



## Menopause Treatments

When women experience menopause, including early menopause, the decision to seek treatment is based on the severity of short-term symptoms, risk of disease in later years, and personal attitudes about menopause and medication. Each woman's menopause experience is different. Women who experience early menopause, either natural or induced, often require more specialized care. Although there are no definitive research data on these populations of women, clinicians may extrapolate data from older menopausal women.

Some women with menopause-related symptoms may obtain adequate symptom relief from nonprescription remedies while others may need prescription therapies. Women who choose prescription therapy to manage symptoms should not feel as if they have “failed” to manage menopause on their own. With treatment, most symptoms decrease or disappear. Some women may need prescription therapies to protect against osteoporosis and other diseases.

Prior to beginning any treatment or combination of treatments, whether intended to alleviate symptoms or prevent disease later in life, a woman should feel confident that the treatment regimen selected is the best for her. This requires an open discussion with a trusted healthcare provider about her health status and concerns, and in-depth information on available treatment options. A clinician with expertise in managing menopause can offer optimal care, especially for women with troublesome symptoms or complex risk profiles.

For the best results, treatment takes time, both for effects to manifest fully and for side effects to diminish. For example, the effects of hormone therapy usually become stable after 6 to 8 weeks. Many nonprescription therapies could take longer for the desired effects.

Therapeutic options for menopause symptoms may change over time because of gradually lowering levels of ovarian hormones and the possible appearance of medical conditions unrelated to menopause or menopause treatments. Also, new research and changing ideas about medicines and health may have an impact on health decisions. Before switching from one therapy to another, a “wash-out” period during which no drugs are used may sometimes be required to clear all drugs from the body.

Various menopause treatment options are available, including lifestyle changes, nonprescription remedies, prescription therapies, and complementary and alternative medicine (CAM) therapies. These four categories of options are discussed fully in the next sections.

## Lifestyle Changes

Positive lifestyle changes can have an enormous impact on health. A customized lifestyle modification strategy is an essential element in a comprehensive therapeutic plan for any woman throughout her life. These adjustable lifestyle choices include discontinuation of substance use, regular exercise, adequate nutrition, weight management, and stress reduction.

### *Substance Use*

Use of tobacco and illegal substances, as well as excessive use of alcohol and caffeine, contribute to poor health. Without doubt, smoking is the single most preventable cause

of illness and premature death. The reasons to quit or never to start are numerous. Smoking increases the risk of heart and lung disease, osteoporosis, and many types of cancer, including lung and cervical cancer. It may double the risk for Alzheimer’s disease, among other diseases. Smokers may also experience menopause up to 2 years earlier than nonsmokers.

Many women successfully quit smoking, sometimes after several attempts. Healthcare providers can offer a variety of prescription smoking cessation aids. Several nicotine products (available in gum, lozenge, nasal spray, or skin patch) and one antidepressant (Zyban) are government approved to help “kick the habit.” Support groups and hypnosis are other potentially helpful options. A combination of behavior modification techniques and prescription drug therapy appears to be the most successful approach. Many smokers who ultimately quit have to do so more than once, so continuing to try is important.

### *Adequate Exercise*

Physical inactivity is a risk factor for many serious diseases. Adequate exercise is a crucial ingredient often missing from daily life. Brisk walking, running, aerobics, dancing, tennis, and weight-training are activities that help the heart, bones, muscles, balance, mood, body weight, and sense of well-being.

Proper exercise is a powerful remedy for many menopause complaints and can help prevent future menopause- and age-related diseases. It not only promotes better, more restorative sleep, but it also stimulates production of “feel-good” brain chemicals (endorphins) that reduce negative thoughts and depressed feelings. Some women report having fewer hot flashes when they exercise

regularly. A key first step is to develop a practical, long-term, individually suited exercise plan.

