT

SERMs are used dependent on their pattern of action in various tissues

Name	Uses	Effects and site of action
Raloxifene	Osteoporosis	Agonist at bone, antagonist at breast and uterus
Tamoxifen	Breast cancer	Agonist at bone and uterus, antagonist at breast
Ospemifene	Vaginal atrophy, dyspareunia	Agonist at bone and urogenital tract, antagonist at breast and uterus
Bazedoxifene	Osteoporosis	Agonist at bone, negligible agonist at uterus, antagonist at breast

NB: Some of the above agents have significant side-effects that contraindicate widespread use e.g. Tamoxifen and hyperplasia.

- Tamoxifen and Raloxifene are not licenced for use in hormone replacement therapy.

Two new SERM preparations are soon to be licensed in the UK for use in menopause
- Ospemifene will be licensed for the treatment of symptoms of vaginal atrophy.
- Conjugated estrogens/Bazedoxifene, a combination product, will avoid the need for progestogen through substitution of a SERM. It should be useful in women with progestogen intolerance. (Tella & Gallagher 2013)

Managing low mood
Mood changes can be attributed to the menopause but may be multifactorial. HRT or cognitive behavioural therapy (CBT) may be used to benefit mood changes. SSRI/SNRIs are not useful in women without a diagnosis of depression with low mood.

Management of Vaginal Atrophy & Dyspareunia

Vaginal atrophic symptoms are typically perceived to be late manifestation of the menopause, but may affect many women early in the perimenopause. Atrophic vaginitis may present with vaginal bleeding, dyspareunia, libido issues and dysuria and frequency of micturition.

Recurrent vaginal infections or vulval pathology are not uncommon and may require onward referral to a GUM clinic or vulval clinic e.g. recurrent thrush, itching, lichen planus, dermatitis, vulvodynia, VIN

Uncomplicated vaginal atrophy may be treated with non hormonal interventions or topical estrogen.

More recently, a product containing dehydroepiandrosterone (DHEA) has been developed and there is evidence for it being effective at reducing vaginal atrophy with minimal systemic absorption (Labrie et al 2009). Topical oxytocin has also shown some benefit in small studies (Johassen et al 2011)

Vaginal Lubricants and Dyspareunia

A variety of vaginal lubricants and bio adhesive moisturisers are available and can be obtained with or without prescription e.g. Replens®. The hypo-estrogenic vulva and vagina may be treated with topical *local estrogens*.

- Lubricants are specifically for dyspareunia and may be used as required / during sexual intercourse.
- Moisturisers are for dry / sore atrophic symptoms and should be used regularly to alleviate symptoms and maintain hydration.

Topical Local Vaginal Estrogens

- After pre-loading, vaginal tissue maturation occurs and systemic absorption is likely to be low.
    - Estradiol (Vagifem) 10mcg pessary – the yearly systemic absorption equates to 1.4mg of systemic estrogen, equivalent to one daily dose of oral estrogen.
- Local estrogen may be used concurrently with systemic HRT with no additional risks and minimal systemic side-effects.
- Local vaginal estrogen may be used unopposed with minimal risk of endometrial hyperplasia. (Krychman 2011). No endometrial thickness monitoring is required.
- There is no indication to discontinue if good benefit is obtained.
- Although some caution should be observed in a history of estrogen sensitive breast cancer and concurrent SERM therapy due to increased serum estrogen levels (Wills et al. 2012). local estrogens can normally be used. Extra caution should be used in women using aromatase inhibitors and topical estrogen use should be discussed with oncologists.
- If 10 mcg dose of estradiol does not relieve symptoms the dose can be increased further.

Managing Estrogen Side Effects

- Estrogenic side effects are mainly breast tenderness & nausea but these tend to decrease with time..
- Use lower dose of estrogen (especially in over 60's) i.e.1mg rather than 2 mg orally or 25mcg patch rather than 50mcg transdermally. It is always best to start with a lower dose and gradually increase even when it is anticipated that a 2mg dose or higher will be required.

Weight Gain with HRT

- There is inconclusive evidence from research data of increase in weight with HRT.
- Weight increases with age due to slowing down of basal metabolic rate.
- Central obesity is naturally observed as age increases.
- Advice should be given on diet and lifestyle. Reducing alcohol intake and discipline regarding regular meals and avoidance of snacking is recommended. Referral to the dietician via the GP may be of benefit.
- It should be mentioned that alcohol and obesity are greater risk factors for breast cancer than HRT.
- There may be an estrogenic or progestogenic class effects on weight gain so changing dose, route and using less androgenic progestogens may be considered.

Hormone Implants

Hormone implants are slow release crystalline formulations, which gradually dissolve and are absorbed from the subcutaneous tissue. They are designed to last six months, but there is a residual effect from remaining pellets continuing to release hormone. This may last up to 12 months or more and can lead to a gradual increase in plasma hormone levels, particularly estradiol, causing tachyphylaxis.

Progestogens need to be continued for up to 3 years when implants are discontinued in patients with a uterus.

Indication of use

- Other modes of treatment have failed.
- Proven for poor compliance or concordance with previous interventions.
- Osteoporosis.
- PMS, estrogen dependant psycho-endocrine disorders.

Estrogen Implants

Reference range for Estradiol

- Standard range 200-1000pmol, max 1400pmol/l.
- Risk of Tachyphylaxis with levels above 1400pmol/l.

Frequency of implant & monitoring

- Every 6/12 implants.
- Not to be re-implanted if E2 levels >1400pmol/l.
- If stable, repeat serum Estradiol annually but require levels 6 monthly initially
- If symptomatic or previous levels supraphysiological, repeat Estradiol every 6 months.

Estradiol implant dose

- Standard dose of Estradiol implant is 50mg, although 25mg may be adequate and still give bone protection.
- 75mg or 100mg may be indicated in some circumstances.
- Estrogen levels can be "topped up" with a patch or gel before a further implant if levels are low and symptomatic
- A 25mg Estradiol implant should be considered for women over the age of 60.
- DEXA scan not required during long term therapy except with confirmed osteoporosis or history of POI.

Tachyphylaxis

Some women are sensitive to the rate of decline of estradiol in their system and present earlier than six months with 'menopausal type' symptoms. This may also occur if too high a dose is being given or if the frequency is less than 6 months. The symptomatic women usually have supra physiological plasma estradiol levels, >1400pmol.

- No further estrogen implants should be given until levels fall below 1400pmols and offered alternative "top up" therapy.
- "Top up" treatment should be discontinued 7 days prior to any serum estradiol sample, as this will affect the overall result.

Discontinuing Estradiol implants

Prolonged release of estrogen may continue for up to 2 years post the last implant. There remains a risk of endometrial hyperplasia.

