



## **Joint BMS / RCOG / RCGP / FSRH framework for restoration of menopause services in response to COVID-19**

The COVID-19 pandemic has resulted in a significant disruption to all aspects of healthcare provision across the spectrum of obstetrics and gynaecology including menopause care. As we begin to exit the critical phase of the crisis, attention moves to the recovery phase and the assessment and planning of the steps required for resumption of clinical services.

The suspension of non-urgent planned care during the earlier part of the pandemic affected a significant proportion of most services, as resources were diverted to critical care and clinical staff were redeployed to cover emergency COVID-19 care to provide support to COVID-19 medical services. During this time most menopause services and the delivery of menopause care were affected.

In addition, delivery of many healthcare services was modified to limit patient visits to healthcare services to an absolute minimum. This has resulted in services in both primary as well as secondary care offering virtual menopause consultations by telephone or web-based video consultations, or increasing this where such virtual consultations were already previously offered.

During the next phase where the restoration of elective services is being planned, there is a need to assess the changes in service provision that happened over the critical phase and to continue where feasible with the adjustments that offered a positive and workable change compared to our conventional structure of delivering menopause care. One example would be virtual menopause consultations with the potential flexibility they offer to patients, whilst also minimising the need for face-to-face contact between the patient and healthcare provider.

The objective of this joint document produced by the British Menopause Society (BMS), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of General Practitioners (RCGP) and the Faculty of Sexual and Reproductive Healthcare (FSRH) is to provide guidance to clinical practitioners on the resumption and running of menopause services in the next phase of restoration of planned clinical services.

We believe it remains vitally important that women are able to access menopause services where they can obtain advice on how to optimise the management of their menopausal symptoms. The menopause transition can have a significant detrimental impact on the physical and mental wellbeing of many women. Women need to be able to access menopause services and be provided with information and advice on their management options including access to starting or continuing HRT for women who wish to do so. This is even more relevant given the additional stress some women may be under in view of the strains of the current COVID-19 pandemic is having on society. The difficulty of managing such additional stress whilst also suffering from menopausal symptoms should not be underestimated and the resulting impact this can have on women and their families. It is essential, in the

next phase of restoration of clinical services that the importance of menopause services is recognised to prevent a setback in this important aspect of women's health.

This document covers guidance on the following aspects:

1. Impact of menopausal symptoms on quality of life: Access to information
2. Menopause services and menopause consultations
3. Prescribing HRT and HRT shortages
4. Unscheduled bleeding on HRT: assessment and management during the COVID-19 pandemic
5. Menopause training

#### **1. Impact of menopausal symptoms on quality of life: Access to information**

- **Women should be encouraged to seek help for managing their menopausal symptoms and should be advised that the COVID-19 pandemic should not be a reason for them to discontinue HRT or withhold starting HRT if required.**
- **Women should be made aware of resources available for guidance.**
- **Advice should be provided to women on how they can access menopause consultations remotely to discuss their management options and the local pathways available for having HRT prescriptions issued or renewed.**

More than 75% of women experience menopausal symptoms, and a quarter of such women describe their symptoms as severe. Although symptoms on average last 7 years, a third of women experience long-term symptoms. Hormone Replacement Therapy (HRT) is the most commonly used treatment for managing menopausal symptoms and has been shown to be the most effective intervention in this context.

HRT intake is likely to help many women control their often difficult menopausal symptoms. This is particularly relevant given the additional stress some women may be under in view of the strains of the current COVID-19 pandemic on society.

Women should be encouraged to seek help for managing their menopausal symptoms and should be advised that the COVID-19 pandemic should not be a reason for them to discontinue HRT or withhold starting HRT if required.

Women should be made aware of resources available for guidance. Links for such information are included below:

<https://thebms.org.uk/>

<https://www.womens-health-concern.org/>

<https://www.menopausematters.co.uk/>

[www.managemymenopause.co.uk](http://www.managemymenopause.co.uk)

<https://pcwhf.co.uk/resources>

In addition, women should be advised how they can access menopause consultations remotely to discuss their management options and the local pathways available for having HRT prescriptions issued or renewed.

