ACOG Revises Guidelines on Treating Menopause Symptoms

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The American College of Obstetricians and Gynecologists has updated its Practice Bulletin for treating vasomotor symptoms of menopause ("hot flushes") and vaginal atrophy.

The 2014 Practice Bulletin introduces new drug information, but there are no new risks or dangers, said Clarisa Gracia, MD, associate professor of gynecology and obstetrics at the Perelman School of Medicine of the University of Pennsylvania, Philadelphia, who helped to develop the recommendations. Of 112 references cited, 93 were published since the last report, many from the last 2 years.

The updated bulletin, which replaces the June 2001 version, was <http://journals.lww.com/greenjournal/Abstract/2014/01000/Practice_Bulletin_No__141___Management_of.37.aspx> published in the January 2014 issue of Obstetrics & Gynecology.

"While the hormone therapy recommendations are similar to prior recommendations, there is more evidence to support nonhormonal alternatives such as [selective serotonin reuptake inhibitors] and [selective serotonin and norepinephrine reuptake inhibitors] for management of vasomotor symptoms. In addition, the document updates newer agents that combine [selective estrogen receptor modulators] and estrogen to reduce negative side effects. Additional long-term data are needed to determine risks associated with new agents," Dr. Gracia told Medscape Medical News. Paroxetine is the only such drug approved by the US Food and Drug Administration (FDA) for menopause symptoms.

Hot flushes affect from 50% to 82% of US women who experience natural menopause, and 10% to 40% report vaginal atrophy. Of those who have hot flushes, 87% suffer daily and 33% have 10 or more episodes daily. Median duration of vasomotor symptoms is from 4 to 10.2 years.

The Women's Health Initiative study demonstrated that the major risks of hormone therapy (HT; estrogen and progestin) are venous thromboembolism and breast cancer. A study from 2013 confirmed that the risks of conjugatedequine estrogen and medroxyprogesterone acetate outweigh the benefits.

An American College of Obstetricians and Gynecologists Committee Opinion from April 2013 found that transdermal delivery is safer than oral administration of HT. The new Practice Bulletin states that HT should not be discontinued at age 65 years, because some women have hot flushes longer.

The report mentions FDA approval of 2 new drugs: bazedoxifene instead of progestin with conjugated estrogen for hot flushes and osteoporosis prevention, and ospemifene for vaginal dryness that may cause dyspareunia.

The Practice Bulletin also points out what to avoid: Progestin alone increases breast cancer risk, and testosterone poses no benefit (except improved sexual satisfaction), but comes with multiple risks.

Too little evidence supports benefit of compounded bioidentical hormones, phytoestrogens, herbal remedies, or exercise. Clonidine and gabapentin have shown some efficacy but are not FDA-approved for treating menopausal symptoms.

"Because all medications have potential side effects and risks associated with their use, it is important to weigh the potential risks and benefits of treatment. Therapy should be individualized," Dr. Gracia told Medscape Medical News.

The recommendations are listed in 3 tiers:

Level A ("good or consistent scientific evidence"):

* Systemic HT, with just estrogen or estrogen plus progestin, is the most effective approach for treating vasomotor symptoms.

* Low-dose and ultra-low systemic doses of estrogen have a more favorable adverse effect profile than standard doses.

* Healthcare providers should individualize care and use the lowest effective dose for the shortest duration.

* Thromboembolic disease and breast cancer are risks for combined systemic HT.

* Selective serotonin reuptake inhibitors, selective serotonin and norepinephrine reuptake inhibitors, clonidine, and gabapentin relieve vasomotor symptoms and are alternatives to HT.

* Local estrogen therapy is advised for isolated atrophic vaginal symptoms.

* The only nonhormonal therapy approved to treat vasomotor symptoms is paroxetine, and to treat dyspareunia is ospemifene.

Level B conclusions ("limited or inconsistent scientific evidence"):

* Data do not support use of progestin alone, testosterone, compounded bioidentical hormones, phytoestrogens, herbal supplements, and lifestyle modifications.

* "Common sense lifestyle solutions" are layering clothing, lowering room temperature, and consuming cool drinks.

* Nonestrogen water-based or silicone-based lubricants and moisturizers may alleviate pain.

Level C recommendation ("based primarily on consensus and expert opinion"):

* Individualize the decision to continue HT.

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