Progestogenic opposition must be continued for up to 3 years post implant of any dosage but we do not monitor estroge levels. If IUS is in situ then must be viable for at least 3 years and left in situ or replaced.

Testosterone implants.

Indications for Testosterone use are lack of energy, reduced metabolism and low libido (Davey 2012)(Davis & Braunstein 2012)(Panay et al. 2010).

- Standard dose 100mg.
- Advisable to start with 50 mg and monitor using serum testosterone levels and degree of symptom relief

Off licence prescribing of Testogel ® ,Testim gel or Tostran gel is an alternative to testosterone implants and may be the best way of introducing testosterone as it is easily reversible in the event of unwanted side effects.

- Prescription 50mg/5g gel with one tube used sparingly over 7-10 days. We suggest using ¼-1/3 of tube of gel or one metered dose of tostran alternate days. No regular monitoring is required.
- Titrate dose according to benefits and androgenic side effects.

GPs may not choose to prescribe testosterone and therefore patients may require repeat prescriptions from BWH on a case by case basis.

Progesterone and Progestogens with Implants

Patients with a uterus using estrogen implants will require progestogens for endometrial protection. The preferred progestogen is the Mirena® IUS for effective endometrial protection. It is also the only reliable non bleed option with an implant.

Progestogens and HRTC19 Androgenic	**C21 Progestogenic**	**C17Anti-mineralocorticoid**	**Hybrid Progestogen**	**Natural Progesterone**
Levonorgestrel Norethisterone Nomegestrol	Dydrogesterone Medroxyprogesterone	Drospirenone Cyproterone Acetate	Dienogest	Progesterone Utrogestan

Progestogens are prescribed to protect against endometrial hyperplasia. Estrogen only HRT has a significant risk for endometrial hyperplasia and resultant atypia than any risk for breast cancer on a CCHRT. Estrogen only HRT is not recommended in post-menopausal women with an intact uterus

Natural progesterone is chemically and structural identical to ovarian progesterone so may be potentially safer with limited supporting data. It is frequently described a bio-identical but more accurately termed body identical. It is only available as a licenced oral soy-based capsule or unlicensed PV pessary and cream.

- Cautions 1. Not suitable for use with condoms.
  2. Contains arachis / peanut oil (nut allergies).

Utrogestan ® is licensed for oral or vaginal use. There is good safety and efficacy data to support PV use and may reduce the PMS side effects and increase endometrial stability. Oral use can induce drowsiness and therefore if used orally we recommend using at night time.

Mirena IUS ® contains LGN which is androgenic in nature. Due to its direct local effect on the endometrium the dose is low and systemic absorption negligible. This makes it ideal for the management of menorrhagia, as part of a CCHRT, in PMS and with estrogen implants.

NB: All Progestogens are off licence in the management of PMS (except Mirena IUS ®)

Progestogenic Side Effects

Progestogenic side effects are dependent upon the base molecule (class effect). They are mainly Progestogenic (PMS-type) or Androgenic. The choice of progestogen is determined by patient choice and previous known side effects. In principal the more androgenic the progestogen the greater the likelihood of PMS side effects but with improved bleeding profile.

The C19 group are most likely to cause PMS side effects but it is not exclusively. To alleviate PMS effects:

- Decrease duration of progestogen to 10 days, bearing in mind that the incidence of endometrial hyperplasia increases to 2% (Pike et al. 1997).

Androgenic side-effects are commonly experienced with C19 progestogens. C19 progestogens are very effective for endometrial stabilisation and bleeding control but with a higher incidence of PMS, acne hirsutism and hair loss.

- Decrease dosage of progestogen to 10-12 days if used cyclically.
- Use product with less androgenic progestogen ie.C21 rather than C19 progestogen.
- Use natural progesterone as progestogenic opposition.
- Use local route; e.g. Levonorgestrel releasing intrauterine system (Mirena IUS ®). Warn about BTB and progestogenic side effects in first 3 to 6 months.

The novel Nomegestrol acetate has been designed to bind very specifically to the progesterone receptor to avoid androgenic, estrogenic or glucocorticoid side effects. (Now available as Zoely: an oral COC with estradiol valerate). However, evidence suggests that compared to drospirenone/ethinylestradiol it may have less favourable acne-related outcomes but shorter and lighter periods (Yang et al 2012)

C17 - Anti-mineralocorticoid progestogens may be selected specifically for their side effect as it may increase diuresis (due HRT induced fluid retention on other progestogens), and be

beneficial in relieving hirsutism and acne. Cyclical CPA 25mg, with estradiol, may be used (e.g. for PCOS).

Grade A RCT suggests that there is a class effect that may influence breast cancer risk. Natural bio-identical progesterone is suggested to confer a lower risk to breast cancer.

Management of Breakthrough Bleeding and Post-Menopausal Bleeding

In Post-Menopausal women, CCHRT confers greater protection against endometrial hyperplasia but an increased incidence of breakthrough bleeding. Sequential HRT has a lower incidence of irregular bleeding with a higher incidence of endometrial hyperplasia in the post-menopausal women on sequential HRT. (Pike et al. 1997)

Sequential therapy: If heavy bleeding occurs:

- Increase dose of progestogen (e.g. NET 5mg to 10mg).
- Change to a more androgenic (C19eg. NET) from C21 progestogen.
- Reduce dose of oral estrogen (e.g. from 2 to 1 mg).
- If persists > 6 months refer to PMB pathway for USS +/ OP hysteroscopy.
- Consider Mirena IUS

Continuous combined: If BTB occurs:

- Allow minimum of 3 months before change in strategy and give reassurance.
- After 3 months either continue for further 3 months with same preparation or switch to:
    - continuous combined with more androgenic progestogen.
    - continuous combined with less estrogen.
    - sequential HRT.
    - Mirena IUS ®.

NB: If BTB continues for more than 4 months or if starts de novo when bleed free for 1 year, arrange for urgent ultra sound or urgent referral to PMB pathway 2 week rule.

Stopping HRT
Patients who wish to stop HRT are advised to reduce gradually by decreasing dose or cutting tablets or patches in half. Women who need to stop HRT for breast cancer or similar treatments are given advice regarding stopping treatment immediately. We advise that vasomotor symptoms may recur in the short term if treatment is withdrawn suddenly but this makes no difference in the long term.

6.6 Risks and Benefits Associated with HRT

Main indication for HRT is for symptom relief and is the most effective treatment for this

BMS/IMS: World Consensus Statement (de Villiers, Gass, et al. 2013)
MHRA: Hormone replacement therapy (HRT) (MHRA 2013)

In accordance with the BMS and IMS (de Villiers et al. 2013), HRT should be prescribed with the lowest effective dose. HRT is usually only prescribed in the 50-59 age group, during the **Window of Opportunity,** when the risks are least pronounced. Risk should be explained in absolute numbers per 1000 women. Pictograms should be used to clearly explain risks and benefits. There is little/no data indicating associated risks under the age of 50. HRT should

be used in POI or early menopause up to this age to protect against osteoporosis and cardiovascular disease – up until the age of 51.

