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Menopause & Hormone Therapy

What every woman should know — symptoms, hormone therapy, non-hormonal options, bone and heart health, and common myths.

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Content curated and designed by Mohammadreza Torbatimoghaddam, Clinical assistant

What is menopause?

Menopause is a **natural stage of life** — not a disease or a deficiency. It marks the permanent end of menstrual periods as the ovaries gradually stop producing estrogen and progesterone. Menopause is confirmed when a woman has gone **12 consecutive months** without a menstrual period, in the absence of other causes.

The transition leading up to menopause is called **perimenopause**. During this time, periods become irregular, and symptoms can begin — sometimes years before the final period.

When does menopause happen?

~51
Average age of menopause; 90% of women reach it between 45 and 56

Mid-40s
When perimenopause typically begins — and it can last several years

~40%
Of a woman's life is spent postmenopausal — long-term health matters

Perimenopause starts when menstrual cycles become variable (cycles differing by **7 or more days**) and progresses to longer gaps between periods (**60 days or more**).

What counts as early menopause?

- **Early menopause** — ages 40–44. About **8–10%** of women experience this.
- **Premature menopause** (premature ovarian insufficiency, or POI) — before age 40. Affects about **1–4%** of women.
- **Surgical menopause** — both ovaries removed before natural menopause (bilateral oophorectomy). A hysterectomy alone (uterus removed, ovaries left) does **not** cause menopause.

Why early menopause matters: Menopause before age 45 — natural, surgical, or from medical treatment — is linked to higher long-term risk of heart disease (about **30–55%** higher cardiovascular events vs average-age menopause), osteoporosis and fractures, possible cognitive decline, and depression/anxiety. For these reasons, women with early or premature menopause are generally recommended to take **hormone therapy at least until the average age of natural menopause (about 51)** to protect long-term health.

When should you see a healthcare provider?

- Hot flashes or night sweats that disrupt sleep, work, or daily life
- Vaginal dryness or pain during intercourse that affects quality of life or relationships
- Mood changes — new or worsening depression, anxiety, or irritability during the transition
- **Irregular or heavy bleeding** — especially **any bleeding after menopause** (after 12 months without a period) — must be evaluated promptly
- Periods stopping before age 45 — investigate to rule out premature ovarian insufficiency
- Urinary symptoms — recurrent UTIs, urgency, or incontinence
- Concerns about bone health, especially with osteoporosis risk factors

About blood tests: Menopause is usually diagnosed from age, symptoms, and menstrual pattern. FSH and estradiol are generally **not needed** to confirm menopause in women over 45 with typical symptoms. Blood tests may be appropriate if menopause is suspected before age 40.

What are the symptoms of menopause?

Symptoms vary widely — some women have mild symptoms; others find them significantly disruptive. They can begin in perimenopause and may last for years.

Vasomotor symptoms — hot flashes and night sweats

- The most characteristic menopause symptom — experienced by **50–75%** of women
- Sudden intense heat, flushing, and sweating, lasting seconds to minutes
- Average of about **4–5 hot flashes per day**; some women have up to 20
- In about **50%** of women, frequent hot flashes last more than **7 years**
- Night sweats can severely disrupt sleep

Genitourinary syndrome of menopause (GSM)

- Vaginal dryness, burning, itching, and discomfort
- Pain during intercourse (dyspareunia)
- Urinary urgency, frequency, and recurrent urinary tract infections
- Affects **45–77%** of postmenopausal women
- **Unlike hot flashes**, these symptoms generally worsen over time and do not go away on their own

Mood and cognitive changes

- Low mood, irritability, anxiety, loss of confidence
- Difficulty with concentration, memory, and multitasking ("brain fog")
- About **10%** of peri- and postmenopausal women experience an episode of major depression
- Women with a history of depression are at higher risk

Sleep and other common symptoms

- Insomnia and disrupted sleep — often worsened by night sweats
- Fatigue and low energy
- Joint and muscle pain · Headaches
- Loss of sexual desire
- Weight gain and changes in body fat distribution
- Hair thinning and dry skin

Q What is hormone therapy (HT) and how does it work?

