Menopause management for women with fibroids and endometriosis

Fibroids (leiomyomas) and endometriosis are benign estrogen-dependent conditions. Fibroids tend to shrink and endometriosis symptoms improve after menopause.

Fibroids
- Evidence regarding different types of menopausal hormone therapy, including tibolone, on fibroid growth is limited.
- Menopausal hormone therapy seems to stimulate the growth of fibroids mainly in the first two years of use. Ultrasound may help in monitoring.
- Fibroids do not represent a contraindication to menopausal hormone therapy, although, anecdotally, submucous fibroids may be associated with breakthrough bleeding or heavier withdrawal bleeds with sequential therapy.
- Treatments other than hysterectomy are available, including myomectomy, endometrial ablation, radio-frequency fibroid ablation, uterine artery embolization, magnetic resonance-guided focused ultrasound and selective progesterone receptor modulators.
- It is not known how fibroids treated without hysterectomy will respond to menopausal hormone therapy.

Endometriosis
- The two key concerns about the use of menopausal hormone therapy by women with endometriosis are reactivation of the disease and the production of new implants.
- The potential for malignant transformation of endometriosis after the menopause, spontaneously or in association with menopausal hormone therapy, is uncertain.
- Use of menopausal hormone therapy depends on age at menopause and symptoms.
- Data regarding menopausal hormone therapy regimens are limited. However, it may be safer to give either continuous combined estrogen–progestogen therapies or tibolone in both hysterectomized and non-hysterectomized women to reduce the risk of recurrence and malignant transformation of residual disease.
- Nonhormonal options for menopausal symptoms or maintenance of bone health are not contraindicated.

Further information
EMAS CareOnline 2020  https://emas-online.org/emas-careonline

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