Menopause and HRT after Hysterectomy – Information leaflet

NHS Dumfries & Galloway

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.

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 bone and cardio vascular health. 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) and heart disease. Therefore in young women hormone replacement therapy (HRT) may be considered to reduce the risk.

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 can include hot flushes and sweats. If surgical menopause occurs before the age of 45years, the risk of osteoporosis and heart disease is increased. HRT should then be considered for symptom control and/or for its protective effect. 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.

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 or daily gel. 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.

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.

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.

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, although currently there are no l**icensed** preparations for use in women.

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 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 any possible increased risks.. At around the age of 50, the decision as to whether or not to continue HRT can be made. This decision is on an individual basis and is likely to depend on a number of factors. Please note there is no arbitrary limit for the length of time women are on HRT. This is the same decision that any woman becoming menopausal at the normal menopausal age make ie whether or not to start HRT.

Useful contact numbers / addresses: -

Website – www.menopausematters.co.uk

Dumfries based helpline
Sister K Martin
Tel: 01387 241121
Thursday mornings 9am – 12 noon

British Menopause Society
Website: www.the-bms.org

Women's Health Concern Ltd.
Website: www.womens-health-concern.org

National Association for Premenstrual Syndrome (NAPS)
Telephone: 08448157311 email:contact@pms.org.uk
Website: www.pms.org.uk

Royal Osteoporosis Society
Manor Farm, Skinner's Hill, Camerton, Bath. BA2 0PJ
Tel – 01761471771 Helpline: 0808 800 0035
Website: www.theros.org.uk

Endometriosis UK
Website: www.endometriosis-uk.org

Daisy Network
Website: www.daisynetwork.org.uk