Hormone therapy (also called menopausal hormone therapy or HRT) replaces the estrogen the ovaries no longer produce. It is the **most effective treatment for hot flashes and night sweats**, reducing their frequency by approximately **75%** — significantly more than any non-hormonal alternative.

Two main types

- **Estrogen-only therapy** — for women who have had a hysterectomy (no uterus)
- **Combined estrogen plus progestogen** — for women who still have a uterus. The progestogen (progesterone or a synthetic progestin) is essential to protect the uterine lining from thickening and cancer caused by estrogen alone

Forms available

- Oral tablets (pills taken daily)
- Transdermal patches (applied to the skin once or twice weekly)
- Gels and sprays (applied to the skin daily)
- Vaginal preparations (creams, tablets, rings — for genitourinary symptoms only)

When is hormone therapy recommended?

Current guidelines from the North American Menopause Society (NAMS) and other major organizations support hormone therapy for:

- Women **under 60** or **within 10 years of menopause onset** who have bothersome vasomotor symptoms and no contraindications
- Women with **early or premature menopause** — HT is recommended at least until the average age of natural menopause (~51) to protect bone, heart, and brain health
- Prevention of bone loss in women at increased osteoporosis risk who also have menopausal symptoms, when other osteoporosis treatments are not appropriate

The benefit–risk balance is most favourable when hormone therapy is started **close to menopause** in younger, healthy women.

When is hormone therapy NOT recommended or should be avoided?

Hormone therapy should be avoided in women with:

- History of breast cancer or other estrogen-sensitive cancers
- History of blood clots (deep vein thrombosis or pulmonary embolism)
- History of stroke or coronary artery disease
- Active liver disease
- Unexplained vaginal bleeding (must be investigated first)
- Known blood clotting disorders

Hormone therapy is also **not recommended** for:

- Prevention of heart disease — it is not a cardiovascular preventive treatment
- Prevention of dementia — evidence does not support this use
- Women **over 60** or **more than 10 years past menopause** who are starting HT for the first time — risks (blood clots, stroke, and possibly heart disease) increase with age and time since menopause

What are the risks of hormone therapy?

Risks depend on the type, dose, route, duration, and timing of hormone therapy.

Combined estrogen plus progestogen

- Small increased risk of breast cancer — about **1 extra case per 1,000 women per year** of use. Risk increases with longer duration and decreases after stopping
- Small increased risk of blood clots (venous thromboembolism) and stroke — about **1 extra event per 1,000 women per year**
- Absolute risks are lowest in younger women (under 60) who start close to menopause

Estrogen-only therapy (no uterus)

- Does **not** increase breast cancer risk — the Women's Health Initiative found a possible **reduction** in breast cancer risk and mortality with estrogen alone
- Still carries a small increased risk of blood clots and stroke

Transdermal (patch/gel) estrogen

- Appears to carry a **lower risk of blood clots** than oral estrogen (observational studies)
- May be preferred for women with higher clot risk, obesity, or migraine

Micronized progesterone (natural progesterone)

- May carry a lower breast cancer risk than synthetic progestins (such as medroxyprogesterone acetate)
- Generally preferred when a progestogen is needed

How long can hormone therapy be used?

There is **no arbitrary time limit** on hormone therapy. The decision to continue should be individualized based on ongoing symptoms, health status, and the benefit–risk balance.

- General principle: use the **lowest effective dose** for the shortest duration needed to control symptoms, with periodic reassessment (at least annually)
- Many women need HT for longer than 5 years because symptoms persist. Continuing is appropriate as long as benefits outweigh risks for that individual
- When stopping, gradual tapering may help reduce symptom recurrence — though some women will experience a return of symptoms regardless of how they stop

What about "bioidentical" and compounded hormones?

- **FDA/Health Canada–approved bioidentical hormones** (such as estradiol patches and micronized progesterone capsules) are chemically identical to the hormones the body produces. They are regulated, tested for safety and effectiveness, and available by prescription. They are a good option.
- **Compounded bioidentical hormones** (custom-mixed by compounding pharmacies) are **not recommended** by major medical organizations. They are not regulated by Health Canada or the FDA, have not been tested for safety or effectiveness, lack standardized dosing, and may not include adequate risk warnings. They should only be considered if a woman has a documented allergy to ingredients in approved products.

What non-hormonal treatments are available for hot flashes?

