



Hormones, Choices and Change

Maria Loupetis NP

Each

Acknowledgement of Country

Each acknowledges the Traditional Custodians of the diverse lands, skies and waterways across Australia and pay our respects to their Elders past, present and emerging. We also extend our respect to all Traditional Owners, and Aboriginal and Torres Strait Islander Peoples, their Elders, cultures, heritages and their right to determine their own futures.

Each recognises that sovereignty was never ceded and acknowledges the continuing impact colonisation has had on Aboriginal and Torres Strait Islander Peoples and Communities.

We also acknowledge the knowledge and skills of our Aboriginal and Torres Strait Islander staff who are currently working, and have previously worked, at Each.



Overview of presentation

1. Nurses role in peri/menopause

Health impacts, screening tools and assessment

2. Contraception updates

Contraception counselling
LARCS (extended use)
What is new on PBS
MEC Criteria
Implanon insertions

3. Medical Abortions in General practice

The process,
prescribing, dispensing, supporting
people
Referral pathways



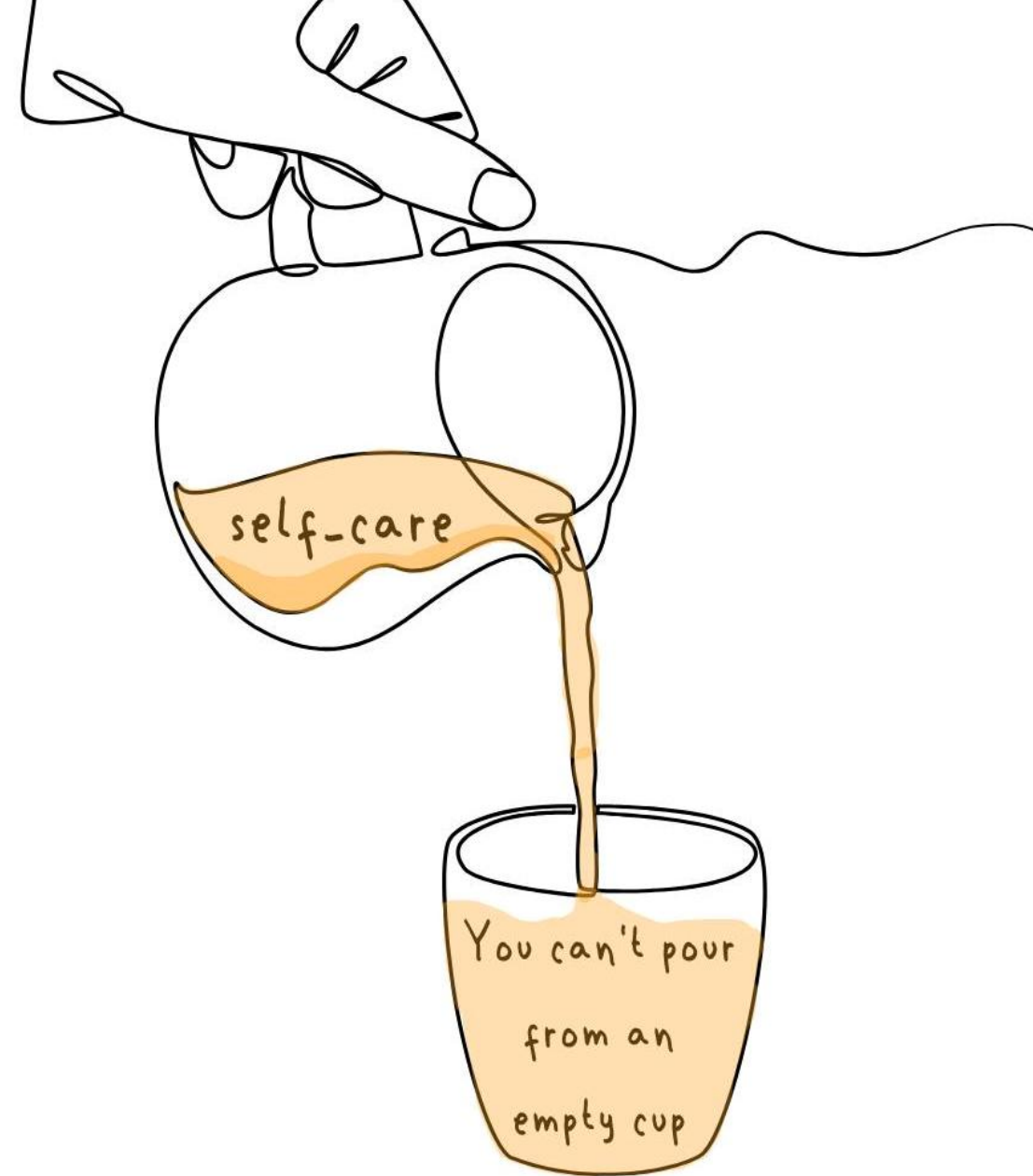
Peri-menopause and menopause

Time of change- physically and mentally

Juggling act at a demanding time in life

Our role as nurses- 'Help people fill their cup' – listen, validate, normalise, educate and support people evidence based, person centred care