## 2. Menopause services and menopause consultations

- **The current advice to minimise hospital visits will result in a significant proportion of menopause consultations being provided remotely (by telephone or web-based video consultations) for the foreseeable future, and potentially beyond that.**
- **The structure of remote menopause consultations should largely follow that used in face to face consultations with assessment of symptoms, bleeding patterns, background medical history and risk factors and changes in weight.**
- **It remains essential that access to face to face consultations remains available where a physical examination is needed (e.g. pelvic or breast examination) and access to endometrial assessment (pelvic ultrasound / endometrial biopsy / hysteroscopy) for women for ongoing unscheduled bleeding on HRT.**
- **Menopause services should aim to offer, where feasible, email / telephone advice and guidance to support primary care.**
- **Consideration should be given for multi-disciplinary menopause clinics (MDTs) to run virtually as video MDTs and email MDTs.**

General Practitioners' (GP) surgeries have been put under additional pressure during the COVID-19 pandemic, with consultations and advice prioritised to dealing with serious and potentially life-threatening medical issues. As we move into the recovery phase for resumption of menopause services, it is necessary to focus on different ways of delivering services that takes into consideration:

1. The demands that clinical services are likely to face in the coming months during the recovery phase.
2. The need to offer services while minimising hospital visits and patient travel and maintaining social distancing where feasible.
3. Changes to staffing levels, with a proportion of staff continuing to be redeployed to the COVID-19 services and some staff continuing to shield due to their medical background.

The majority of menopause consultations that took place in both primary and secondary care since the COVID-19 pandemic started were conducted remotely by telephone or web-based video consultations. The ongoing advice to minimise hospital visits will mean that a significant proportion of menopause consultations are likely to be provided remotely (by telephone or web-based video consultations) for the foreseeable future, and potentially beyond that. Virtual menopause consultations also likely to offer women more flexibility, less need for travel and result in less disruption to women's social and work life.

The structure of remote menopause consultations should largely follow that used in face to face consultations with assessment of symptoms, bleeding patterns, background medical history and risk factors and changes in weight.

The nature of menopause consultations lends itself well to virtual consultations as a significant majority of consultations are conducted without the need for a physical examination. It, however, remains essential that access to face to face consultations remain available where a physical examination is needed (e.g. pelvic or breast examination) and access to endometrial assessment (pelvic ultrasound / endometrial biopsy / hysteroscopy) for women for ongoing unscheduled bleeding on HRT. The latter is discussed in more detail later in this document.

In addition, menopause services should aim to offer where feasible email / telephone advice and guidance to support primary care. This is likely to further support menopause management in primary care and minimise the number of secondary care clinical appointments that patients require.

Further, in services where multi-disciplinary (MDT) menopause clinics take place, consideration should be given to running such joint clinics virtually including video MDTs and email MDTs.

Setting up remote menopause consultations may require additional technical and administrative support including having web cameras and microphones linked to the PCs used by the clinical service, identifying secure software for remote video consultations that maintains patient confidentiality, and having administrative support to allow the communication of the clinical and prescribing plans to patients and GPs, which ideally should take the form of a letter to the patient, summarising the discussion and agreed plan with a copy to the referring healthcare professional.

HRT implants require a face to face outpatient visit to have the implants inserted. Both estradiol and testosterone implants have been in short supply over the last decade due to the discontinuation of implant production for commercial reasons. Further, during the COVID-19 pandemic the limited number of clinical providers that offered implant insertion withheld these services as part of the overall suspension of non-urgent planned care.

Women on HRT implants could consider switching to alternative HRT preparations either on a temporary basis until the resumption of face to face outpatient services that offer implant insertion, or on a long-term basis should they wish to do so. Alternative HRT options can be identified through the BMS website through the following link:

<https://thebms.org.uk/wp-content/uploads/2019/11/HRT-alternatives-04.11.2019.pdf>

### **3. Prescribing HRT and HRT shortages**

- **Healthcare professionals and prescribers should develop pathways on how advice is communicated to women regarding how HRT prescriptions are issued and collected and to provide similar information on how to request and obtain repeat HRT prescriptions.**
- **Prescribers can access information on the availability of HRT preparations through the BMS website where updates are provided on the current availability of HRT products.**
- **Where shortages of a particular HRT preparation are experienced, consideration should be given to prescribing an equivalent alternative HRT preparation.**
- **Patients should be advised that for most HRT preparations there are usually a number of equivalent alternatives that can be considered if they are unable to obtain their HRT preparation due to supply shortages.**
- **Guidance on suitable equivalent HRT preparations is available on the BMS website and provides advice on alternative HRT preparations that can be considered where there is difficulty obtaining a preparation affected by the shortages.**

We recognise that many women are likely to experience difficulties in obtaining HRT supplies due to the current COVID-19 pandemic. We also appreciate that continuing HRT intake is likely to help many women control their often difficult menopausal symptoms, which is particularly relevant if they are under additional stress due to pressures arising from the current pandemic.

