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HORMONE REPLACEMENT THERAPIES IN MENOPAUSE

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Abstract: Objective: To evaluate the databases on climacteric symptoms and the positive and negative effects of menopausal hormone therapy. **Methods:** An integrative review was carried out, using as criteria the search in the National Library of Medicine (PubMed) and Scientific Electronic Library Online (SciELO) databases using the descriptors (i) climacteric (ii) hormone replacement (iii) menopause, with the Boolean operator "AND". Studies published from 2020 to 2024 were included. **Results:** Among the benefits of hormone therapy are improved sleep, mood disorders, reduced insulin resistance, reduced risk of dementia, improved quality of life, and prevention of cardiovascular diseases when started within the window of opportunity. It must be noted that there are negative points in carrying out hormone replacement therapy, such as an increased risk of gynecological neoplasms, increased liver complications, in addition to there being numerous contraindications to its use. **Final considerations:** It is known that the benefits of HRT outweigh the risks as long as it is well indicated, within the therapeutic window for its initiation, and respecting the contraindications to the use of the therapy. The improvement in quality of life, sexual practice and years lived in this phase become less difficult with the correct implementation of hormone replacement therapy, thus providing support so that women can get through this phase in the best possible way.
Keywords: climacteric, hormone replacement therapy and menopause.

INTRODUCTION

The female body begins to prepare for menopause between the ages of 45 and 55. Menopause is the name given to the woman's last period, a phase that brings with it a series of changes and adaptations (PACIUC; JOHN, 2020).

As life expectancy increases, women are spending more days in menopause, which brings with it numerous symptoms such as vasomotor symptoms (SVM), mood swings, sleep disorders, dizziness, palpitations, irritability, depression, osteoporosis, genitourinary changes such as urinary infections and recurrent vulvovaginitis, directly affecting quality of life over many years (COSTA et al., 2022).

In addition to the complaints already mentioned, women during this period present complaints that are not always explicit, such as lack of sexual desire, lack of arousal, absence of orgasm and pain during sexual intercourse (ZANDONÁ et al., 2022).

The onset of symptoms is related to several factors, such as tissues and organs that have estrogen receptors that are in a situation of hypoestrogenism. They are also related to the aging process and psychosocial factors. Ethnic, geographic and individual factors also affect the prevalence and severity of symptoms (ELMAS et al., 2023). In addition to all the symptoms associated with menopause, menopause itself is a risk factor for other pathologies such as cardiovascular disease, gynecological cancers, dementia, osteoporosis, among others. Changes occur in body composition during this period with a gradual reduction in metabolism and an increase in body fat mass that progressively increase the risk to which women are exposed (ELMAS et al., 2023). Therefore, studies and updates on hormone therapy in menopause are necessary, since its correct application allows these women to have an improvement in their quality of life, significantly reducing risk factors and providing years of symptom-free life.

DEVELOPMENT

Menopause is a major event in women's lives that can negatively affect their lives. Its onset marks the end of reproductive life, with a course that varies from short to long years, and is most often a slow and gradual process, occurring at an average age of fifty years. Natural menopause is defined as the final menstrual period, diagnosed retrospectively after twelve consecutive months of spontaneous amenorrhea without an apparent cause (NESS et al., 2021).

As menopause progresses, several changes in the body are noticed, among them that lean and bone mass decreases in the first years of menopause, with a metabolic shift towards an increase in lipids, represented by a higher level of total cholesterol and high-density lipoproteins. Studies indicate that postmenopausal women are more likely to be obese and have vaginal atrophy, and are more likely to develop sexual dysfunction, including difficulty in relation to sexual desire, arousal, lubrication and orgasm (TRENTO et al., 2021).

Vulvoaginal atrophy leads to a reduction in mucus and tissues of the vulva and vagina caused by the state of hypoestrogenism that occurs during this period, with irritation, vaginal discharge, itching, dryness, dysuria and dyspareunia being among the most common complaints. However, although there is an increase in rates of sexual dysfunction, it is not clear whether they are related to the reduction in ovarian hormone levels (KENDA et al., 2021).