People cannot give from an empty cup



Peri-menopause and menopause symptoms

How do they present? (with help from the audience)

- Cognitive and mood symptoms
- Vasomotor symptoms (temperature regulation)
- Menstrual and reproductive changes
- Sleep disturbances
- Physical/body changes
- Urogenital symptoms
- *Outliers that don't fit neatly into any of the other areas*

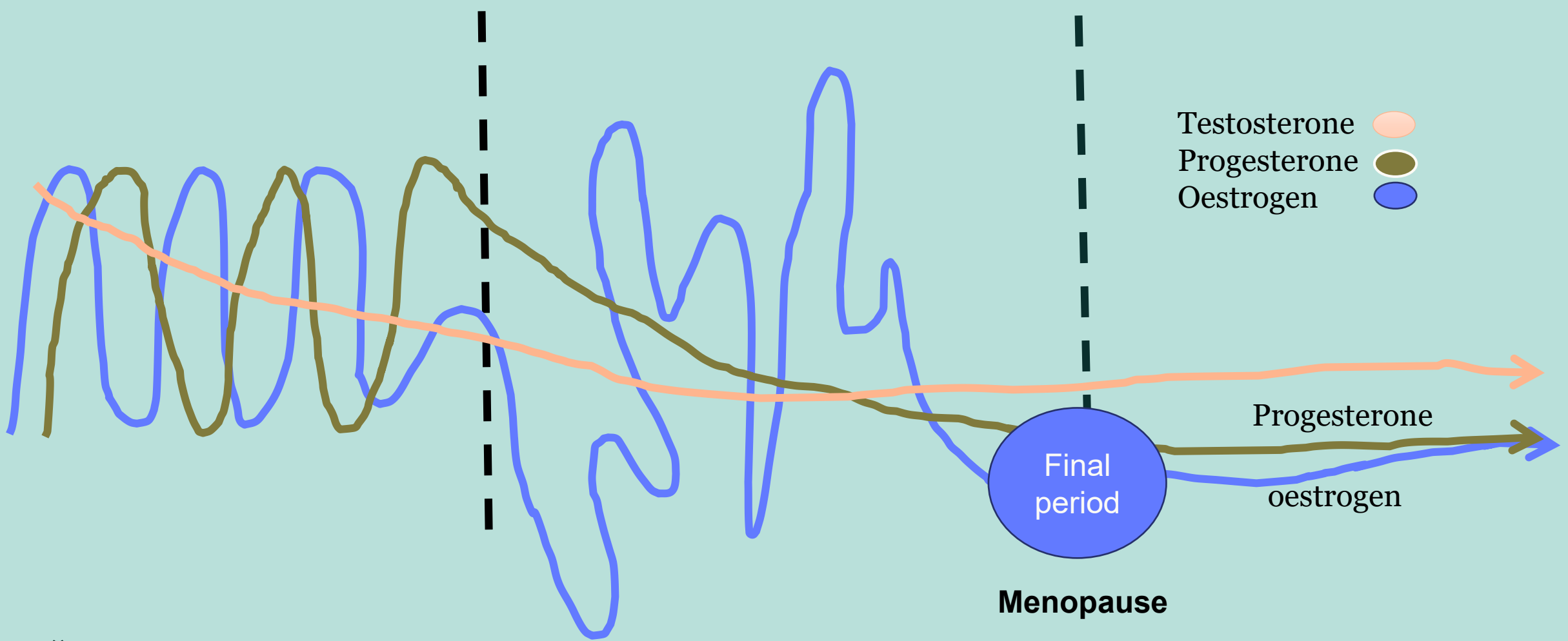


Menopause map...explaining the symptoms

Late reproductive phase

Perimenopause (zone of chaos)

Post Menopause



Definitions

Perimenopause is when an onset of new vasomotor or other symptoms (big list) are experienced, there is persistent change in the pattern of menstrual bleeding which continues until there has been 12 months since last menstrual period. On average experienced between the ages of 35-45.

Menopause is one day- when it has been twelve months since your last period, on average around 51 years of age

Post menopausal- the day after...

Item numbers

Both **695 and 19000- comprehensive assessment:**

Perimenopause/ menopause history (peri/post status, symptoms)

Observations (BP, weight, etc.)

