Menopausal Hormone Therapy (MHT) - the European Perspective

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In Europe, the dominant estrogen used for Menopausal Hormone Therapy (MHT) is 17-beta-Estradiol (E2) and not conjugated equine estrogens (CEE) as in the US, and the main progestogen used is not medroxyprogesterone acetate (MPA), not available in many European countries. Furthermore, the increasingly preferred way of administration of MHT is the cutaneous and not the oral route. Today, in Northern Europe the non-oral route (transdermal, implants, intramuscular) represents about 50%, in Southern Europe over 70% of all prescriptions. Therefore, the risk-benefit-ratio based on US data cannot be simply transferred to Europe. E.g., there is increasing evidence that non-oral routes of estradiol have little or no increased risk of VTE and of stroke.

From the European perspective, low-dose transdermal administration of estradiol (?50µg/day) should be the first line regimen. The combination of estradiol with micronized progesterone, dydrogesterone oral norethisteron-acetate or a transdermal synthetic progestogen might be a better choice than CEE+MPA. The available evidence suggests that there is a therapeutic window of benefit for long-term fracture prevention, cardioprotection and possibly long-term neuroprotection if non-oral MHT is prescribed within this window of opportunity (age 50-59 years or less than 10 years after menopause) and continued for several years.