There are three types of exercise: aerobic, weight-bearing, and flexibility. A moderate aerobic exercise regimen of at least 30 minutes each day has the greatest effect on heart and lung health. A brisk 2-mile walk is a good aerobic exercise. Weight-bearing exercise, such as fast walking or working with weights to build muscle, can delay or prevent bone loss. Early in life, exercise promotes higher bone mass; later in life, it can have a modest impact on slowing bone loss. Flexibility exercises, such as yoga and stretching, help maintain function while aging. These exercises may also improve balance, which can decrease the risk of fractures caused by falls.

A healthcare provider can help determine the initial level of exercise appropriate for individual needs. Finding ways to make exercise a permanent part of daily life will help ensure a healthier future.

### *Healthy Diet*

“You are what you eat” may sound trite, but it’s true. A balanced diet low in saturated fat and high in whole grains, fruits, and vegetables, with adequate water, vitamins, and minerals contributes to good health. There are two conditions are especially linked to diet – heart disease and osteoporosis.

Heart disease risk can be lowered by consuming little or no cholesterol or animal fat. Both saturated and unsaturated fat increase cholesterol levels, a major contributor to heart disease. For heart disease prevention, daily dietary guidelines include eating two or more servings of fruit, three or more servings of vegetables, limiting salt and

alcohol intake, limiting fat intake to less than 30% of total calories (with saturated fat limited to 10%), and limiting intake of hydrogenated oil (found in some peanut butters and margarines as well as in many packaged foods). Adding soy foods (such as soy milk and tofu) may help lower cholesterol levels (see Complementary & Alternative Medicine).

A balanced diet is also important for bone development and maintaining bone strength. Some women – especially those who are elderly and have reduced appetites, who diet frequently, who don’t consume dairy products, or who have eating disorders – may not consume adequate vitamins and minerals to maintain optimal bone mass.

Osteoporosis risk can be lowered by adequate intake of calcium throughout life. This builds bone mass and bone strength to a peak during the 20s and allows the body to draw from this “bone bank account” from then on. As women reach menopause, consuming adequate calcium is as important as ever. NAMS recommends that all postmenopausal women consume 1,200 to 1,500 mg of elemental calcium daily. This is significantly more than the amounts than most women aged 50 to 65 consume in their diet – only 700 mg per day.

Calcium intake can be increased by eating more calcium-rich dairy products (low-fat or nonfat preferred). A glass of milk or portion of other dairy product provides about 300 mg of calcium. Increased intake of leafy green vegetables and calcium-fortified foods and juices also increases calcium intake. If sufficient calcium is not obtained in the diet, a calcium supplement may be required (see Nonprescription Remedies).

Vitamin D also plays a major role in helping the body absorb calcium. At least 15 minutes of sun exposure daily (without a sunscreen) is the generally accepted amount the body needs to form its supply. Certain foods (such as fortified milk, liver, and tuna) or a multivitamin can help reach the recommended daily level for postmenopausal women – 400 to 600 IU. New research suggests that at least this amount is needed by women who have limited sun exposure, including those who live in northern regions during the winter (see Nonprescription Remedies).

### *Weight Management*

Being overweight increases the risk for heart disease and other diseases, such as diabetes and arthritis. The most dangerous location of body fat for heart health is the waistline and stomach. During their 40s, women often gain 2 or more pounds (about 1 kg) per year. Because of changes in metabolism with aging, all menopausal women should reassess their caloric intake and exercise levels to reach a balance that maintains a healthy weight. When diet and exercise are not enough to control weight, support groups or weight-management organizations may help. Additional therapies are available for those who have a more severe weight problem.

Being too thin is not healthy either. Premenopausal women who over-diet or over-exercise can become so thin that their menstrual periods stop temporarily. This temporary low estrogen state increases the risk of osteoporosis later in life. Everyone needs to work on strategies to maintain a healthy weight.