Consideration of investigations (e.g. screening, mammograms, bone density)

Discussion of **management options** (hormonal and non hormonal)

Preventive health advice and a **management plan**

⚠️ **Important context for GP billing**

Menopause is **not limited to these items**. In practice, GPs may also use:

Standard GP attendance items (e.g. 23, 36, 44)

For shorter or less structured consults about menopause

Chronic disease / care planning items (e.g. 721, 723, 10997 etc.)

If menopause-related issues contribute to chronic conditions

Mental health or allied health items

If relevant (e.g. mood symptoms, psychology referrals)



Assessment tools



SYMPTOM SCORE (Modified Greene Scale)¹

	Score before MHT	3 months after starting MHT	6 months after starting MHT
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS

SCORE: None =0; Mild =1; Moderate =2; Severe =3

NB. The symptoms are grouped into 4 categories, vasomotor, psychological, locomotor and urogenital. If one group does not respond to MHT, look for other causes and specific treatments for that group.

Not all of the symptoms listed are necessarily oestrogen deficiency symptoms.



Assessment tools



MONASH
MEDICINE,
NURSING AND
HEALTH SCIENCES

A Practitioner's Toolkit for Managing Menopause



Developed by the Women's Health Research Program in the Monash University School of Public Health and Preventive Medicine, 2023.

The supporting notes for the Practitioner's Toolkit for Managing Menopause are published, with free access, in *Climacteric*, the journal of the International Menopause Society.

tandfonline.com/doi/epdf/10.1080/13697137.2023.2258783



Endorsed by:



A Practitioner's Toolkit for Managing Menopause

A Woman* (40 years+) presents with:

Symptoms

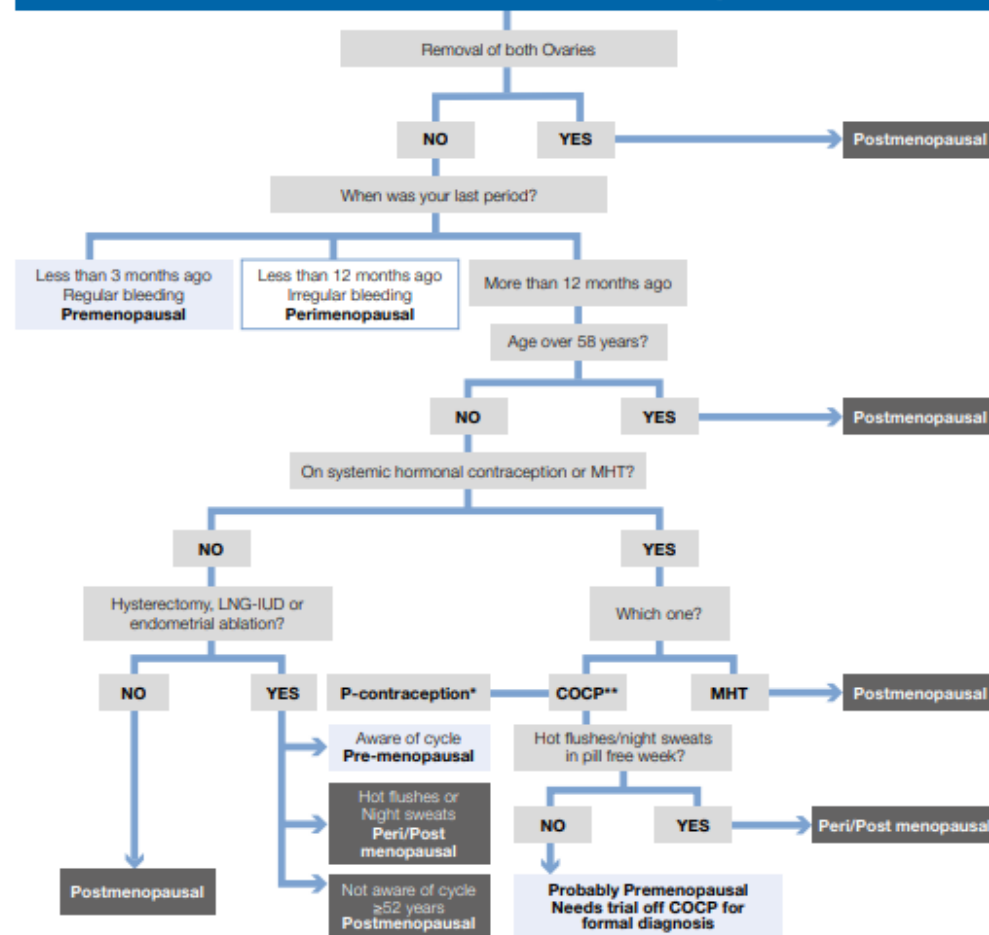
- Irregular bleeding
- Vasomotor
 - Hot flushes
 - Night sweats
- Poor sleep
- Joint pain
- Anxiety/low mood
- Cognitive concerns
- Urogenital symptoms
 - Vaginal dryness/soreness
 - Bladder/urinary Sx
- Lost interest in sex
- Central weight gain

Concerns

- Osteoporosis
- Cardiovascular risk
- Dementia
- Diabetes
- Obesity

AND/OR

Is this Patient Pre/Peri/Postmenopausal?



