A CLINICAL REFERENCE FROM HORMONAL HUB

The HRT *Reference Card.*

UK first-line HRT is body-identical, transdermal oestrogen plus micronised progesterone. This card covers what to ask for, how the four components work, and how to know if your regime is right for you.

OESTROGEN · TRANSDERMAL (FIRST LINE)

- **Patch** — Evorel, Estradot · 25–100 mcg, 2× weekly
- **Gel** — Oestrogel, Sandrena · 1–4 measures daily
- **Spray** — Lenzetto · 1–3 sprays daily

Lower VTE and stroke risk than oral oestrogen. Body-identical when delivered transdermally.

PROGESTERONE · UTERINE PROTECTION

- **Utrogestan** — 100 mg nightly (continuous) or 200 mg nights 1–12 of cycle (sequential)
- **Mirena IUS** — 5-year coil; protection plus heavy bleeding control

Body-identical · improved sleep · lower breast cancer signal than synthetic progestogens.

VAGINAL OESTROGEN · GENITOURINARY SYMPTOMS

- **Vagifem** — 10 mcg pessary, 2× weekly
- **Estring** — 3-monthly ring
- **Imvaggis** — 50 mcg estriol pessary

Minimal systemic absorption · long-term safe · can be used alongside systemic HRT or alone.

TESTOSTERONE · OFF-LABEL

- **Testogel** — 0.5 sachet weekly (1/8 the male dose)
- For persistent low libido despite optimised HRT
- BMS-supported · usually specialist-initiated

Monitor blood levels every 6 months to avoid going above the female range.

The decision tree

Do you have a uterus?

→ **No:** oestrogen alone is the formal default (but read page 3 — there are reasons you may still benefit from progesterone).

→ **Yes:** oestrogen plus progesterone, either every day or for 12 nights per month.

Still having periods?

→ **Yes:** sequential regimen (progesterone nights 1–12) — gives you a monthly bleed.

→ **No, 12+ months without a period:** continuous regimen (progesterone every day) — bleed-free.

BEFORE YOU START — IMPORTANT CONTEXT

Who HRT might *not be suitable for.*

Most women can safely take HRT, and for many it transforms quality of life. But some situations need careful thought, specialist input, or a different choice. The list below isn't a verdict — it's a starting point for the conversation.

Absolute caution

HRT generally not recommended without specialist input.

- **Current or recent breast cancer** (within the last 5 years; case-by-case beyond)
- **Untreated endometrial cancer** or other active oestrogen-sensitive cancer
- **Undiagnosed vaginal bleeding** — investigate first, treat later
- **Active venous thromboembolism** — current DVT or pulmonary embolism
- **Active severe liver disease** with abnormal liver function
- **Pregnancy**
- **Severe, untreated hypertension** — treat first, then revisit

Relative caution

HRT may still be appropriate — but warrants careful discussion.

- **Personal history of VTE** — transdermal preferred (no clot risk, unlike oral)
- **Breast cancer in long remission** — rarely, with specialist input
- **Migraine with aura** — transdermal preferred over oral oestrogen
- **Other hormone-sensitive cancer history** — oncology and menopause specialist input
- **Gallbladder disease** — transdermal preferred (bypasses the liver)
- **Severe liver impairment** — transdermal preferred
- **Stroke or coronary artery disease** — needs cardiovascular assessment
- **Strong family history of hormone-sensitive cancer** — warrants careful discussion

If any of the above apply to you, HRT may still be possible — but you need a clinician who knows the nuance. The British Menopause Society maintains a directory of menopause-trained specialists at thebms.org.uk.

AND ONE MORE THING WORTH KNOWING

Progesterone *without a uterus.*

NICE NG23 does not recommend progesterone for women without a uterus — its formal job is to protect the endometrium. But practice has moved beyond what the guideline covers. Many menopause specialists now prescribe micronised progesterone off-label in this context, citing potential benefits beyond uterine protection: sleep (via its GABAergic effect), anxiety and mood, hormonal migraine, and protection in women with a history of endometriosis.

This is off-label prescribing — legal, increasingly mainstream in menopause clinics, but requiring a clinician comfortable with the reasoning. If you've had a hysterectomy and feel under-served by oestrogen alone, this conversation is worth having.