Current therapies aim to deal with individual and specific symptoms regarding sexual complaints, but there are no approaches related to the entire spectrum of sexual dysfunction, as it is a complaint that encompasses several aspects in addition to the biological state of hypoestrogenism (KENDA et al., 2021).

There are some hormonal therapies available on the market, such as hormonal therapies with estrogens and androgens, as well as non-hormonal therapies that include lubricants and long-lasting vaginal moisturizers, which are commonly used (MEHTA et al., 2021).

It is known that topical and systemic estrogens can improve symptoms, but there are reservations about their use in relation to patients with contraindications where hormonal therapy cannot be recommended, such as for patients with a history of hormone-dependent breast cancer (KENDA et al., 2021).

The actions of medications available as estrogen help with vaginal trophism, improving symptoms of urinary infections, vulvovaginitis, dryness and vasomotor symptoms, however, these effects are not well understood, due to the wide variety of drugs, routes, metabolism, doses and routes of administration (KENDA et al., 2021).

Menopausal hormone replacement therapy is not only indicated in physiological post-menopause, but also in cases of surgical menopause, primary ovarian insufficiency and premature menopause, where the main indications are the treatment of vasomotor symptoms, genitourinary syndromes and the prevention of osteoporosis and osteoporotic fractures in these women (MEHTA et al., 2021). Local estrogen therapy has evidence of improving symptoms more consistently and must be indicated in moderate to severe cases of urogenital atrophy. For women who have dyspareunia and vasomotor symptoms, systemic menopause hormone therapy by oral or transdermal route is indicated and may be associated with local therapy (MEHTA et al., 2021).

The benefits of hormone therapy include: improved sleep, mood disorders, reduced insulin resistance, reduced risk of dementia, improved quality of life, and prevention of cardiovascular diseases when started within the window of opportunity (SHUFELT et al., 2021).

Despite all the great benefits, it must be noted that there are negative aspects to isolated estrogen replacement therapy, such as an increased risk of gynecological neoplasms, increased liver complications, and cardiovascular diseases if started outside the window of opportunity (SHUFELT et al., 2021).

Menopausal hormone therapy must be continued for the shortest possible time to ensure symptom relief. However, some patients require longer use, requiring prolonged monitoring, as long as the benefits of its use are maintained and outweigh the risks (HOGERVORST et al., 2022).

Among the alternatives to its use are androgens and tibolone, with tibolone being a steroid that has a triple action, presenting both estrogen, progestogen and androgen receptors, acting in the control of vasomotor symptoms, urogenital symptoms and in the maintenance of bone mineral density, being strongly associated with the improvement of symptoms such as loss of libido, fatigue, sarcopenia and improvement of general female well-being (MIDAGLIA et al., 2022).

Androgens, on the other hand, have an adjuvant role in the therapy of hypoactive sexual desire in postmenopausal women who do not have contraindications to HRT, where the benefits of their use bring great satisfaction to users. It must be emphasized that sexual relations go beyond hormonal stimuli, involving psychological, social, hormonal and cultural factors, and a multidisciplinary approach with the couple is indicated (TRÉMOLLIERES et al., 2022).

It is worth remembering that androgenic supplementation worsens the lipid profile, leads to an increase in triglycerides and LDL, especially when used in isolation, without association with estrogens, and is associated with insulin resistance, symptoms of hyperandrogenism such as clitoromegaly, hirsutism and acne (GULLO et al., 2022).

Therefore, it is important to know guidelines on effective alternative therapies for women who cannot use hormone replacement therapies and for those who do not have contraindications, it is recommended that a lifestyle change be made in association with replacement therapy, thus providing an overall improvement in health status during menopause.

CONCLUSION

Therefore, there is a real need for more reviews on the subject, with better evidence to facilitate everyday decisions regarding menopausal hormone therapies. Given that the benefits outweigh the risks as long as they are well indicated, within the window of opportunity for their initiation, as well as respecting the contraindications to the use of therapy and always being carried out under the guidance of a qualified health professional.

From this, it is known that improving the quality of sexual life is possible and that the years lived in this phase become less undesirable, thus providing support so that women can get through menopause in the best possible way.

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