* assigned female at birth; **diagnosis of menopausal status requires detailed reproductive history. In some women, an option is to cease the COCP and then review.



What do you need to know?

Full assessment recommended for midlife women

Medical History

Relevant gynae facts:

- Bleeding pattern or LMP
- Past surgery eg hysterectomy/oophorectomy
- Current use of any exogenous hormones
- +/- contraceptive needs

Major medical illnesses – ask about:

- DVT/PE
- Breast cancer/endometrial cancer
- Thyroid disease
- Cardio/cerebrovascular disease including HT
- Osteoporosis
- Diabetes
- Depression/anxiety/postnatal depression
- Recurrent UTI's
- Liver disease

Family History:

- Cardio/cerebro vascular disease
- Osteoporosis/fractures
- Dementia
- Cancer

Smoking/alcohol use

Current medication including non prescription medications

Social history

Sexual wellbeing

Examination

- Height and weight
- Blood pressure
- Breast exam (not required if recent breast imaging/ breast checks)

Investigations for menopause diagnosis

≥ 45 years old

- Diagnosis symptom based; measure FSH and E only if atypical presentation

< 45 years old

- Measure FSH and E
– Of no value in women on COCP
- Prog/LH/AMH levels of no diagnostic value

Midlife women general health assessment:

- Cervical screen test
- Mammogram (if available)
- Lipid profile
- FBG
- TSH
- Renal and liver function
- FBE/ ferritin
- FOBT
- Vit D in at risk women



Menopausal 'Hormone' Therapy

MHT

Not a one stop shop....

Try- review
Increase- review
Swap- review



Cyclical combined MHT	Continuous combined MHT	Vaginal therapy	Oestrogen only therapy	Progestogen
<ul style="list-style-type: none"> • Often for women going through perimenopause and have irregular spontaneous menstrual periods or recent menopause. • Can also be continued for longer if preferred. • Combined packs are available 	<ul style="list-style-type: none"> • Often used when post menopausal • Early introduction close to menopausal transition may lead to irregular, unscheduled breakthrough bleeding. • Breakthrough bleeding can occur in first six months-unscheduled bleeding should be investigated. • Combined packs available 	<ul style="list-style-type: none"> • Indicated for vaginal dryness and discomfort, urinary symptoms like frequency, urgency or incontinence. • Creams, tablets and suppositories. • Localised treatment delivering oestrogen directly to tissues-reducing risk of side effects of CVD or blood clots and no increased risk of breast cancer • Can provide rapid relief as well as long term benefits. • If vaginal oestrogen prescribed rather than systemic hormone therapy (oral), progestogen is not required. 	<ul style="list-style-type: none"> • Used if person has had a hysterectomy or in combination with a progestogen or Mirena (intrauterine device) if intact uterus. • Can be taken tablet, gel or patch or pessary form. • Safety profile of delivery system differs for women 	<ul style="list-style-type: none"> • Can be taken in tablet/capsule or intrauterine system



The science behind the risks

Risk factors for Breast Cancer:

Life-style VS MHT

Based on incidence of breast cancer per 1000 women age 50-59 over 5 years.
Source: BMS / NICE

23 cases of breast cancer diagnosed in the UK general population



An additional four cases in women on combined hormone replacement therapy (HRT)



Four fewer cases in women on oestrogen only Hormone Replacement Therapy (HRT)



An additional four cases in women on combined hormonal contraceptives (the pill)