All-Cause Mortality – Age Related
HRT is not advocated for long term health prevention although in hysterectomised women overall health benefit is observed compared to non-HRT users between the ages of 50-59 (LaCroix et al. 2011) and increase beyond 60 (Manson et al. 2013). Meta-analysis of RCTs in women using HRT from 1966 to Sept 2002 of 26, 708 women mean age 54 years demonstrated a significant reduction in mortality (39%) in women less than 60 years of age. RR 0.61 (CI 0.39 – 0.95). (Salpeter et al. 2004)

Benefits of HRT

Primary Grade A evidence from WHI (Manson et al. 2013)and subsequent reanalysis

Bone Benefits
Grade A evidence of fracture prevention in both hip and spine.
HRT increases bone density, remodelling and increases of trabecular bone structure. Benefits are maintained many years after stopping HRT and may be achieved with ultra-low doses of HRT (Huang et al. 2007).

Cardiovascular Benefits
In the **50-59 year age group** there is no increase in risk of CHD / stroke with a 30% reduced risk of all-cause mortality (10:10000 less deaths) (LaCroix et al. 2011). Grade A evidence for Transdermal HRT, by avoiding first pass effect, with beneficial effects on triglycerides and biological markers (Stevenson et al. 1993). Presence of cardiovascular risk factors is not a contraindication to HRT but should be optimally managed.

Colorectal Benefits
Grade A evidence supports Estrogen is protective, reducing incidence of bowel cancer with HRT (Manson et al. 2013)(Hartz et al. 2012)

Diabetes
In women with Type 2 diabetes HRT is not associated with an adverse effect on blood glucose control.

Dementia
The likelihood of HRT affecting the risk of dementia is unknown

Muscle mass and strength
There is limited evidence to suggest that HRT may improve muscle mass and strength.

Risks with HRT

Breast Cancer

Breast cancer is the most commonly cited fear associated with the use of HRT. The risk is much lower than that associated with obesity, alcohol intake and delay in first pregnancy.The absolute increase in breast cancer risk is 5 extra cases/1000 women for 7.5 years of combined HRT use (BMS consensus) and reverts back to the population risk 5 years after stopping. HRT does not affect the risk of dying from breast cancer.The same risk is not seen with Estrogen only. In fact there is no or a reduced risk of breast cancer with estrogen only

HRT use. The use of HRT does not exaggerate that due to a family history of breast cancer and is not contraindicated. Patients carrying a high risk due to family history should be assessed via the clinical genetics pathway and advised there about additional screening if relevant.

Mutation carriers who have had risk reducing surgery are usually seen in the specialist clinic where monitoring of BMD and duration can be discussed on an individual basis.
Discussion on lifestyle issues, weight loss and exercise to reduce risk are appropriate in this context.
Refer to NICE guidance on breast cancer section 1.13 and section 1.7 of the NICE guidance on familial breast cancer

Venous Thromboembolism Risks
Venous thromboembolism (VTE) can pose a serious health risk and in the most severe cases can cause death. HRT in the oral form is known to transiently influence blood clotting parameters and increase the risk of VTE two- to four-fold, with the highest risk in the first year of use. VTE risk is further increased in those with a personal or family history of VTE, advanced age, obesity and other risk factors such as surgery or hospitalisation. The risk associated with transdermal HRT given in standard doses is no greater than baseline population risk.

Endometrial Cancer Risks
There is no significant risk of malignancy with CCHRT although there may be an increase in BTB and hyperplasia (Wren et al. 2000). The prevalence of endometrial hyperplasia associated with sequential HRT is 5.4%, and that of atypical hyperplasia (endometrial intraepithelial neoplasia) is 0.7%. If previous history of endometrial carcinoma, weigh pros and cons based on symptoms, risk of osteoporosis versus differentiation, stage and prognosis of lesion. Use of either a continuous progestogen regimen or Mirena IUS is preferable.

Cardiovascular risks
The baseline risk of CHD or stroke varies from woman to woman according to the presence of risk factors. HRT with oestrogen alone is associated with no or reduced risk of cardiovascular disease. HRT with oestrogen and progesterone is associated with little or no increased risk of cardiovascular disease. Transdermal HRT does not confer at increased risk of stroke and oral HRT may be associated with a small increased risk. The baseline risk of stroke in women < 60 yrs is very low.

6.7 Management of specific conditions

Patient with history of VTE/thrombophilia

Risk Factors

Significant risk factors for VTE:
1. Personal history of VTE
2. Known thrombophilia
3. Anti cardiolipin or lupus anticoagulant positive
4. Family history of VTE
5. Recurrent miscarriage
6. Obesity

7. Heavy smoker
8. Significant varicose veins

Investigations

In all circumstances a detailed history should be taken. If a thrombophilia is suspected due to family or personal history, a referral should be made to a consultant haematologist for a haematological opinion. If there is a history of recurrent miscarriage and this has not previously been investigated then it is appropriate to test for anti cardiolipin antibodies and lupus anticoagulant.

Management of patient with history of VTE/thrombophilia

The VTE risk is associated with oral rather than transdermal estrogen administration and there is increasing evidence that risk is greater in combination with certain progestogens such as norpregnane derivatives and medroxyprogesterone acetate. Individuals requiring HRT should be risk assessed and counselled regarding their VTE risk. In individuals with an increased risk of VTE who require HRT, transdermal preparations should be used including a combined estrogen/progestogen patch. If a separate progestogen is required, suitable options might include micronized progesterone or the levonogestrel IUS.

Management of patient with history of breast cancer

The vast majority of breast cancers are estrogen receptor positive and require adjuvant treatment for 5-10 years post treatment (tamoxifen, aromatase inhibitors)
The side effects of these treatments can be acute and debilitating menopausal symptoms.

Randomised studies on the use of HRT in such patients are confusing as some had the appropriate use of tamoxifen with no recurrences (Von Schoultz et al 2005) while another revealed increased recurrence with inadequate use of tamoxifen.(Holmberg et al 2004) The use of HRT in breast cancer survivors is therefore by patient choice.

There is inadequate information on over the counter herbal and alternative therapies in these patients. Although there is some evidence that St John's wort may be of benefit in the relief of vasomotor symptoms, there is uncertainty about appropriate doses, persistence of effect, variation in the nature and potency of preparations and potential serious interactions with other drugs (including tamoxifen, anticoagulants and anticonvulsants).
Information about the stage of the disease at the time of diagnosis gives a guide to the prognosis, the current adjuvant therapy being used and the time since diagnosis are important considerations. HRT nullifies the effect of aromatase inhibitors and would be contraindicated in such cases. Most women wish to avoid hormonal intervention but a few will opt for quality of life and seek respite from their symptoms with a trial of HRT. In such it is advisable to liase with her oncologist/ breast team and document the decision in the notes.