### *Stress Reduction*

Prolonged stress can have a severe impact on health. Although menopause has not been shown to raise stress levels, women at menopause face many stressors, some of them for the first time. A number of coping strategies can be used to help reduce stress. Exercise and meditation may help. Deep, slow, abdominal breathing can increase relaxation and may also reduce hot flashes. Some women report fewer hot flashes when they engage in meditation, yoga, massage, or just a leisurely bath. It is beneficial to reduce stress and take time to relax each day. Women need to care for themselves, both physically and spiritually.

### **Nonprescription Remedies**

Many products are available without a prescription (“over-the-counter”) that may help with specific menopause-related complaints. Healthcare professionals can provide some information about these products, including vitamin and mineral supplements and vaginal lubricants and moisturizers. A woman’s healthcare provider should be involved in the decision to use nonprescription products because no therapy is without potential risk.

### *Vitamins & Minerals*

Probably every woman could benefit from a good quality, daily multivitamin and mineral supplement. After menopause, most women should not choose a supplement containing iron, because iron is no longer lost through menstrual bleeding. During perimenopause, when periods are heavy, an iron supplement may be recommended to avoid anemia.

A typical daily supplement contains 400 IU of vitamin D, providing the amount that most women need. For those older than 70 who are never in the sun, 600 to 800 IU per day is recommended.

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A “multi” preparation may not contain the daily requirement of calcium, however, because the tablet would be too large to swallow. If adequate calcium cannot be consumed in the diet, a separate calcium supplement may be needed to reach the recommended level of 1,200 to 1,500 mg elemental calcium daily. Several types of calcium are available, including calcium carbonate (such as Tums), calcium citrate (such as Citracal), and calcium phosphate (Posture). Calcium-fortified foods provide another source. Some women choose a combination supplement of calcium and vitamin D (such as Os-Cal). For the best absorption, calcium must be taken with meals in 250 to 500 mg doses throughout the day. Calcium should not be taken with fiber or iron supplements. Up to 1,500 mg of calcium per day does not increase the risk of kidney stones, but drinking plenty of water is advised when taking the supplement.

Vitamin E (daily doses of 400 or 800 IU) has been used in an effort to reduce hot flashes, although studies are mixed. For easiest digestion, this supplement should be taken with a meal that contains fats. It may take 2 to 6 weeks before feeling the optimum effects, if any. High doses of vitamin E may thin the blood in women with vitamin K deficiency.

Other vitamins and minerals are available over-the-counter. A woman’s healthcare provider can offer guidance regarding her needs for these products.

### *Vaginal Lubricants & Moisturizers*

Nonhormonal vaginal lubricants and moisturizers are often used by women for treating vaginal dryness, including women using postmenopausal hormone therapy. To ease intercourse, water-based vaginal lubricants (such as K-Y Personal Lubricant,

Astroglide, Lubrin, or Moist Again) are available. Unlike lubricants, vaginal moisturizers (such as Replens or K-Y Long-Lasting Vaginal Moisturizer) act directly on tissue to make it less dry. Moisturizers may be preferred by women who have symptoms of irritation and burning that are not limited to sexual activity. Because moisturizers help maintain an acidic vaginal environment, they may also help prevent recurring vaginal infections.

If lubrication is desired, only products specifically designed for vaginal use should be considered. Most hand lotions contain ingredients such as alcohol and perfume that can irritate vaginal tissue. Oil-based products (such as Vaseline petroleum jelly and baby oil) can also cause irritation, damage condoms and diaphragms, and cling to vaginal tissue, providing a habitat for infection. One exception may be vaginally applied vitamin E oil, reported to provide lubrication and relief from itching and irritation without adverse effects.

Vinegar douches or vaginally applied cultures of lactobacilli or yogurt are not effective for moisturizing and are not recommended. Antihistamine pills taken for allergies have a drying effect on all mucous membranes, including those in the nose and the vaginal walls. It is also advisable to limit the use of soap, bubble baths, and bath oils. Women should not use talcum powder in the vaginal area because of a possible link with ovarian cancer; cornstarch powder is preferred.