An additional five cases in women who drink 2 or more units of alcohol per day



Three additional cases in women who are current smokers



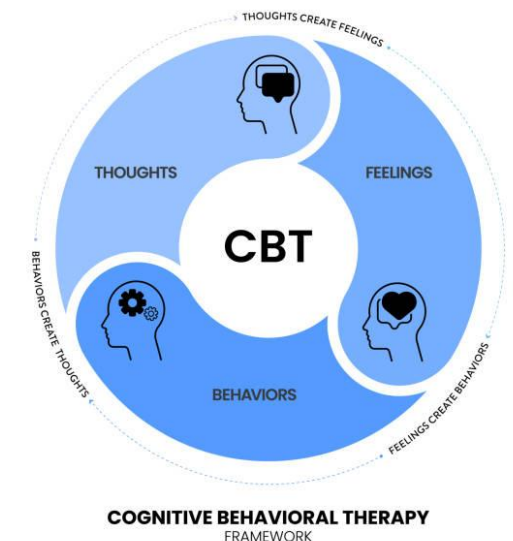
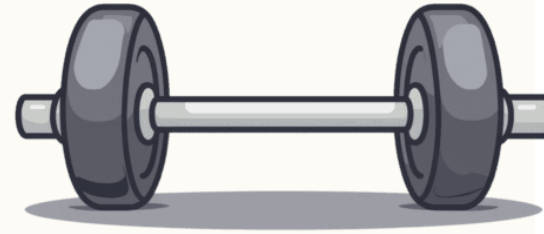
An additional 24 cases in women who are overweight or obese (BMI equal or greater than 30)



Seven fewer cases in women who take at least 2½ hours moderate exercise per week

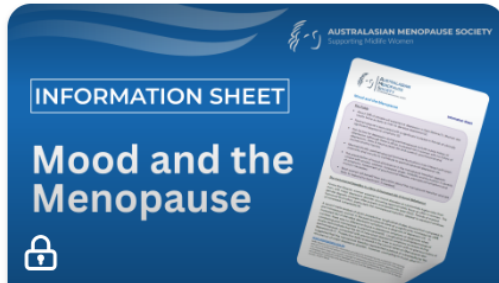


Non- hormonal options



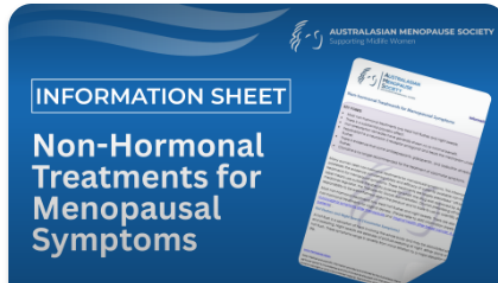
Lifestyle modifications	Psychological therapies	Dietary/herbal supplements	Prescribed therapies	
<ul style="list-style-type: none"> • Sleep hygiene • Diet • Social support/interactions • Improving cooling through environmental control • Avoiding triggers (reducing alcohol) of vasomotor symptoms • Exercising (any way that you can enjoy) regularly • Mind and body-based therapies (yoga, paced breathing, relaxation) • Reducing triggers • Acupuncture 	<ul style="list-style-type: none"> • Cognitive behavioral therapy • Hypnosis 	<p><u>With limited evidence of benefit:</u></p> <ul style="list-style-type: none"> • Soy foods • Pollen extract • Ammonium succinate • Rhubarb <p><u>Without demonstrated evidence of benefit/inconclusive evidence:</u></p> <ul style="list-style-type: none"> • Black cohosh • Wild yam • Evening primrose • Ginseng • Omega 3 fatty acid 	<p><u>Antidepressants</u></p> <ul style="list-style-type: none"> • SNRIs- serotonin and noradrenaline are known to affect mood and may also impact thermoregulation • SSRIs-selective serotonin reuptake inhibitors shown to be effective for hot flushes, especially after breast cancer. 	<p><u>Neurokinin B antagonist</u></p> <ul style="list-style-type: none"> • Designed to treat vasomotor symptoms. • Targets neural pathways involved in thermoregulatory centre

Resources for patients/clients



Mood and the Menopause

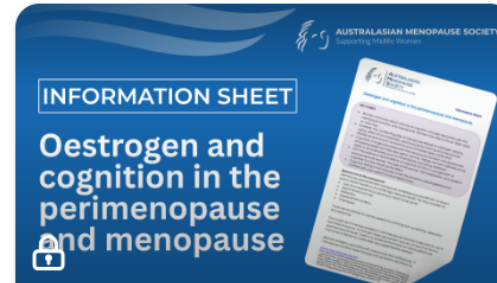
CAROLINE GURVICH
07/04/2026



Non-Hormonal Treatments for Menopausal Symptoms | Information...

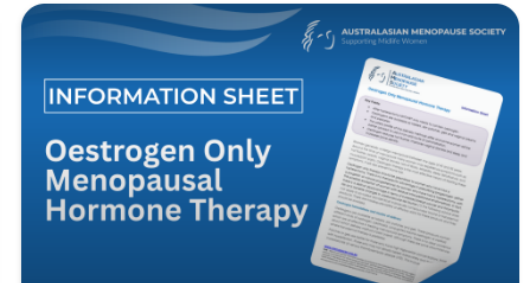
08/09/2024

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Oestrogen and cognition in the perimenopause and menopause