Patients with ER-ve breast cancer may opt to use HRT or tibolone. Tibolone did not increase the recurrence rate in ER-ve patients diagnosed with breast cancer within 5 years (Bundred et al. 2012)) Recurrence of ER-ve disease is higher in the first 5 years after treatment and drops significantly thereafter. Due to the lack of research with HRT in these patients the decision to use it or not lies with the patient. These facts need to be explained in order for the woman to make an informed choice and documented in the notes to avoid unnecessary recriminations

Non hormonal treatments
Clonidine 50ug tds is licensed for management of hot flushes
SSRI's in low doses are unlicensed but reduce the severity and frequency of vasomotor symptoms by 60%.
SNRI's (venlafaxine) is only suitable for use with tamoxifen. Paroxetine and fluoxetine should not be offered to these women.
Gabapentin 300mg tds also unlicensed can reduce the frequency and severity of vasomotor symptoms.
We suggest a 3 month trial of one of the above and if effective then continue. If ineffective then discontinue and evaluate a second option.
GP's can evaluate the non-hormonal methods but referral to the specialist clinic would be appropriate for those in whom all of these failed to give relief**.**

Management of Premenstrual Syndrome

RCOG: Management of Premenstrual Syndrome (RCOG 2007)

PMS is a cyclical hormone disorder that causes distress (Rapkin & Akopians 2012). Symptoms by definition only occur a few days a month, generally in the luteal phase of the menstrual cycle, from ovulation and resolving with 2-3 days or menstruation. If no cyclical pattern is observable it is not a PMS. The key question is 'How many good days do you have a month'. PMS is not diagnosed through laboratory testing as hormonal results generally will be normal. Symptoms are due to personal genetic and psychological predisposition.

Many women experience some degree of premenstrual physical or psychological symptoms. However, only a few have symptoms that severally affect their quality of life and wellbeing. Typical symptoms range from mild bloating and pelvic pain to cyclical migraines, depression, anxiety and self-harming. The age range of women affected is from teens to the perimenopause. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) classes extreme PMS that causes distress as premenstrual dysphoric syndrome (PMDD).

Most women will have tried simple lifestyle changes prior to being referred but these should always be revisited and noted e.g. low GI diet, nutritional supplements and excise. CBT or counselling should be offered, accessible via the GP. Where clear diagnosis is evident from a patient diary and history, then cycle suppression with HRT or COC may be considered. (See Algorithm, Appendix B)

SSRIs are commonly used as a treatment for PMD. Meta analyses have shown up to 60% improvement in symptom relief with the use of SSRIs and serotonin norepinephrine reuptake inhibitors (Rapkin AJ et al 2008). The most useful drugs appear to be fluoxetine and sertraline and are effective either used continuously or only in the luteal phase of the cycle (Pearlstein TB et al 2000). Other anxiolytics and anti-depressants which act only on augmenting noradrenergic activity do not appear to significantly improve symptoms associated with PMD (Pearlstein TB et al 1997; Freeman EW et al 1996; Eriksson E et al 1995).

Estrogen is the one of the most effective means for down regulation. The transdermal route provides a more physiological and consistent delivery, with least side effects. Young women will require higher dose to achieve down regulation between 75-200mcg using estradiol patches. Higher doses will require consultant agreement and recorded in the notes.

Micronised progesterone is the preferred first choice progestogen in PMS if CCHRTin the form of tibolone is not well tolerated. It is used with estrogen for the prevention the risk of endometrial hyperplasia. Progestogens themselves, through direct action and their metabolites, may induce PMS-type symptoms and are typically not well tolerated. Cyclical regimens may be shortened to minimise this effect but should not be used for less than 10 days. Luteal phase estrogen may be prescribed in some instances to overcome this but all none standard regimens should be agreed by a specialist within the clinic prior to implementation. Mirena IUS may be better tolerated than oral progestagens.

In severe PMDD down regulation may be needed with GnRHa. Add-back HRT is required as the down regulation induces hypoestrogenism. This can lead to the reintroduction of PMS like symptoms. A lower dose or shortened course of progestagen can alleviate this and Tibolone has been demonstrated to cause less PMS symptoms than other CCHRT (Wyatt et al 2004). The use of the Mirena IUS in conjuction with estrogen is also a suitable alternative. With few exceptions all hormonal treatment for PMS is off licence and the patient must be likewise advised with information given and this recorded in their notes. GPs are not obligated to provide ongoing treatment. In this instance repeat prescriptions are available via the patient helpline.

Management of Premature Ovarian Insufficiency

BMS: Consensus – Premature Menopause (BMS 2013). There are no ratified national or international standard guidelines. Evidence based good practice principles are followed.

Age <40 years. These women must be managed in the specialist POI clinic and reviewed yearly.

The pathogenesis of POI is poorly understood (Rapkin & Akopians 2012). A significant proportion of women will have no known cause. With the increasing survival of juvenile and young adult cancers many women will be surviving decades following an iatrogenic menopause (Thomas-Teinturier et al. 2013). Between 2-8% may have identifiable genetic or autoimmune causes although this may be widely under reported (Ferrarini et al. 2013). The long term sequela is premature cardiovascular disease and osteoporosis (Maclaran et al. 2010). HRT is required until the average age of the menopause.

Initial Investigation

- Hormone profile: FSH, LH, E2 on at least two occasions 4-6 weeks apart
- Anti Mullerian Hormone (AMH) (privately) not routinely performed
- Depending on presenting history: Thyroid function test, prolactin.
- Genetic testing: Fragile X and molecular cytogenetics
- Autoimmune antibodies: Adrenal, Ovarian, Thyroid.
- Bone density scan – caution: depending upon age of onset peak bone mass may not have been achieved.
- TVUSS can be useful if primary amenorrhoea to assess for presence of ovaries/uterus. If patient is considering donor egg treatment TV USS useful to assess uterine size.

Initial Treatment

- If not seeking a pregnancy – HRT for long term heart and bone health +/- symptom relief. HRT will offer bone and cardiovascular protection and should be continued until at least 50 yrs. HRT is not a contraceptive and if this is required the combined oral contraceptive pill (COCP) may be preferable.

- If seeking pregnancy – avoid HRT implants and refer to fertility clinic. Advise contraception or reversible HRT.
- Note: Although lower doses of estrogen appear to be bone conserving in older women, we should try to aim for the standard doses of estrogen in women <50 years, if tolerated. COCP can be used instead of conventional HRT. Both will offer bone protection and HRT may have a beneficial effect on blood pressure combined to COCP.
- HRT should be continued until aged 50 yrs and beyond.

