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Position statement

Global Consensus Statement on menopausal hormone therapy☆

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The following Consensus Statement is endorsed by The American Society for Reproductive Medicine, The Asia Pacific Menopause Federation, The Endocrine Society, The European Menopause and Andropause Society, The International Menopause Society, The International Osteoporosis Foundation and The North American Menopause Society.

The past 10 years saw much confusion regarding the use of menopausal hormone therapy (MHT). New evidence challenged previously accepted clinical guidelines, especially on aspects of safety and disease prevention. This led to many women unnecessarily being denied the use of MHT. Detailed revised guidelines were published and regularly updated by the major regional menopause societies. The confusion was initially escalated by significant differences amongst published guidelines. In recent revisions, the differences have become much less. In view of this, The International Menopause Society took the initiative to arrange a round-table discussion, in November 2012, between representatives of the major regional menopause societies to reach consensus on core recommendations regarding MHT. The aim was to produce a short document in bullet-point style, only containing the points of consensus. It is acknowledged that, in view of the global variance of disease and regulatory restrictions, these core recommendations do not replace the more detailed and fully referenced recommendations prepared by individual national and regional societies. This document serves to emphasize international consensus regarding MHT and is aimed at empowering women and health-care practitioners in the appropriate use of MHT.

- MHT is the most effective treatment for vasomotor symptoms associated with menopause at any age, but benefits are more likely to outweigh risks for symptomatic women before the age of 60 years or within 10 years after menopause.
- MHT is effective and appropriate for the prevention of osteoporosis-related fractures in at-risk women before age 60 years or within 10 years after menopause.
- Randomized clinical trials and observational data as well as meta-analyses provide evidence that standard-dose estrogen-alone MHT may decrease coronary heart disease and all-cause mortality in women younger than 60 years of age and within 10 years of menopause. Data on estrogen plus progestogen MHT in this population show a similar trend for mortality but in most randomized clinical trials no significant increase or decrease in coronary heart disease has been found.
- Local low-dose estrogen therapy is preferred for women whose symptoms are limited to vaginal dryness or associated discomfort with intercourse.
- Estrogen as a single systemic agent is appropriate in women after hysterectomy but additional progestogen is required in the presence of a uterus.
- The option of MHT is an individual decision in terms of quality of life and health priorities as well as personal risk factors such as age, time since menopause and the risk of venous thromboembolism, stroke, ischemic heart disease and breast cancer.
- The risk of venous thromboembolism and ischemic stroke increases with oral MHT but the absolute risk is rare below age 60 years. Observational studies point to a lower risk with transdermal therapy.
- The risk of breast cancer in women over 50 years associated with MHT is a complex issue. The increased risk of breast cancer is primarily associated with the addition of a progestogen to estrogen therapy and related to the duration of use. The risk of breast cancer attributable to MHT is small and the risk decreases after treatment is stopped.
- The dose and duration of MHT should be consistent with treatment goals and safety issues and should be individualized.
- In women with premature ovarian insufficiency, systemic MHT is recommended at least until the average age of the natural menopause.
- The use of custom-compounded bioidentical hormone therapy is not recommended.

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- Current safety data do not support the use of MHT in breast cancer survivors.

These core recommendations will be reviewed in the future as new evidence becomes available.

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