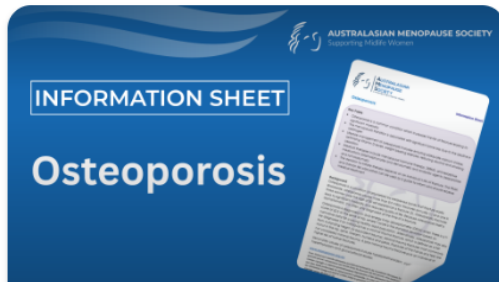
11/07/2020



Oestrogen Only Menopausal Hormone Therapy | Information Sheet

23/02/2017

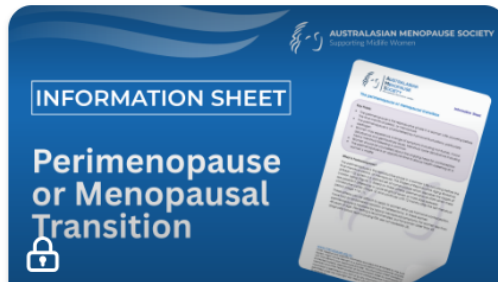
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Osteoporosis | Information Sheet

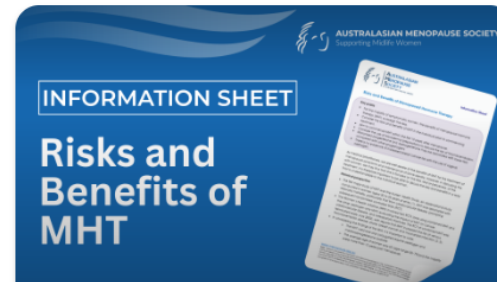
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Perimenopause or Menopausal Transition

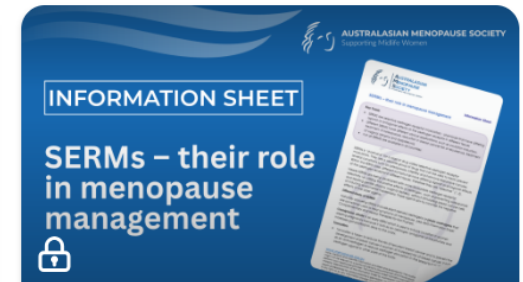
28/03/2023



Risks and Benefits of MHT | Information Sheet

20/01/2021

VIEW



SERMs – their role in menopause management

16/05/2023



Other resources for patients/clients

Podcasts

- Thriving in Menopause
- Dear Menopause
- Rage against the Vagine
- UnPaused

Websites

- Australasian Menopause Society
- International Menopause Society
- Jean Hailes For Women's Health
- Sexual Health Victoria



Contraception

Practice nurses are instrumental in contraception counselling and care coordination



How effective is my contraceptive method?

In 1 year, what are my chances of getting pregnant?

>99%
Set and forget



Contraceptive Implant
99.95% effective
Lasts up to 3 years



Homonal IUD
99.7-99.9% effective
Lasts up to 5 years



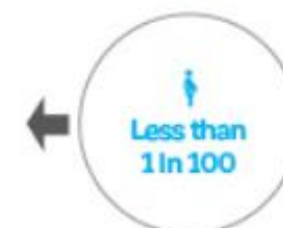
Copper IUD
99.5% effective
Lasts 5-10 years



Tubal surgery
99.5% effective
Permanent



Vasectomy
99.5% effective
Permanent



93-99%
Works well if used perfectly every time



Contraceptive Injection
Used typically 96%
Used perfectly 99.8%



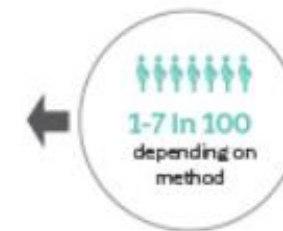
Vaginal ring
Used typically 93%
Used perfectly 99.5%



The Pill (COC)
Used typically 93%
Used perfectly 99.5%



The Pill (POP)
Used typically 93%
Used perfectly 99.5%



76-99%
Less effective methods



Condom external
Used typically 88%
Used perfectly 98%



Condom internal
Used typically 79%
Used perfectly 95%



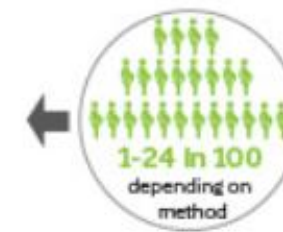
Diaphragm
Used typically 82%
Used perfectly 86%



Fertility awareness
Used typically 76 - 93%
Used perfectly 95-99.5%



Pulling out
Used typically 80%
Used perfectly 95%



Used perfectly – when the rules are followed perfectly EVERY time
Used typically – real life use where mistakes can sometimes happen (for example: forgetting a pill, condom not used correctly).
 If you experience unwanted side-effects with your contraceptive method, it is important to seek medical advice from a health professional.