For women who cannot or prefer not to take hormone therapy:

Prescription medications

- **SSRIs/SNRIs** (paroxetine, venlafaxine, escitalopram, citalopram, desvenlafaxine) — reduce hot flash frequency by about **40–65%**. Paroxetine is the only non-hormonal medication specifically approved for this purpose
- **Fezolinetant (Veozah)** — a newer medication (neurokinin 3 receptor antagonist) approved in 2023 that reduces moderate-to-severe hot flashes by about **20–25%**. Requires liver function monitoring due to a boxed warning about potential liver injury
- **Gabapentin** — reduces hot flashes by about **40–65%**. Particularly helpful for nighttime symptoms. Can cause drowsiness and dizziness
- **Oxybutynin** — may reduce hot flashes by **30–50%**; can cause dry mouth and constipation
- **Clonidine** — modestly reduces hot flashes (**20–40%**); can cause drowsiness and low blood pressure

Behavioural therapies

- **Cognitive behavioural therapy (CBT)** — reduces the impact of hot flashes by about **15–25%** and also improves sleep and mood. One of the best-supported non-drug approaches
- **Clinical hypnosis** — may reduce hot flashes by **45–55%** in some studies, though evidence is limited

What does NOT work better than placebo

Acupuncture, relaxation therapy, phytoestrogens (soy isoflavones), exercise, and black cohosh have not been shown to be significantly better than placebo for reducing hot flashes in well-designed trials — though black cohosh has some limited supportive evidence.

Q What can be done for vaginal dryness and urinary symptoms?

Genitourinary symptoms are very common and treatable — yet many women suffer in silence.

First-line options

- **Vaginal moisturizers** (regularly, 2–3 times per week) — help maintain moisture; available over the counter
- **Lubricants** (during intercourse) — reduce friction and discomfort; water-based or silicone-based

Prescription options (when moisturizers/lubricants are not enough)

- **Low-dose vaginal estrogen** (creams, tablets, suppositories, or rings) — the most effective treatment. Improves dryness, pain during intercourse, and urinary symptoms by about **60–80%**. Acts locally with minimal absorption into the bloodstream
- **Vaginal DHEA (prasterone)** — improves dryness and pain during intercourse by **40–80%**
- **Oral ospemifene** — a non-estrogen prescription option for dryness and painful intercourse

Important facts about vaginal estrogen

- Safe for long-term use — no evidence that low-dose vaginal estrogen increases risk of breast cancer, heart disease, or blood clots
- A progestogen is generally **not needed** for endometrial protection with low-dose vaginal estrogen
- It is a **separate treatment** from systemic hormone therapy — you can use vaginal estrogen even if you are not taking pills or patches for hot flashes
- Women with a history of breast cancer should discuss vaginal estrogen with their oncologist; non-hormonal options are preferred first

Q Does menopause affect heart health?

Yes. After menopause, women often see unfavourable changes in cholesterol, blood pressure, blood sugar, and body fat distribution. Premature menopause (before 40) increases cardiovascular disease risk by about **55%**, and early menopause (40–44) by about **30%**, compared with menopause at the average age. Heart disease is the leading cause of death in Canadian women — and risk accelerates after menopause.

What you can do

- Know your blood pressure, cholesterol, and blood sugar numbers
- Maintain a healthy weight · Exercise regularly (at least 150 minutes of moderate activity per week)
- Eat a heart-healthy diet (fruits, vegetables, whole grains, fish, healthy fats) · Do not smoke
- Discuss cardiovascular risk assessment with your healthcare provider — especially if you had early menopause

Q Does menopause affect bone health?

Yes. Estrogen helps maintain bone strength. After menopause, bone loss accelerates — most pronounced in the first **2–3 years**. About **1 in 3** postmenopausal women will develop osteoporosis. Hormone therapy reduces fracture risk at all sites by **20–40%**, including a **29–35%** reduction in hip fractures.

What you can do to protect your bones

- **Calcium:** 1,000–1,200 mg/day, preferably from food (dairy, fortified plant milks, leafy greens, canned fish with bones). Supplements if diet is insufficient
- **Vitamin D:** 600–800 IU/day (some experts recommend more in Canada, where winter sun is limited)
- **Weight-bearing exercise:** walking, jogging, dancing, stair climbing, and resistance training
- **Fall prevention:** good lighting, remove tripping hazards, balance exercises
- **Bone density testing (DEXA):** ask your provider, especially with risk factors (early menopause, family history, low body weight, smoking, long-term steroids)

Q Can lifestyle changes help with menopause symptoms?

