NICE guideline on menopause 2024: practice-changing points

1. NICE guideline on menopause 2024: practice-changing points

The NICE guideline for menopause first came out in 2015 and was the first national guideline to provide evidence-based advice on menopause. It was hailed as an important and welcome publication to guide clinicians in effective and evidence-based management of menopausal women's symptoms, especially with regard to the use of HRT.

This article was written in December 2024.

1.1. What's happened since 2015?

Change in the menopause landscape: the rise of the British Menopause Society

Since 2015, the landscape of menopause medicine has greatly changed, accompanied by increased awareness and interest from patients, the media and the medical profession. The British Menopause Society (BMS), in particular, has grown into an influential organisation which is the principal national authority on menopause practice.

The BMS publishes its own journal, organises conferences, provides education, and has been prolific in producing evidence-informed best practice guidelines and consensus statements on many aspects of menopause care; these are often endorsed by other national medical bodies such as the RCOG, FSRH, RCGP and the BGCS (British Gynaecological Cancer Society).

Is NICE guidance on menopause still relevant?

As time has passed and new data has published, menopause practice has changed, and the 2015 NICE guidance has become increasingly outdated (and perhaps a little redundant). Consequently, in 2024, NICE revised and updated its original guideline.

Has this new version added anything to what we know already? The 2024 NICE guideline is 106 pages long and contains links to other related NICE guidelines, as well as additional supplements and evidence review summaries. It provides a comprehensive review of the evidence, and (for the most part) reflects and reinforces best practice endorsed by the BMS.

In this article, we do not summarise the whole document because many of its recommendations are not new and are already covered by our other menopause articles. Instead, we include the main practice-changing areas which may be new to us in primary care (NICE, 2015 (updated 2024), NG23).

1.2. CBT for vasomotor symptoms, depressive symptoms and insomnia

NICE recommends 'menopause-specific' cognitive behavioural therapy (CBT):

- As a treatment option for vasomotor symptoms alongside or instead of HRT.
- For depressive symptoms if associated with vasomotor symptoms.
- For insomnia associated with menopause.

It has based this recommendation on 14 RCTs which compare CBT with 'treatment as usual'; this includes no treatment or non-hormonal treatments. NICE found the data to be low in quality, but justifies its recommendation given that CBT is a safe intervention with few adverse effects.

What is menopause-specific CBT? And is it available??

By 'menopause-specific', NICE means CBT which is tailored to an individual's symptoms. It could therefore be delivered by CBT-trained practitioners face to face or remotely, and as individual or group sessions. Alternatively, it may be accessed independently as a 'self-help' option (e.g. in

written form). NICE acknowledges that additional costs would be required to train practitioners in this area, and that it may result in pressure on existing services. Waiting times may be long if adequate provision is not put in place. Adaptations to online CBT or group sessions may improve availability.

See our article *Cognitive behaviour therapy (CBT) for menopausal symptoms* for more information on this.

1.3. Management of genitourinary symptoms of menopause

Do you mean urogenital atrophy?

Yes. In the updated guideline, NICE has modified its terminology in reference to the condition: in 2015, it was 'urogenital atrophy'; in 2024, it is 'genitourinary symptoms'. Removing the word 'atrophy' is arguably a good thing – nobody wants to be told their genitals are atrophic.

What does NICE recommend for the management of genitourinary symptoms?

Vaginal oestrogens

- Should be used first line for women with genitourinary symptoms and no contraindications to oestrogen.
- Lubricants and moisturisers may be used alongside vaginal oestrogens.
- May be considered for menopausal women with overactive bladder or recurrent UTIs .

Prasterone

- If vaginal oestrogens are ineffective for genitourinary symptoms, we can consider vaginal prasterone.
- Prasterone is dehydroxyepiandrosterone (DHEA), a precursor steroid which converts to oestrogens and androgens within vaginal cells.
- Its brand name is Intrarosa, and it comes as a 6mg pessary which is inserted nightly.