Severe vaginal dryness and atrophy that persist with lubricants or moisturizers may respond to a short course of vaginal estrogen therapy (see Prescription Therapies). After tissues are restored to a more healthy state, use of nonhormonal lubricants or moisturizers can be resumed, as needed.

## Prescription Therapies

Several prescription drugs are available to help relieve menopause-related symptoms and decrease long-term risks. However, none have been adequately tested in women experiencing early menopause, whether natural or induced. For these women, clinicians have traditionally selected therapies tested in older women reaching menopause.

A number of factors should be considered when a woman, with the guidance of her healthcare provider, decides which therapy is right for her. Each woman is unique and must make her own decision after being fully informed. There is no “one size fits all.”

### *Estrogen Therapy*

The decision to use, or not use, estrogen therapy is a personal and complex one, especially for younger women. Treatment suggestions should be based on their unique health profile and wishes. Hormone treatment should always be prescribed at the lowest effective dose for the shortest time needed. Length of therapy will vary from woman to woman, depending on her individual health profile and risks of developing serious diseases.

Women who experience early menopause have more reasons to consider estrogen than women who reach menopause at the typical time. Furthermore, full-dose estrogen should be considered, rather than the lower doses used by women reaching menopause at midlife. Low-dose estrogen does not maintain bone density as effectively in younger women.

Some women with induced menopause, on the other hand, may not be able to choose estrogen. If the surgery, chemotherapy, or pelvic radiation therapy was performed for estrogen-sensitive cancers (such as breast or

uterine), the woman may not be able to use hormones. Some women will choose local estrogen. Other treatments, along with a commitment to making healthy lifestyle choices, will be needed to manage symptoms and long-term health risks. If the treatment was performed for a benign condition, the risks and benefits of estrogen can be determined based on the woman’s other health issues and risk profile.

Many kinds of estrogen therapy are available in the United States and Canada to treat menopause-related symptoms (see Chart on page 46). A variety of dosage forms, types, and strengths give each woman a better chance to find what is best for her. Generic products are available for some estrogen types. Finding the right regimen may require time, patience, and trying different prescriptions.

Treatment of menopause-related conditions with estrogen is often called estrogen replacement therapy (ERT). However, the term “replacement” is a misnomer because this therapy provides only a fraction of the estrogen once produced by the ovaries; estrogen supplementation is more accurate. The FDA now uses the term estrogen therapy (ET). ET has been widely studied and used for more than 50 years by millions of women.

Estrogen is government approved for the treatment of moderate to severe hot flashes and vaginal atrophy. It is also approved for the prevention of osteoporosis, if used long-term. Some studies suggest that estrogen has beneficial effects on certain sleep disturbances and mood swings during perimenopause. For some women, there is a positive effect on quality of life; they report that they simply “feel good” while on therapy. Thus, if a woman needs therapy for many conditions, ET can be viewed as a

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*No medication has been adequately tested in women experiencing early menopause.*





## Estrogen Products Used for Menopause in the United States and Canada

Estrogen Type	Oral Tablet Product Name	Skin Patch/Gel Product Name	Vaginal Form Product Name
conjugated equine estrogens	Premarin	Not available	Premarin Vaginal Cream
synthetic conjugated estrogens	Cenestin* Congest** CES** PMS-conjugated**	Not available	Not available
esterified estrogens	Menest* Neo-Estrone**	Not available	Neo-Estrone Vaginal Cream**
estropipate (piperazine estrone sulfate)	Ortho-Est* Ogen	Not available	Ogen Vaginal Cream
17beta-estradiol	Estrace	Alora* Climara Esclim* Estraderm Estradot** Estroge ** Oesclim** Vivelle Vivelle-Dot*	Estrace Vaginal Cream* Estring Vaginal Ring
ethinyl estradiol	Estinyl*	Not available	Not available
estradiol hemihydrate	Not available	Not available	Vagifem Vaginal Tablet
estradiol acetate	Not available	Not available	Femring Vaginal Ring*

*Products not marked are available in the United States and Canada.*

*\* Available only in the United States.*

*\*\* Available only in Canada.*

convenient choice. If fewer conditions need treatment or if ET is not an option, more targeted therapies must be used, usually one therapy for each condition. Like all therapies, ET is associated with risks, and these must be considered when making a decision about therapy (see ET/EPT Risks on page 51).