Management of Post-Menopausal Osteoporosis

Explain to women that the baseline risk of a fragility fracture is low in women around menopausal age.

NICE: Primary Prevention Osteoporosis (NICE 2011a)
NICE: Secondary Prevention Osteoporosis (NICE 2011b)
The British Menopause Society and Endocrine Society recommend that HRT can be used for bone protection between the ages of 50-59 years. (BMS 2013) (de Villiers et al. 2013)

Bisphosphonates
The **bisphosphonates** (Alendronic Acid, Ibandronic acid and Risedronate, are effective for treating and preventing postmenopausal osteoporosis. **Hormone replacement therapy** (HRT) is an option where other therapies are contra-indicated, cannot be tolerated, or if there is lack of response. The CSM has advised that HRT should **not** be considered first-line therapy for long-term prevention of osteoporosis in women over 50 years of age. HRT is of most benefit for the prophylaxis of postmenopausal osteoporosis if started early in menopause and continued for up to 5 years, but bone loss resumes (possibly at an accelerated rate) on stopping HRT. Bone density may be maintained for longer if HRT is continued. Women of Afro-Caribbean origin appear to be less susceptible to osteoporosis than those who are white or of Asian origin.

Postmenopausal osteoporosis may be *treated* with a **bisphosphonate**. The bisphosphonates (such as Alendronate ®, Ibandronate and Risedronate ®) decrease the risk of vertebral fracture; Alendronate and Risedronate have also been shown to reduce non-vertebral fractures. If oral bisphosphonates are unsuitable, **parenteral forms of treatment including IV Zoledronic Acid or Denosumab** may be appropriate. **Teriparatide** is a synthetic form of parathyroid hormone that is used in the treatment of severe postmenopausal osteoporosis.

Risk factors for osteoporosis
Major risk factors (other than previous fragility fracture) include the following:
1. Genetic – family history of osteoporosis, especially first degree relative.
2. Parental history of hip fracture.
3. Glucocorticoids for longer than 3 months.
4. Disease associated with osteoporosis: inflammatory bowel disease, chronic liver disease, hyperparathyroidism, hyperthyroidism, malabsorption, rheumatoid arthritis and other chronic inflammatory conditions..
5. Radiological osteopenia.

Other risk factors include: alcohol intake > 4units per day, early menopause (<40), low body weight, cigarette smoking, height loss, or low bone mass as assessed by other techniques and lack of physical exercise.

Lifestyle advice:

- Adequate nutrition with intake of at least calcium (1000mg/day) and vitamin D (800iu/day).
- Regular weight bearing exercise.
- Avoidance of tobacco use and alcohol abuse.

The FRAX tool for assessing fracture risk

- The FRAX® algorithms give the 10-year probability of fracture and are the contemporary means of assessing fracture risk and need for BMD measurement (**WWW.SHEF.AC.UK/FRAX**). The output is a 10-year probability of hip fracture and the 10-year probability of a major osteoporotic fracture (clinical spine, forearm, hip or shoulder fracture). The tool assesses patients 40-90 years based on BMI, age, smoking, alcohol and medical, family and fracture history. This should be completed prior to requesting a DXA as it links with the national osteoporosis guideline group (NOGG) and will advise if BMD measurement is required.

Indications for DEXA scanning

- Patients with POI may benefit from baseline DXA
- Osteopenia **reported** on plain X-ray.
- Patients > 50 who have experienced any low impact fracture.
- A medical condition predisposing to osteoporosis e.g. metabolic bone disease, thyroid disease, liver disease, anorexia nervosa
- Systemic glucocorticoids for at least 3 months (or planned for 3 months or longer).
- Patients with a family history of osteoporosis or fractures.
- Parental history of hip fracture.

Interpretation of Bone Mineral Density (BMD) results
Age matched to white female Caucasian at peak bone density age 25-35

Category	BMD T-score
Normal	> -1SD
Osteopenia	< -1 but > -2.5
Osteoporosis	<or= -2.5
Severe osteoporosis	<or= -2.5 and prevalent fracture

Management of migraines/epilepsy and menopause.

Women who suffer from migraine with aura may be at greater risk of a cerebrovascular accident as result of estrogen treatment. However, it is the fluctuations in hormone levels which tends to trigger migraines and therefore maintaining a steady state of estogen should prevent migraines increasing in frequency. Similarly, seizure threshold can also be lowered around the time of the menopause as estrogen levels fluctuate. If a stable level of estrogen can be achieved then an increase in seizure frequency can be avoided.

Initial management
Fully assess patient and if epileptic ensure patient under neurologist and maximum control has been achieved.

Wherever possible initiate transdermal estrogen therapy in the form of patch, gel or implant. A summary of Risks v Benefits can be found in Appendix A

Guidance for choosing HRT Regimens can be found in Appendix B.

7 Review, Monitoring, and Revision Arrangements

7.1 All Trust policies / guidelines will be monitored for compliance in one of three ways:

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

7.2 Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

Monitoring	Method	Frequency	Lead	Reporting to	Action Plan Review by
New to follow up ratio	Audit	2 yearly	Lynne Robinson	Gynaecology Directorate	Clinical Governance Lead
Patient Experience	Survey	2 yearly	Lynne Robinson	Gynaecology Directorate	Clinical Governance Lead
Incidence / complications within the clinic to inform best practice	Audit	2 yearly	Lynne Robinson	Gynaecology Directorate	Clinical Governance Lead

8. Associated Documents

- Hormone Implant Clinic Guidelines

9. References

Anderson, G.L. et al., 2012. Conjugated equine oestrogen and breast cancer incidence and mortality in postmenopausal women with hysterectomy: extended follow-up of the Women's Health Initiative randomised placebo-controlled trial. *The lancet oncology*, 13(5), pp.476–86. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3412626&tool=pmcentrez&rendertype=abstract [Accessed December 17, 2013].

Beral, V.et al 2003. **Million Women Study**, "Breast cancer and hormone-replacement therapy in the Million Women Study". *Lancet* **362** (9382): 419–427.

Bertrand, K.A. et al., 2013. Mammographic density and risk of breast cancer by age and tumor characteristics. *Breast cancer research : BCR*, 15(6), p.R104. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24188089 [Accessed January 3, 2014].

Biglia, N. et al., 2010. Tibolone in postmenopausal women: a review based on recent randomised controlled clinical trials. *Gynecological endocrinology : the official journal of the International Society of Gynecological Endocrinology*, 26(11), pp.804–14. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20586550 [Accessed January 3, 2014].

BMS, 2013. The British Menopause Society: Consensus Article - Prevention and treatment of osteoporosis in women. *accessed 2014*. Available at: http://www.thebms.org.uk/statementpreview.php?id=6 [Accessed January 4, 2014].