Without contraception around 80 in 100 women of reproductive age will get pregnant in a year.



Figure 1. Family Planning Alliance Australia contraceptive efficacy card. [Click here to enlarge](#)

LARCs Long-acting contraception

Method	Generic/clinical term	Brand(s) in Australia	Duration	Non-contraceptive uses (evidence-based)
Hormonal IUD	Levonorgestrel Intrauterine system	Mirena, Kyleena	5–8 years	Heavy menstrual bleeding (first-line), endometrial protection in MHT
Copper IUD	Copper IUD (CuT380A)	Multiload, Copper T	5–10 years	Emergency contraception
Implant	Etonogestrel	Implanon NXT	3 years	Dysmenorrhoea (variable evidence)
Injection	Medroxyprogesterone acetate	Depo-Provera	12 weeks	Amenorrhoea for heavy bleeding



Oral and systemic hormonal contraception

Method	Generic/clinical name	Brand(s) in Australia	Duration	Non-contraceptive uses (evidence-based)
Combined oral contraceptive pill (COCP)	Ethinylestradiol + progestin	Yaz, Yasmin, Microgynon, Levlen ED	Daily	Acne, PMS/PMDD (some off-label), cycle regulation, dysmenorrhoea, endometriosis symptom control (off-label)
Progestogen-only pill (POP)	Levonorgestrel / Drospirenone	Slinda, Noriday, Microlut	Daily	Limited; possible acne/bloating benefit (limited evidence)
Vaginal ring	Ethinylestradiol + etonogestrel	NuvaRing	Monthly	Cycle regulation, PMS symptom relief, acne (variable)



Emergency contraception

Method	Generic/clinical name	Brand(s) in Australia	Duration	Non-contraceptive uses (evidence-based)
Emergency contraceptive pill	Levonorgestrel / Ulipristal acetate	Postinor-1, EllaOne	Single dose	Emergency contraception only
Copper IUD (for EC use)	Copper IUD	Multiload, Copper T	Insert within 5 days	Emergency contraception (most effective method)



Oral contraceptives

Key PBS-listed combined oral contraceptives (recent additions)

In the last 1–2 years, Australia expanded PBS access to newer pills including:

Drospirenone-containing pills

Yaz

Yasmin

Indications:

contraception

acne

PMS / PMDD (Yaz in particular)

These are now more **affordable under PBS (~\$30–\$130/year depending on concession status)**

Progestogen-only pill PBS expansion

Slinda

Increasing use for:

contraindications to oestrogen

postpartum contraception

migraine with aura / VTE risk patients



Inserting and removing implants/Implanon

RNs who complete training and work under medical governance are able to insert and remove implants/Implanon

Prescribed by GPs, including local anaesthetic

Training includes online theory and simulation training

Training is provided by Sexual Health Victoria and The Royal Women's Hospital



Extended use of IUD- Mirena



Australian Government

Department of Health, Disability and Ageing
Therapeutic Goods Administration

Mirena (levonorgestrel) intrauterine device

Australian Prescription Medicine Decision Summary

Published: 17 July 2024

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Product name	Mirena
Active ingredient	Levonorgestrel
Submission type	Major Variation
Decision	Approved - duration of use for contraception extended from 5 to 8 years.
Decision date	5 June 2024
Registration date	7 June 2024
What this medicine was approved for	Mirena, a levonorgestrel-releasing intrauterine system is a long-acting reversible contraceptive. The duration for use as a contraceptive has been extended from 5 years to 8 years.



Medical Abortion/ Medical termination of pregnancy

Refers to administration of medication to end a pregnancy.

Medications are marketed as MS2Step under licence from MS Health- part of Marie Stopes International.

MS2Step is a composite pack and consists of Mifepristone 200mg tablet and Misoprostol 4X200 microgram tablets.

Indicated for use in eligible women and pregnant people for purpose of medical abortion of a developing intrauterine pregnancy, up to 63 days gestation- 9 weeks

Aim of service is to provide **timely, respectful, and accessible care pathways** for all patients



Care pathway- process

Sensitive and careful discussion required to determine degree of certainty of decision and understanding process and risk factors of decision.