Although long-term ET can help prevent osteoporosis and related fractures, NAMS recommends that other therapeutic options also be considered for bone health. Because of increased risk for heart disease and breast cancer, estrogen use for osteoporosis is reserved only for those specific women in whom benefits outweigh the risks. Women using ET to lower their risk for osteoporosis should revisit the decision annually or earlier, if there is a change in their risk status.

Estrogen therapy is available in two dosage forms, systemic and local.

- **Systemic dosage form.** When used orally (tablet), through the skin (patch, gel), or as an injection, estrogen circulates throughout the body's system and affects many different tissues. All of these systemic forms have the potential to provide the full range of benefits (and risks) associated with ET. However, estrogen injections are not recommended for menopause therapy, since the estrogen level in the blood fluctuates from a high peak after injection to a low level later on, instead of supplying a consistent level. Women with a uterus who use systemic ET should also use another hormone (progestogen) to protect the uterus from endometrial cancer.

- **Local dosage form.** The majority of the vaginal estrogen products (vaginal cream, ring, or tablet) are considered "local" therapy, affecting only a specific or localized area of the body. Local dosage forms, sometimes called "vaginal" forms, are used to treat moderate to severe vaginal dryness and atrophy. With almost all local forms, only a very small amount of estrogen circulates through the body and, thus, cannot relieve hot flashes or prevent osteoporosis. However, the new estradiol acetate vaginal ring (Femring) delivers a systemic dose of estrogen, also relieving hot flashes. Adding a progestogen is recommended with Femring and higher doses of other local ET therapies, as enough estrogen may get into the blood to possibly increase the risk of endometrial cancer.

**Custom ET products.** In addition to the estrogen products listed in the Chart on page 46, custom-made formulations prepared by a compounding pharmacist from a prescription are also available. These products are different from those patented products that are government approved, providing women with different types and amounts of estrogen as well as ways of using it. These include capsules, skin creams and gels, subdermal implants (pellets placed under the skin), sublingual tablets (under the tongue), rectal suppositories, and nasal sprays. One type of estrogen only available in custom products is estriol, a weak estrogen with 5% to 10% the strength of 17beta-estradiol. It may be compounded in an oral mixture of three estrogens (usually 80% estriol, 10% estrone, and 10% 17beta-estradiol), sometimes called Tri-Est. Estriol is also used as a vaginal cream.

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*ET stands for  
estrogen therapy.  
EPT stands for  
combined estrogen-  
progestogen therapy,  
prescribed for  
women with  
a uterus.*



Most women do not need customized formulations of hormones. Women may request custom products that are not government regulated when they are misled by unproven health claims. Often, women are attracted to hormones marketed as “natural,” which they perceive as better or safer than other hormones. For example, compounding pharmacies may promote estriol products (including Tri-Est) as providing the benefits of patented products without increasing certain risks, such as cancer. Although estriol is a weak estrogen, it can still have a stimulatory effect on the breast and uterine lining. Most information promoting these products as safer is not supported by good scientific research. Until more is known, women with a uterus who use estriol products should also use a progestogen to protect the uterus. Studies have not determined what effect estriol has on breast cancer risk.

Although much is known about the active estrogen ingredient(s) in custom products, often little or nothing is known about the custom formulation or vehicle that delivers the estrogen into the body. While the active ingredient is government approved to be on the market, the formulation is not. These products have not been tested as thoroughly as patented products and some have not been tested at all. Their safety, reliability, effectiveness, and optimal dose are uncertain. All custom products are experimental and must be used with caution.