Healthcare professionals and prescribers should develop pathways on how advice is communicated to women regarding how their HRT prescriptions are issued and collected and to provide similar information on how to request and obtain repeat HRT prescriptions.

The joint BMS, RCOG, RCGP and FSRH statement in March 2020 recommended that General Practitioners and healthcare providers consider having HRT prescriptions available on repeat order (especially to women who have been on HRT and have not been experiencing any problems with their intake).

This will minimise the need for many women to visit their GP surgeries and assist with obtaining repeat prescriptions.

We also recognise that many women have been experiencing difficulties in obtaining HRT supplies with the ongoing HRT shortages. The burden of the COVID-19 pandemic on the health service and resulting difficulties in obtaining clinical appointments and accessing pharmaceutical services is likely to have added further to this situation.

The BMS has continued to issue regular updates on the current availability of HRT products to provide guidance to BMS members and clinical practitioners in response to the ongoing HRT shortages. The latest update on HRT product availability can be accessed through the BMS website through the following link: <https://thebms.org.uk/2020/05/british-menopause-society-further-update-on-hrt-supply-shortages-30-april-2020/>

The advice remains that where clinical practitioners are unable to prescribe a certain HRT preparation due to shortages in supplies, consideration should be given to prescribing an equivalent alternative preparation to the ones their patients are using.

Patients should be advised that for most HRT preparations there are usually a number of alternatives that can be considered if they are unable to get their HRT preparation due to supply shortages. For example if a patient is taking Evorel 50 HRT patch and they are unable to obtain supplies for it, they can switch to another patch that delivers the same amount of estradiol such as Estradot 50, Estraderm 50, Progynova TS 50. A similar concept would apply to estradiol gel preparations (using Oestrogel or Sandrena) and with oral HRT preparations.

Generic prescribing of estradiol patches where feasible (for example prescribing estradiol 50 microgram patch) may allow pharmacists more flexibility in offering patients supplies of available preparations rather than being restricted to a specific brand.

Consideration should also be given to prescribing estrogen and progestogen separately to make the closest match or find a suitable alternative. Different brands for the same medication may vary in appearance or excipients. However, they would provide equivalent amounts of hormones when used in similar doses.

Switching to such alternatives where indicated, allows patients to continue with their current preferred delivery methods (patch, gel or tablets) and with the same dose of their HRT intake.

The BMS has produced a document on alternative HRT preparations in response to the ongoing HRT shortages to provide guidance to BMS members and clinical practitioners who may be experiencing

difficulties with HRT supplies. This provides guidance to suitable equivalent alternatives that can be considered if there is difficulty obtaining a preparation affected by the shortages. This document can be accessed on the BMS website through the following link:

<https://thebms.org.uk/wp-content/uploads/2019/11/HRT-alternatives-04.11.2019.pdf>

In addition, BMS members can post prescribing queries on the BMS forum if any clarifications are required.

#### **4. Unscheduled bleeding on HRT: assessment and management during the COVID-19 pandemic**

- **Unscheduled bleeding on HRT can initially be assessed through remote consultation and medical advice offered where appropriate to minimise the need for women to visit their healthcare providers.**
- **For the majority of cases modifying progestogen intake would often control the bleeding especially in women who experience unscheduled bleeding in the first few months after commencing HRT.**
- **Women who continue to have unscheduled bleeding beyond 6 months despite modifying their progestogen intake or where there is a concern about the clinical presentation or bleeding amount / pattern should consider having pelvic ultrasound scan assessment and endometrial biopsy or assessment of the endometrial cavity by hysteroscopy.**

The RCOG, British Society for Gynaecological Endoscopy (BSGE) and British Gynaecological Cancer Society (BGCS) have released a joint guidance document on the management of abnormal uterine bleeding including postmenopausal bleeding to guide clinical practice in the current Coronavirus (COVID-19) pandemic.