Ospemifene

- If applying topical preparations is difficult, e.g. due to disability, we can consider oral ospemifene.
- This is a selective oestrogen receptor modulator licensed for urogenital symptoms of menopause.
- It has an oestrogenic effect on the vaginal epithelium.

See our article *Genitourinary symptoms of menopause* for more information.

1.4. Women with breast cancer

In its 2015 guideline, NICE recommends that management of menopause in women with a history of breast cancer should be guided by a specialist in the field, and that non-hormonal options should be first line. This still stands in the 2024 guidance, except in reference to urogenital symptoms.

NICE now advises that:

- We can consider using vaginal oestrogens off-licence for women with a

history of breast cancer if lubricants and moisturisers have not worked, unless she is taking an aromatase inhibitor (when she should be referred to a specialist).

- We inform patients that it is unknown whether vaginal oestrogen affects the risk of breast cancer recurrence, but very little oestrogen is absorbed into the bloodstream of users.
- Vaginal oestrogens are likely to be safe if a woman has had an oestrogen receptor-negative tumour.
- For women with a history of an oestrogen receptor-positive tumour, risk associated with topical oestrogen use is unknown. However, if she is on tamoxifen, it is likely to be safe.

There is a paucity of good-quality evidence looking at the safety of vaginal oestrogens. While the NICE guidance is not at odds with BMS recommendations, the BMS is more cautious, advocating the involvement of specialists before vaginal oestrogens are prescribed to any woman with a history of breast cancer, irrespective of oestrogen-receptor status or treatment.

See our article *Managing menopause after a diagnosis of breast cancer* for more information.

1.5. Discussing risks or 'specific health outcomes' associated with HRT use

The 2015 NICE guideline included tables listing absolute rates of developing diseases such as CVD, breast cancer and VTE in women on different types of HRT, for varying durations of time and according to different sources of evidence. This was intended to help clinicians counsel women about the risks of HRT use. It was pretty confusing.

The 2024 guidance still has tables, but they now refer to 'specific health outcomes' rather than risks (probably a reflection that some types of HRT increase likelihood of a certain disease and other types reduce it, as with endometrial cancer. *But maybe also because a 'specific health outcome' sounds less scary than a risk!).*

The information in the 2024 tables is laid out more clearly, with links to a document titled 'HRT and the likelihood of some medical conditions – a discussion aid for GP and patients'. This contains visual decision aids displaying the likelihood of developing a particular disease on HRT compared with non-use. It is helpful and clearly laid out, *but is also 39 pages long*.

Overall, the message is the similar to that from 2015 (and the BMS position), which is that there may be small risks associated with HRT use, but this is usually outweighed by the benefits in a symptomatic menopausal woman.

Our HRT: GEMS contains a much smaller table on counselling for HRT which summarises the main risks and benefits – and may be a more time-efficient resource for consultations.

1.6. What does the British Menopause Society say about the new NICE guideline?

Following the publication of the NICE guidance, the BMS responded with a statement in which it welcomed the new guidance, particularly its focus on individualised care and patient safety.

However, the BMS:

- Highlighted some concerns regarding the interpretation of, as well as

exclusion of, some evidence surrounding the risks and benefits of HRT.

- Pointed out two 'substantive errors' regarding ovarian cancer risk and breast cancer mortality, which overstated risks.
- Stated that it had challenged some of these interpretations and conclusions when the draft guideline was made available the previous year.

BMS statement in response to the publication of the updated NICE Menopause guideline (NG23)

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- Offer menopause-specific CBT as a treatment option for vasomotor symptoms alongside or in-stead of HRT, as well as for depressive symptoms and insomnia.
- If vaginal oestrogens are not effective or practical for genitourinary symptoms, we can offer vaginal prasterone or oral ospemifene as second-line alternatives.
- If women with a history of breast cancer experience genitourinary symptoms which are not relieved by moisturisers or lubricants, we can offer vaginal oestrogens off-licence, unless the patient is taking aromatase inhibitors.
- There is limited data to inform us about risks of recurrent breast cancer with vaginal oestrogens, but the doses are very small.
- There may be small risks associated with HRT use, but these are usually outweighed by the benefits in a symptomatic menopausal woman.

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