Brown, S., 2013. IMS updates its recommendations on the use of HRT. *Menopause international*, 19(3), pp.105–6. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24195130 [Accessed January 3, 2014].

Bundred, N.J. et al., 2012. Tibolone increases bone mineral density but also relapse in breast cancer survivors: LIBERATE trial bone substudy. *Breast cancer research : BCR*, 14(1), p.R13. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3496130&tool=pmcentrez&rendertype=abstract [Accessed January 3, 2014].

Chlebowski, R.T. et al., 2013. Estrogen plus progestin and breast cancer incidence and mortality in the Women's Health Initiative Observational Study. *Journal of the National Cancer Institute*, 105(8), pp.526–35. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23543779 [Accessed December 18, 2013].

Davey, D.A., 2012. Androgens in women before and after the menopause and post bilateral oophorectomy: clinical effects and indications for testosterone therapy. *Women's health (London, England)*, 8(4), pp.437–46. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22757734 [Accessed January 3, 2014].

Davis, S.R. & Braunstein, G.D., 2012. Efficacy and safety of testosterone in the management of hypoactive sexual desire disorder in postmenopausal women. *The journal of sexual medicine*, 9(4), pp.1134–48. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22304681 [Accessed January 3, 2014].

Elshafie, M.A.A. & Ewies, A.A.A., 2007. Transdermal natural progesterone cream for postmenopausal women: inconsistent data and complex pharmacokinetics. *Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology*, 27(7), pp.655–9. Available at: http://www.ncbi.nlm.nih.gov/pubmed/17999287 [Accessed January 3, 2014].

Eriksson, E. et al., 1995. The serotonin reuptake inhibitor paroxetin is superior to the noradrenaline reuptake inhibitor maprotiline in the treatment of premenstrual syndrome. *Neuropsychopharmacology,* 12(2), pp 167-76

Ferrarini, E. et al., 2013. Clinical characteristics and genetic analysis in women with premature ovarian insufficiency. *Maturitas*, 74(1), pp.61–7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23107817 [Accessed January 3, 2014].

Freeman, E.W. et al., 1996. Sertraline versus desipramine in the treatment of premenstrual syndrome: an open-label trial. *J Clin Psychiatry,* 57(1), pp 7-11.

Fritz, H. et al., 2013. Soy, red clover, and isoflavones and breast cancer: a systematic review. *PloS one*, 8(11), p.e81968. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3842968&tool=pmcentrez&rendertype=abstract [Accessed January 3, 2014].

Ghazal, S. & Pal, L., 2013. Perspective on hormone therapy 10 years after the WHI. *Maturitas*, 76(3), pp.208–12. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24094493 [Accessed January 3, 2014].

Hartz, A., He, T. & Ross, J.J., 2012. Risk factors for colon cancer in 150,912 postmenopausal women. *Cancer causes & control : CCC*, 23(10), pp.1599–605. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22855257 [Accessed January 3, 2014].

Holmberg, L., Anderson, H., 2004. HABITS (hormonal replacement therapy after breast cancer--is it safe?), a randomised comparison: trial stopped. *Lancet*, 7;363(9407):453-5

Huang, A.J. et al., 2007. Endogenous estrogen levels and the effects of ultra-low-dose transdermal estradiol therapy on bone turnover and BMD in postmenopausal women. *Journal of bone and mineral research : the official journal of the American Society for Bone and Mineral Research*, 22(11), pp.1791–7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/17620054 [Accessed January 3, 2014].

Jonasson AF et al., 2011. Topical oxytocin reverses vaginal atrophy in postmenopausal women: a double-blind randomized pilot study. *Menopause International,* 17(4), pp120-5

Kane, S.C. & Quinn, M.A., 2009. Complex endometrial hyperplasia in the context of tibolone administration. *The Australian & New Zealand journal of obstetrics & gynaecology*, 49(3), pp.338–9. Available at: http://www.ncbi.nlm.nih.gov/pubmed/19566575 [Accessed January 3, 2014].

Krychman, M.L., 2011. Vaginal estrogens for the treatment of dyspareunia. *The journal of sexual medicine*, 8(3), pp.666–74. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21091878 [Accessed January 3, 2014].

Labrie, F. et al., 2009. Intravaginal dehydroepiandrosterone (Prasterone), a physiological and highly efficient treatment of vaginal atrophy. *Menopause*, 16(5) pp. 907-22

LaCroix, A.Z. et al., 2011. Health outcomes after stopping conjugated equine estrogens among postmenopausal women with prior hysterectomy: a randomized controlled trial. *JAMA : the journal of the American Medical Association*, 305(13), pp.1305–14. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3656722&tool=pmcentrez&rendertype=abstract [Accessed January 3, 2014].

Leach, M.J. & Moore, V., 2012. Black cohosh (Cimicifuga spp.) for menopausal symptoms. *The Cochrane database of systematic reviews*, 9, p.CD007244. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22972105 [Accessed January 3, 2014].

Maclaran, K., Horner, E. & Panay, N., 2010. Premature ovarian failure: long-term sequelae. *Menopause international*, 16(1), pp.38–41. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20424285 [Accessed January 3, 2014].

Manson, J.E. et al., 2013. Menopausal hormone therapy and health outcomes during the intervention and extended poststopping phases of the Women's Health Initiative randomized trials. *JAMA : the journal of the American Medical Association*, 310(13), pp.1353–68. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24084921 [Accessed December 23, 2013].

MHRA, 2004. Current Problems in Pharmacovigilance. , 30, pp.1–12. Available at: http://www.mhra.gov.uk/Publications/Safetyguidance/CurrentProblemsinPharmacovigilance/CON007447 [Accessed February 2, 2014].

MHRA, 2013. Hormone replacement therapy (HRT). *Medicines and Healthcare products Regulatory Agency (MHRA), www.mhra.gov.uk, info@mhra.gsi.gov.uk*. Available at: http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/Product-specificinformationandadvice/Product-specificinformationandadvice-G-L/Hormonereplacementtherapy(HRT)/ [Accessed January 3, 2014].

NICE, 2011a. Osteoporosis - primary prevention. Available at: http://www.nice.org.uk/ta160 [Accessed January 3, 2014].

NICE, 2011b. Osteoporosis - secondary prevention including strontium ranelate. Available at: http://www.nice.org.uk/ta161 [Accessed January 3, 2014].

Panay, N. et al., 2010. Testosterone treatment of HSDD in naturally menopausal women: the ADORE study. *Climacteric : the journal of the International Menopause Society*, 13(2), pp.121–31. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20166859 [Accessed January 3, 2014].

Panay, N. & Fenton, A., 2012. Premature ovarian insufficiency: working towards an international database. *Climacteric : the journal of the International Menopause Society*, 15(4), pp.295–6. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22762437 [Accessed January 3, 2014].