Lifestyle changes alone may not eliminate symptoms, but they can make a meaningful difference:

- **Regular exercise** — improves mood, sleep, bone health, cardiovascular fitness, and overall well-being. Resistance training is particularly important for muscle and bone
- **Healthy diet** — a Mediterranean-style pattern (fruits, vegetables, whole grains, fish, nuts, olive oil) supports heart and bone health. Limiting caffeine and alcohol may help reduce hot flashes in some women
- **Healthy weight** — excess weight can worsen hot flashes and increase cardiovascular risk
- **Sleep hygiene** — cool bedroom, regular schedule, limit screens before bed
- **Stress management** — mindfulness, yoga, and CBT can help with mood, sleep, and the perceived impact of hot flashes
- **Quit smoking** — linked to earlier menopause, worse hot flashes, and higher cardiovascular and osteoporosis risk
- **Limit alcohol** — excess can worsen hot flashes, disrupt sleep, and increase breast cancer risk

Q What about supplements and natural remedies?

- **Vitamin D** — supported by high-certainty evidence for safety and moderate evidence for fracture risk reduction. Important for bone health, especially in Canada
- **Black cohosh** — moderate-certainty evidence suggests it may modestly improve hot flashes and menopausal symptoms, but preparations vary widely and long-term safety data are limited
- **Soy isoflavones (phytoestrogens)** — may provide modest relief for some women, but trial results are inconsistent and they are not significantly better than placebo in well-designed studies
- **Evening primrose oil, dong quai, wild yam, and other herbals** — no reliable evidence of benefit for menopausal symptoms

"Natural" does not mean safe or effective. Always tell your healthcare provider about any supplements you take — some can interact with medications.

Common myths — corrected

MYTH	TRUTH
"Menopause symptoms are just something you have to live with."	Effective treatments exist. No woman should suffer in silence — talk to your healthcare provider about options.
"Hormone therapy is dangerous for everyone."	For healthy women under 60 or within 10 years of menopause, benefits generally outweigh risks. Much of the fear came from misinterpretation of the Women's Health Initiative, which enrolled mostly older women. Started at the right time, HT is safe and effective for most women.
"You can only take hormone therapy for 5 years."	There is no fixed time limit. Treatment should be individualized and reassessed regularly. Many women safely use HT longer than 5 years.

MYTH	TRUTH
"Compounded 'natural' hormones are safer than prescription hormones."	Compounded hormones are not regulated, not tested for safety, and not recommended. FDA/Health Canada–approved bioidentical hormones (estradiol, micronized progesterone) are the evidence-based choice.
"Menopause only causes hot flashes."	Menopause affects nearly every system — brain, heart, bones, urinary tract, and sexual health. Many symptoms are under-recognized.
"Vaginal dryness is just aging — nothing can be done."	Vaginal estrogen is safe, effective, and can be used long-term. Painful intercourse or recurrent UTIs are not inevitable.

Key takeaways

1. Menopause is a natural life stage — but symptoms are real, treatable, and deserve attention.
2. Hot flashes affect most women and can last more than 7 years. Genitourinary symptoms often worsen without treatment.
3. Hormone therapy is the most effective treatment for hot flashes (~75% reduction) and is safe for most healthy women under 60 or within 10 years of menopause.
4. Non-hormonal options exist — SSRIs/SNRIs, gabapentin, fezolinetant, CBT, and others.
5. Vaginal estrogen is safe for long-term use and treats dryness, painful intercourse, and urinary symptoms.
6. Early menopause (before 45) raises heart, bone, and cognitive risks — HT is generally recommended until at least age 51.
7. Lifestyle matters: exercise, diet, calcium/vitamin D, not smoking, and healthy weight support long-term health.
8. No fixed time limit on HT — individualize and reassess. Prefer regulated bioidentical hormones over compounded products.

You do not have to suffer in silence. Talk to your healthcare provider about your symptoms — effective help is available.

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