

Useful contact numbers / addresses: -

Website – www.menopausematters.co.uk

Dumfries based helpline – 01387 241121
Thursday mornings 9am – 12 noon

British Menopause Society

Website: www.the-bms.org

Women's Health Concern Ltd.
Whitehall House, 41 Whitehall, London.
Tel – 020 7451 1377

Website: www.womens-health-concern.org

National Association for Premenstrual Syndrome (NAPS)

41 Old Road, East Peckham, Kent. TN12 5AP
Tel – 0870 777 2178 (office) / 0870 777 2177 (helpline)

Website: www.pms.org.uk

National Osteoporosis Society

Camerton, Bath. BA2 0PJ
Tel - 01761 471771 / Helpline – 0845 450 0230

Website: www.nos.org.uk

Endometriosis UK

50 Westminster Palace Gardens, Artillery Row
London. SW1P 1RL

Tel. 020 7222 2781 / 020 7222 2786

Helpline – freephone 0808 808 2227

Website: www.endo.org.uk

Daisy Network

PO Box 183, Rossendale. BB4 6WZ

Website: www.daisynetwork.org.uk

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Menopause and HRT after Hysterectomy.



Information leaflet

estrogen. This thickening can be prevented, by adding in progestogen. To find out if progestogen is required, it may be suggested to use estrogen combined with cyclical progestogen for 3 months after your operation. If there is monthly bleeding in this time, it means that cells are present which are responding to the hormones so estrogen and progestogen should be used thereafter. **(These hormones can however be given together continuously to avoid monthly bleeding)**. If there is no bleeding in the first 3 months, then estrogen can be given on its own thereafter. This will be explained further whilst you are in hospital.

If HRT is commenced because of an early menopause after surgery, it can be continued until the age of 50 years without concern about the increased risk of breast cancer. At around the age of 50, the decision as to whether or not to continue HRT should be made. This is the same decision that any woman becoming menopausal at the normal menopausal age would have to make, i.e. whether or not to commence HRT.

Endometriosis is the presence of deposits of the lining of the uterus (endometrium) out with the uterus, e.g. on the bladder, bowel and other organs in the body. These deposits are sensitive to the hormones produced by the ovaries. After hysterectomy and removal of the ovaries, there have been reports of endometriotic deposits being stimulated following estrogen only HRT. It is thought that estrogen combined with progestogen HRT is less likely to cause stimulation of these deposits, although there is little scientific evidence to support this.

For further information on endometriosis, visit www.endo.org.uk

Role of testosterone after hysterectomy

If the ovaries are removed at the time of hysterectomy, as well as the estrogen level falling, there is also a 50% decrease in testosterone production. Some doctors recommend testosterone replacement along with estrogen replacement, as testosterone can help energy levels, mood and libido.

However testosterone replacement does not seem to be required by all and the ideal route and dose of testosterone for women is still being researched. It is therefore not routinely recommended following removal of the ovaries but can be considered for some women who do not fully benefit from estrogen replacement alone.

Sub-total hysterectomy

If the main part of the uterus has been removed but the cervix retained, it is currently uncertain whether HRT can be given in the form of estrogen only or estrogen combined with progestogen. The slight concern of using estrogen only, is that there may be some of the cells of the lining of the uterus in the cervical canal, which could become thickened from the

Introduction

Many women undergo hysterectomy (surgical removal of the uterus or womb) for various gynaecological reasons. These include intolerable periods not controlled by medical means, fibroids, endometriosis, prolapse, and malignant or premalignant changes of the uterus, cervix (neck of the womb) or ovary.

Hysterectomy can either be **total**, where both the uterus and cervix are removed, or **sub-total**, where the main part of the uterus is removed but the cervix is retained. Reasons for each should be discussed with your surgeon. If the cervix is retained, then you should continue with regular cervical smears.

At the time of a hysterectomy, the ovaries may be conserved (left behind) or removed. The decision as to which type of hysterectomy is needed will be determined by the nature of your gynaecological problem, past medical history, family history and after consideration of your wishes.

If **one or both ovaries are conserved** at the time of your hysterectomy, 3 scenarios are possible: -

1. Continuing normal ovarian function.

The ovaries may continue producing hormones in their fluctuating manner until the normal age of menopause (usually 51 years of age). This fluctuating hormone production may cause symptoms of “premenstrual syndrome” (PMS), even in the absence of periods. This is because PMS symptoms are due to the changing hormone levels, and not due to the presence of bleeding. Estrogen deficiency symptoms, if they occur, would happen at the normal menopausal age.

For further information on PMS, visit www.pms.org.uk

2. Early ovarian failure-apparent.

Following a hysterectomy, the ovaries may stop producing hormones sooner than expected. This can even happen within 1-2 years, following the hysterectomy when symptoms of estrogen deficiency may be noticed. If this happens, it is very important that you discuss these symptoms and the possible use of Hormone Replacement Therapy (HRT) with your doctor or practice nurse.

3. Early ovarian failure-silent.

In some women, the conserved ovaries may fail early but the falling estrogen level may not cause the usual signs of estrogen deficiency. It is therefore recommended that following a hysterectomy with one or both ovaries conserved before the age of 45, a blood test should be taken approximately once per year to check hormone levels, for evidence of an early menopause. If menopausal symptoms have developed, blood tests are not required.

The importance of reporting symptoms of early ovarian failure, or detecting silent early ovarian failure: -

- a. Estrogen deficiency symptoms can be unpleasant and effective therapy is available.
- b. Estrogen is very good for maintaining bone strength. If the production of estrogen is lost at an early age (before 45years) then the individual is thought to have an increased risk of **osteoporosis** (bone thinning). Very effective treatments are now available to both prevent and treat osteoporosis.

For further information on osteoporosis, visit www.nos.org.uk

If the **ovaries are removed** (oophorectomy) at the time of your hysterectomy, a sudden loss of ovarian hormone production, in particular estrogen occurs. This sudden, surgical menopause may cause estrogen deficiency symptoms within a few days of your operation. These symptoms include hot flushes and sweats. If surgical menopause occurs before the age of 45years, the risk of osteoporosis is increased.

HRT should then be considered for symptom control and/or for its protective effect on bone. Whether or not to commence HRT will be decided after a full discussion with you and the menopause nurse or gynaecologist, whilst you are in hospital. This decision will be influenced by factors such as your age, past history (including any medical reasons why you should not take HRT) and family history. HRT is usually recommended if the operation causes an early menopause (before 45 years) because of the significant increased risk of osteoporosis.

Type of HRT following hysterectomy.

If HRT is commenced following hysterectomy, it is usually prescribed as an estrogen only preparation. This can be taken as a daily tablet, a weekly or twice weekly patch, a daily gel, a 3 monthly vaginal ring or a 6 monthly implant. The particular type of prescription is tailored to suit your individual needs and is chosen after consideration of such factors as personal preference and any past medical history. The most common prescription is estrogen HRT in a tablet form.

HRT using a combination of estrogen and progestogen (which is recommended when the uterus is still present) is often used after a hysterectomy if widespread **endometriosis** is found at the time of surgery.