



HRT regimen after subtotal hysterectomy: A survey of BMS members

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Objective:

Hormone replacement treatment (HRT) is widely prescribed following hysterectomy when combined with bilateral salpingo-oophorectomy, however, there is no clear guidance on the HRT regimen to be used following subtotal hysterectomy (SH). This survey of British Menopausal Society (BMS) members was carried out to evaluate the prescribing practices in UK following SH.

Design:

An electronic survey was designed and sent to 2300 members of BMS by the BMS admin team and the results were analysed using Microsoft Excel.

Method:

All the survey respondents were asked the following 5 questions: their profession, whether they were menopause specialist, number of women with menopausal symptoms seen per year, whether they prescribed HRT to women after SH and if yes, then the prescribed regimen.

Results:

Of the 233 completed surveys received, (response rate 10%), the prescribers included general practitioners (53.2%), hospital doctors (26.6%), advance nurse practitioners (11.6%), sexual health staff (5.1%), and general practice nurses (3.4%). Half of them were menopause specialist, nearly 3/4th (76.5%) reported seeing over 50 menopausal women a year and 85.1% had prescribed HRT for women after SH.

The prescribed HRT regimen included: continuous combined HRT (31.7%), sequential progestogens HRT for the first 3 months followed by continuous combined HRT (21.4%), sequential progesterone for up to 3 month and if no bleeding then oestrogen only HRT (16.3%), unsure of the regimen (14.5%), oestrogen only HRT (13.3%), none prescribed (1.7%) and unknown regimen used (0.8%).

Conclusions:

Our survey confirmed the significant variation in the practise of HRT prescribing after SH. BMS publication (2021) on 'Progestogens and endometrial protection' acknowledges that there is limited evidence to guide practice in relation to the need for progestogen replacement in women who have had subtotal hysterectomy. It recommends that one must consider sequential progestogens for up to 3 months, and in case of no bleeding (indicating absence of residual endometrium), then estrogen only HRT can be sufficient.

Ongoing progestogen intake should be considered if there are concerns that the remnant cervical stump may contain residual endometrial tissue in women who experience cyclical bleeding with sequential HRT. In our survey only 16.3% of prescribers chose this regimen. Given the inconsistency in HRT prescribing in women after SH, it will be helpful for BMS produces a separate 'Tool for clinicians' for this group of women.