THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

ESTROGENS

Deprescribing in older people: A clinical practice guideline

dRx™

ESTROGENS

Estradiol*

Estriol*

*Common Pharmaceutical Benefits Scheme medicines

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	**Systemic Menopausal Hormone Therapy (MHT)** We suggest deprescribing be offered to older women taking MHT (menopausal hormone therapy i.e. estrogen monotherapy or estrogen combined with progestogen) whose menopausal symptoms have resolved or improved over time, provided this aligns with the individual's goals and preferences and following informed consent. **Vaginal MHT** We suggest deprescribing be offered to older women on low-dose vaginal estrogen therapy for genitourinary syndrome of menopause whose symptoms have resolved or improved over time.
GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	We suggest continuing MHT in people who experience symptom recurrence that impact their quality of life and cannot be managed with non-hormonal options. If deprescribing is unsuccessful, we suggest non-hormonal and non-pharmacological therapies (e.g. lifestyle interventions) for genitourinary syndrome of menopause such as moisturisers, lubricants or pelvic floor muscle exercises may be considered as alternative options before considering the reinitiation of MHT. If MHT needs to be resumed, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy periodically including the possibility of switching to another route of administration (e.g. topical low-dose estrogen intravaginal cream for localised symptoms).

CBR, consensus-based recommendation; GPS, good practice statement

HOW TO DEPRESCRIBE

CBR We suggest stopping MHT abruptly without the need for tapering; however, some patients may prefer gradual tapering by reducing the dose or dosing frequency.

For oral formulations, we suggest reducing one dose per week every two to four weeks (e.g. reducing from daily administration to six days a week with one day off for two to four weeks, then to five days a week for two to four weeks, and so on, until discontinuation).

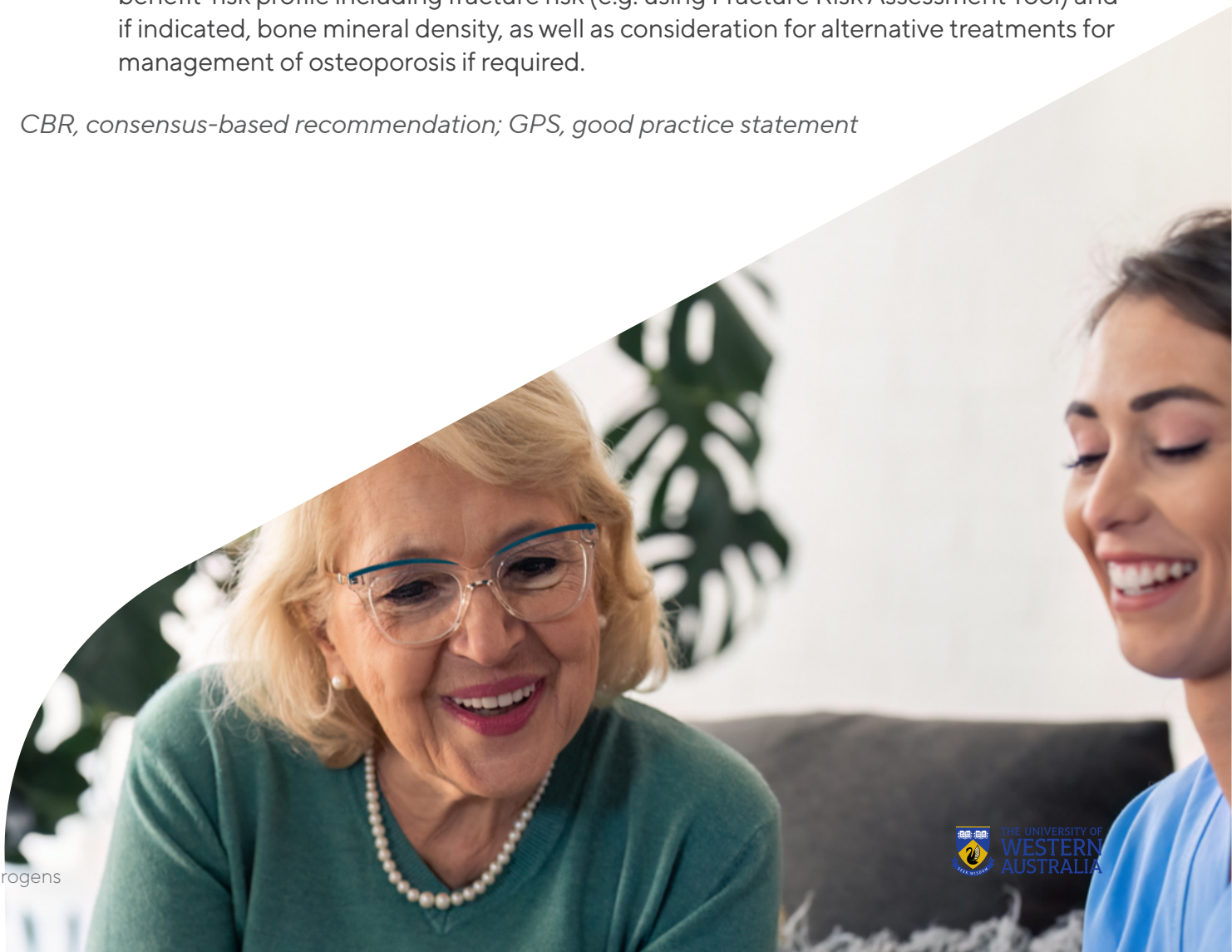
For transdermal formulations, we suggest gradually reducing the strength of the patch over three to six months, depending on the available preparations.

For gel, cream or pessary formulations, we suggest tapering by reducing the dosing frequency every two to four weeks.

MONITORING

CBR We suggest periodic evaluation of patient preferences, symptom control and ongoing benefit-risk profile including fracture risk (e.g. using Fracture Risk Assessment Tool) and if indicated, bone mineral density, as well as consideration for alternative treatments for management of osteoporosis if required.

CBR, consensus-based recommendation; GPS, good practice statement



Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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Suggested citation: Quek HW, Reus X, Lee K, Etherton-Beer C, Page A on behalf of the Guideline Development Group. Deprescribing in older people: A clinical practice guideline. Perth: The University of Western Australia; 2025.