Assessment & Eligibility

Initial assessment

- Confirm pregnancy and gestational age
- Exclude ectopic pregnancy
- Medical history and contraindications
- Assess support, safety, and access to emergency care

Eligibility considerations

- Gestation ≤ 63 days (note very early medical abortions without US available)
- No contraindications to medications
- Ability to understand process and follow instructions

Nurse role

- Assist with history-taking and screening (LNMP, preg test, obstetric history, gynae history)
- Provide clear explanations of options
- Support informed, patient-centred decision-making



Characteristics of abortion procedures	
Medical abortion	Surgical abortion
Available up to 63 days of pregnancy	Availability depends on service capacity
Avoids anaesthesia and surgery	Timing of abortion controlled by the clinic
Mimics the process of a natural miscarriage	Generally, involves two separate hospital visits, one for clinic consultation and second for procedure
Medications are self-administered, and abortion occurs at home	Actual procedure quick, complete within 10 to 15 minutes
Takes time to complete abortion, and the timing may not be predictable	On day of procedure, may be at the hospital for up to 5-6 hours
Pain and bleeding expected. Potential gastrointestinal side effects due to misoprostol	Predictable timeframe and high degree of certainty about the outcome
IUD can be inserted once complete abortion is confirmed, usually during follow up	May require cervical preparation in advance of the procedure
Support person required during the abortion	Able to have long-acting reversible contraception (LARC) inserted at time of procedure
Longer period of bleeding, average 16 days, may be up to 30 days	Overnight support is required after an anaesthetic
Need to be active in follow-up care	Shorter period of bleeding
Severe complications are rare	Severe complications are rare
Risk of teratogenicity - requires commitment to completion once treatment is commenced	No known absolute contraindications
Contraindications (i.e., extra-uterine pregnancy, unknown gestation, chronic adrenal failure, haemorrhagic disorders, hypersensitivity to medications)	



Abortion risk and complications:

Complication	Risk
Haemorrhage and heavy bleeding	Defined as blood loss greater than 500ml or severe bleeding requiring transfusion, is low across all methods and gestations. The risk is lower for early abortions, 1-3:1000 in first trimester, 1-10:1000 in second trimester.
Infection	Uncommon, usually caused by a pre-existing bacterial infection. Opportunistic screening for bacteria of the lower genital tract or prophylactic antibiotics reduces this risk.
Retained products of conception (RPOC)/ incomplete abortion	Uncommon. Routine follow-up ultrasound is not recommended if asymptomatic. Occurs in approximately 1-4:100 for medical abortion and may require surgical management. Approximately 1:100 for surgical abortion.
Ongoing pregnancy/ failed abortion	Less than 1:100 pregnancies across both methods; more common in early abortions and requires surgical management.
Cervical trauma	For surgical abortion only, risk no greater than 1:100, decreased risk with earlier gestations, cervical priming, and experienced practitioner.
Uterine perforation and damage to surrounding structures	For surgical abortion only, risk is 1-4:1000, decreased risk with cervical priming, earlier gestations, and experienced practitioner.
Future reproductive outcome	There are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. There may be an association between abortion and subsequent risk of preterm birth, this increases with the number of abortions or later gestation.





Medications and pain relief options

Step 1. Green box

Mifepristone Linepharma 200mg Tablet

Swallow the tablet on (date) _____ at (time) _____

Step 2. Purple box

Prior to taking the Step 2 tablets, please take 1 x tablet of Ondansetron on _____

and 2 x tablets of Panadeine Forte on _____ at _____.

Misoprostol 200mcg Tablet. To be taken more than 24hrs but less than 48hours (36hrs) after you take Step 1.

Take 4 tablets on _____ at _____

Place 4 tablets between your teeth and gums as shown to you by your nurse. Allow these to soften in your mouth for approximately 30 minutes and swallow the remainder with a drink of water.

If you are experiencing nausea or vomiting

Ondansetron 4mg Tablet: Take 1 tablet every 8 hours only as required. Your Doctor will send/give you a script at your



Follow-Up & Ongoing Care

Usually at **1–2 weeks**

Confirm completion (history, bhCG 80% decrease in serum levels 8-16 days later, negative lower sensitivity urine pregnancy test from day 14 is appropriate)

Warning signs (require urgent care)

Heavy bleeding (soaking >2 pads/hour for 2 hours)

Severe abdominal pain

Fever or signs of infection

Nurse role

Follow-up calls/check-ins (3–5-day phone call)

Assess symptoms and wellbeing

Provide contraception counselling if desired



Resources- referral pathways

- 1800 My Options- Provides support, training resources, locates providers, and information on becoming an MTOP provider
- Sexual Health Victoria- offers clinical resources, training for medical abortion and clinics at Box Hill and CBD as well as Early Medical Abortion (criteria).
- Each's Virtual Women's Health Clinic
- AusCAPPS- The Australian Contraception and Abortion Primary Care Practitioner Support Network



Resources- referral pathways (Surgical)

- Eastern Health (Box Hill) up to 16 weeks. GP referral via Healthlink
- Royal Women's Hospital (limited capacity- complexity, vulnerability, longer gestation)
- MSI Australia (Melbourne, St Kilda) Private (Medical and surgical)
- Fertility control Clinic



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Thank you

Any questions?



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Resources

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