The guidance recommends carrying out assessment and advice through remote consultation in the first instance and offering medical advice where appropriate to minimise the need for women to visit their healthcare providers and to limit the risk of person to person viral transmission. The document can be accessed through the BSGE website:

<https://mk0britishsociep8d9m.kinstacdn.com/wp-content/uploads/2020/03/Joint-RCOG-BSGEBGCS-guidance-for-management-of-abnormal-uterine-bleeding-AUB-in-the-evolving-CoronavirusCOVID-19-pandemic.pdf>

As referred to in the BMS comment on the management of unscheduled bleeding on HRT ([https://thebms.org.uk/wp-content/uploads/2020/03/BSGE-document-HMB31.3.20final .pdf](https://thebms.org.uk/wp-content/uploads/2020/03/BSGE-document-HMB31.3.20final.pdf)), similar management principles can be applied to women who experience unscheduled bleeding on HRT beyond 3- 4 months from commencing HRT.

An initial assessment could be carried out through a virtual (telephone / web-based video) consultation and consideration should be given to modifying women's progestogen intake as an initial management step.

For the majority of cases modifying progestogen intake would often control the bleeding especially in women who experience unscheduled bleeding in the first few months after commencing HRT. Progestogen intake could be modified as follows:

- For continuous combined HRT regimens the dose of progestogen could be increased (e.g. go up from utrogestan 100 mg daily to 200 mg daily on continuous basis). Those on continuous combined HRT regimens that contain a progestogen in a combined preparation or have the Mirena IUS, could have utrogestan / medroxyprogesterone acetate or norethisterone added to their HRT regimen. If they continue to experience ongoing unscheduled bleeding, the HRT regimen could be changed to a cyclical intake of progestogen.
- For cyclical HRT regimens: Increase progestogen dose (e.g. Utrogestan 300 mg for 12 days a month instead of 200 mg) or increase duration of progestogen intake (can take progestogen for 14 days a month or for 21 days out of a 28-day HRT intake cycle).
- Women who continue to have unscheduled bleeding beyond 6 months despite modifying their progestogen intake or where there is a concern about the clinical presentation or bleeding amount / pattern should consider having pelvic ultrasound scan assessment and endometrial biopsy or assessment of the endometrial cavity by hysteroscopy.
- If breakthrough bleeding occurs following the switch to continuous combined HRT and does not settle after three to six months, then the woman can be switched back to a sequential regimen for at least another year.

The risk of endometrial cancer in women with unscheduled bleeding on HRT is significantly lower than that with postmenopausal bleeding in women not on HRT especially in women who had not been experiencing bleeding before commencing HRT and who are taking progestogen.

## 5. Menopause training

- **The COVID-19 pandemic has resulted in a detrimental impact on menopause training as well as training in various other medical specialties.**
- **Modifications to the way menopause education and training are delivered may be required. An increasing proportion of educational meetings are likely to be delivered virtually. In addition, online educational resources and webinars and may offer additional educational resources that can be accessed remotely.**
- **Any adaptations to the structure of menopause training that may be required in the coming months is likely to be in line with that followed by other national educational bodies.**

COVID-19 has resulted in a significant disruption to training at various levels in all medical specialties including menopause training.

The RCOG Educational Committee are communicating with national education bodies on the handling of training and assessment during the current pandemic and the move to the recovery and restoration phase. Any adaptations to the structure of menopause training is likely to be in line with that applied by the RCOG and other national educational bodies in the course of the coming months.

Given that a number of NHS services have already set up processes for virtual patient consultations, such a system can also be considered to conduct training remotely. This may include three-way web-based video consultations involving the trainer, the patient and the trainee. Such remote training could also allow remote assessment with the trainer observing the trainee conducting a virtual consultation in their own practice. Any such pathways should have a clear process related to patient consent and

confidentiality and may require piloting when first introduced to ensure feasibility of application. It will also subsequently require validation against current conventional face to face methods of training.

It is likely that in the course of the coming months during the recovery and restoration phase that an increasing proportion of educational meetings will be delivered virtually. It is also likely that some meetings that are scheduled to be delivered face to face will also offer the option of remote attendance.

The BMS Annual conference originally scheduled for July 2020 was postponed and moved to July 2021 and is planned to be delivered face to face.

However, the option remains for some of the forthcoming study days to be delivered virtually or delivered face to face with an option of remote attendance.

In addition, webinars and online educational resources (such as IMPART offered by the International Menopause Society) may offer additional educational resources that can be accessed remotely.

In summary, the above changes to practice should enable women to continue to be able to access advice on how they can optimise the management of their menopausal symptoms and address other menopause related concerns. Given the potentially unpredictable nature of the COVID-19 pandemic it is important that the provision of menopause services adapts to the pressures on health services and reflects the latest guidance on minimising patient hospital visits. This document will be kept be under review and updated to reflect any appropriate changes.

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