Pearlstein, TB. et al., 2000. Psychosocial functioning in women with premenstrual dysphoric disorder before and after treatment with sertraline or placebo. *J Clin Psychiatry.* 61(2), pp 101-9.

Pearlstein, TB. et al., 1997. Comparison of fluoxetine, bupropion, and placebo in the treatment of premenstrual dysphoric disorder. *J Clin Psychopharmacol.* 17(4), pp 261-6.

Pike, M.C. et al., 1997. Estrogen-progestin replacement therapy and endometrial cancer. *Journal of the National Cancer Institute*, 89(15), pp.1110–6. Available at: http://www.ncbi.nlm.nih.gov/pubmed/9262248 [Accessed January 3, 2014].

Pinkerton, J. V et al., 2013. Phase 3 randomized controlled study of gastroretentive gabapentin for the treatment of moderate-to-severe hot flashes in menopause.

Menopause (New York, N.Y.). Available at: http://www.ncbi.nlm.nih.gov/pubmed/24149930 [Accessed December 29, 2013].

Pitkin, J., 2012. Alternative and complementary therapies for the menopause. *Menopause international*, 18(1), pp.20–7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22393177 [Accessed January 3, 2014].

Rada, G. et al., 2010. Non-hormonal interventions for hot flushes in women with a history of breast cancer. *The Cochrane database of systematic reviews*, (9), p.CD004923. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20824841 [Accessed January 3, 2014].

Rapkin, A.J. & Akopians, A.L., 2012. Pathophysiology of premenstrual syndrome and premenstrual dysphoric disorder. *Menopause international*, 18(2), pp.52–9. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22611222 [Accessed January 3, 2014].

Rapkin, A.J. & Winer, S.J., 2008. The pharmacologic management of premenstrual dysphoric disorder. *Expert Opin Pharmacother*, 9(3), pp 429-45

RCOG, 2007. Premenstrual Syndrome, Management (Green-top 48). *RCOG*. Available at: http://www.rcog.org.uk/womens-health/clinical-guidance/management-premenstrual-syndrome-green-top-48 [Accessed January 3, 2014].

Rossouw, J.E. et al., 2002. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results From the Women's Health Initiative randomized controlled trial. *JAMA : the journal of the American Medical Association*, 288(3), pp.321–33. Available at: http://www.ncbi.nlm.nih.gov/pubmed/12117397 [Accessed December 27, 2013].

Salpeter, S.R. et al., 2004. Mortality associated with hormone replacement therapy in younger and older women: a meta-analysis. *Journal of general internal medicine*, 19(7), pp.791–804. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1492478&tool=pmcentrez&rendertype=abstract [Accessed January 3, 2014].

Shams, T. et al., 2013. SSRIs for Hot Flashes: A Systematic Review and Meta-Analysis of Randomized Trials. *Journal of general internal medicine*. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23888328 [Accessed January 3, 2014].

Speroff, L., 2009. The LIBERATE tibolone trial in breast cancer survivors. *Maturitas*, 63(1), pp.1–3. Available at: http://www.ncbi.nlm.nih.gov/pubmed/19327923 [Accessed January 3, 2014].

Stevenson, J.C. et al., 1993. Oral versus transdermal hormone replacement therapy. *International journal of fertility and menopausal studies*, 38 Suppl 1, pp.30–5. Available at: http://www.ncbi.nlm.nih.gov/pubmed/8499957 [Accessed January 3, 2014].

Sturdee, D.W. et al., 1978. Relations between bleeding pattern, endometrial histology, and oestrogen treatment in menopausal women. *British medical journal*, 1(6127), pp.1575–7. Available at:

http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1605378&tool=pmcentrez&rendertype=abstract [Accessed January 10, 2014].

Sweetland, S. et al., 2012. Venous thromboembolism risk in relation to use of different types of postmenopausal hormone therapy in a large prospective study. *Journal of thrombosis and haemostasis : JTH*. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22963114 [Accessed January 3, 2014].

Tella, S.H. & Gallagher, J.C., 2013. Bazedoxifene + conjugated estrogens in HT for the prevention of osteoporosis and treatment of vasomotor symptoms associated with the menopause. *Expert opinion on pharmacotherapy*, 14(17), pp.2407–20. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24093499 [Accessed January 3, 2014].

Thomas-Teinturier, C. et al., 2013. Age at menopause and its influencing factors in a cohort of survivors of childhood cancer: earlier but rarely premature. *Human reproduction (Oxford, England)*, 28(2), pp.488–95. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23154067 [Accessed January 3, 2014].

De Villiers, T.J. et al., 2013. Global consensus statement on menopausal hormone therapy. *Climacteric : the journal of the International Menopause Society*, 16(2), pp.203–4. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23488524 [Accessed December 31, 2013].

Von Shoultz, E. et al., 2005. Menopausal hormone therapy after breast cancer: the Stockholm randomized trial. *J Natl Cancer Inst,* 6;97(7):533-5

Wyatt, KM., et al., 2004. The effectiveness of GnRHa with and without 'add-back' therapy in treating premenstrual syndrome: a meta analysis. *BJOG*, 111:585–93

Wills, S. et al., 2012. Effects of vaginal estrogens on serum estradiol levels in postmenopausal breast cancer survivors and women at risk of breast cancer taking an aromatase inhibitor or a selective estrogen receptor modulator. *Journal of oncology practice / American Society of Clinical Oncology*, 8(3), pp.144–8. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3396801&tool=pmcentrez&rendertype=abstract [Accessed January 3, 2014].

Wren, B.G. et al., 2000. Effect of sequential transdermal progesterone cream on endometrium, bleeding pattern, and plasma progesterone and salivary progesterone levels in postmenopausal women. *Climacteric : the journal of the International Menopause Society*, 3(3), pp.155–60. Available at: http://www.ncbi.nlm.nih.gov/pubmed/11910616 [Accessed January 3, 2014].

Yenen, M.C. et al., 2003. Hormone replacement therapy in postmenopausal women with benign fibrocystic mastopathy. *Climacteric : the journal of the International Menopause Society*, 6(2), pp.146–50. Available at: http://www.ncbi.nlm.nih.gov/pubmed/12841885 Accessed January 3, 2014].

Appendix A

Summary of Risk versus Benefits associated with using HRT

Taken from: Current Problems in Pharmacovigilance: Volume 30 (pages 1-12) October 2004
(MHRA 2004). (Also refer to BNF HRT risk table http://www.evidence.nhs.uk/formulary/bnf)

Condition	Age of woman (yr)	Number of cases/ 1000 non-HRT users		Extra number of cases in 1000 HRT users for 5 years HRT use over the same period*	
Cumulative cancer risk over 5 years				**Oestrogen-only**	**Combined HRT**
Breast cancer Million Women Study	50-64	14[a]		1.5 (±1.5)	6 (±1)
		CEE[b]	CEE + MPA[b]		
WHI	50-79	15	16	No significant effect	4 (±4)
Endometrial cancer	50-69	3[b]		5 (±1)[c]	Cannot be estimated[d]
Ovarian cancer[e]	50-69	3		1 (±1)	Not known
Cardiovascular risks over 5 years					
		CEE[b]	CEE + MPA[b]		
Stroke	50-59 60-69	8 15	3 11	2 (±2) 6 (±4)	1 (±1) 4 (±3)
VTE	50-59 60-69	6.5 11.5	3 8	1 (±1) 4 (±4)	4 (±2) 9 (±5)
Benefits over 5 years				**Reduced number of cases in 1000 HRT users over the same period**	
		CEE[b]	CEE + MPA[b]		
Colorectal cancer	50-59 60-69	6 10	3 8	No significant effect	1 (±1) 3 (±2)
Fracture of neck of femur[9]	50-59 60-69	0.5 5.5	1.5 5.5	0.3 (±0.5) 3 (±2)	0.3 (±1) 3 (±2)

Numbers are best estimates (± approximate range from 95% Confidence Intervals).
* All values are from the WHI trial unless otherwise stated.
[a] A cumulative risk of 14 cases/1000 non-HRT users over 5 years has been used to facilitate comparison of the MWS and the WHI studies.
[b] Estimates from the placebo groups of the WHI trial.
[c] Relative risk associated with 5 years' use of oestrogen-only HRT (RR = 2.8[2.3-3.5] from meta-analysis[15].
[d] Risk cannot be reliably estimated - the addition of a progestogen for at least 12 days per month greatly reduces the additional risk of endometrial cancer due to unopposed oestrogen, but the magnitude of the reduction is poorly defined at present.
[e] Sources of data for all ovarian cancer estimate [12, 13, 14].

See full document for references

Appendix B

HRT Regimens

<table>
<tr><th colspan="3">Choosing HRT Regimens</th></tr>
<tr><td colspan="3">Dependent upon - age : past medical history : patient choice</td></tr>
<tr><th colspan="2">Without Uterus</th><th>With Uterus</th></tr>
<tr><td colspan="2">Estrogen only HRT</td><td>Perimenopausal
Still menstruating</td><td>Postmenopausal
12 months post LMP</td></tr>
<tr><td colspan="2"></td><td>Sequential Combined HRT
Until age 51 or after 1 year of SCHRT</td><td>Continuous Combined HRT
After age 51 or 1 year after SCHRT</td></tr>
<tr><th colspan="3">PMS and PMDD Algorithm Medical Management</th></tr>
<tr><td colspan="3">Patient choice of cycle suppression or psychiatric approach or both</td></tr>
<tr><td>First Line</td><td colspan="2">• Exercise, cognitive behaviour therapy, Vitamin B6
• Combined new generation contraceptive pill eg Zoley, Yasmin, Qlaira, Cilest (cyclically or back to back)
• Continuous or luteal phase (day 15-28) low dose SSRI e.g. citalopram or citalopram</td></tr>
<tr><td>Second Line</td><td colspan="2">• Estradiol patches (100mcg) + oral / vaginal progesterone e.g. Utrogestan
• Higher dose SSRI continuously or luteal phase</td></tr>
<tr><td>Third Line</td><td colspan="2">• GnRHa analogue + add back HRT (Continuous estrogen +progesterone or Tibolone)</td></tr>
<tr><td>Fourth Line</td><td colspan="2">• Total hysterectomy + BSO + HRT (Inc testosterone)</td></tr>
</table>

Appendix C – Plan for Dissemination of Procedural Documents

To be completed by the Head of Corporate Affairs and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**Menopause Service Clinical Guidelines**		
Date finalised:	**22.03.16**	**Dissemination lead: Print name and contact details**	**Lynne Robinson**
Previous document already being used?	**No**		
If yes, in what format and where?			
Proposed action to retrieve out-of-date copies of the document:			
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
	Email notification	**Electronic**	
	EVE / Intranet		

Dissemination Record to be used once document is approved

Date put on register / library of procedural documents		**Date due to be reviewed**		
Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**

Appendix D – Equality Impact Assessment Tool

Policy/Function Details	
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	**Menopause Service Clinical Guidelines**
Is this a new policy or function?	New ✓ Existing ☐ Updated ☐
Responsible Manager	Miss Lynne Robinson
Date Assessment Completed:	15.03.16
Sources of Data	British Menopause Society, Chelsea and Westminster Menopause Service Guidelines

Screening Assessment					
Equality Group	**Impact**		**Status of Impact**		**Brief Detail of impact**
	Yes	**No**	**Positive**	**Negative**	
Race, Ethnicity, Colour, Nationality or national origin (incl. Romany Travellers, refugees and asylum seekers)		✓			
Gender or Marital Status of Men or Women		✓			
Gender or Marital Status of Transsexual or Transgender people		✓			
Religion or belief		✓			
Physical or Sensory Impairment		✓			
Mental Health Status		✓			
Age or perceived age		✓			
Sexual Orientation (Gay, Lesbian, Bisexual)		✓			
Offending Past		✓			
Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)		✓			

[1] Policy/Function for the purpose of this document also includes Services, Plans, SLAs, Contracts, Care Pathways and Service or Care Frameworks.

Assessment Narrative	
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?	
No	
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?	
No	
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?	
No impact – will apply to all patients referred on menopause pathway	
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?	
On Intranet	
How will the impact of the policy/service be monitored and reviewed?	
See Section 7	
Assessor Name:	**Miss Lynne Robinson**
Assessor Job Title:	**Clinical Lead – Menopause Services**
Date Completed:	**15.03.16**

Appendix E – Policy Checklist

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Yes**	
	Has all the information on the front page been completed?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	**Yes**	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Is the responsible policy leads name and title clearly printed?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?	Yes	
5.	**Format**		
	Does the policy conform to the prescribed policy format?	**Yes**	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Yes**	
	Are key references cited using Harvard referencing?	**Yes**	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Approval**		
	Does the document identify which committee/group will approve it?	**Yes**	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	**N/A**	
8.	**Document Control**		
	Has a version control sheet been placed at the front of document, and been filled out correctly?	**Yes**	
9.	**Process to Monitor Compliance and Effectiveness**		
	Is there a plan to review or audit compliance with the document?		**Section 7**
10	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?	**Yes**	
11	**Equality Assessment**		
	Has an equality impact assessment been carried out?	**Yes**	

Individual Approval			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name/Designation		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name/Designation	**Salmah Mahmood (on behalf of Gynae Directorate)**	Date	
Signature			