### *Progestogen & EPT*

Another hormone, progestogen, has sometimes been used alone during perimenopause to treat symptoms such as hot flashes, but its most common use is to protect against uterine cancer associated with ET. Using ET alone for 5 or more years can triple the risk of developing cancer of the

uterine lining (endometrium), but adding progestogen prevents the endometrium from thickening, which reduces the cancer risk to the level of using no hormones. Women who have had their uterus removed (called a hysterectomy) are not at risk for uterine cancer and, thus, have no reason to take progestogen with ET.

Combined estrogen and progestogen therapy was once known as hormone replacement therapy (HRT), but because the word “replacement” is no longer used by the FDA, NAMS prefers using the term estrogen-progestogen therapy (EPT).

Combined estrogen-progestogen therapy and progestogen-alone therapy are also used as birth control pills. However, the doses used for menopause are not high enough to provide birth control. Until menopause is reached (12 straight months without periods or removal or damage of both ovaries), some type of contraception must be used to avoid an unwanted pregnancy.

**Progestogen types.** There are various progestogen options to allow tailoring to a woman’s unique needs (see Chart on page 49). These include progesterone (identical to the hormone produced by the ovaries) and several different progestins (compounds synthesized to act like progesterone). As with estrogen, progestogen is available in custom-made formulations prepared by a compounding pharmacist following a healthcare provider’s prescription. As with custom estrogen formulations, these should be viewed as experimental therapies. Progesterone skin creams, whether custom-made from a prescription by a compounding pharmacy or purchased without a prescription, should not be used in EPT. Studies have not demonstrated that custom

progestogen formulations protect the uterus from estrogen stimulation.

**EPT and uterine bleeding.** In most women with a uterus, using a progestogen with estrogen causes the endometrium to shed and pass from the uterus as bleeding, similar to a menstrual period (although fertility is not restored). Some women find this progestogen-induced bleeding unacceptable, although the bleeding often decreases or stops over time. For many women, it is difficult to decide whether to tolerate the bleeding in exchange for estrogen’s benefits.

Newer dosage schedules that combine estrogen and progestogen daily can eventually result in no uterine bleeding while protecting the lining of the uterus. However, many women, particularly those recently past menopause, do have uterine bleeding or spotting during the first 6 months or more of these regimens. Each woman will develop her own typical bleeding pattern when taking EPT. A woman should report any change from that pattern to her clinician right away.

**EPT regimens.** Various EPT schedules (often called “regimens”) can be used. Each woman should feel comfortable exploring different options with her clinician to determine which is best for her. The most common EPT regimens are the following:

- Cyclic EPT provides estrogen for 25 days each month, adding progestogen on the last 10 to 14 days, followed by 3 to 6 days of no therapy. Thus, both hormones are “cycled.” The popularity of this regimen has waned because of uterine bleeding each month when the progestogen cycle ends (called “withdrawal bleeding”) and the possibility of hot flashes returning during the estrogen-free interval.
- Continuous-cyclic EPT (sometimes called continuous-sequential EPT) provides estrogen every day, with progestogen added for 10 to 14 days each month. As with cyclic EPT, this regimen causes uterine bleeding in about 80% of women when the progestogen cycle ends each month. However, bleeding gradually declines and stops in many women over several months.



## Progestogen Products Used for EPT in the United States and Canada

Progestogen Type	Product Name
<i>Progestin: Oral Tablet</i>	
medroxyprogesterone acetate (MPA)	Provera multiple generics
norethindrone (norethisterone)	Micronor Nor-QD*
norethindrone acetate	Aygestin*
norgestrel	Ovrette*
<i>Progestin: Intrauterine Device (IUD)</i>	
levonorgestrel	Mirena
<i>Progesterone: Oral Capsule</i>	
micronized progesterone USP (in peanut oil)	Prometrium
<i>Progesterone: Vaginal Gel</i>	
progesterone	Prochieve 4%*

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## Estrogen-Progestogen Products Used for Menopause in the United States and Canada

Regimen	Composition	Product Name
Oral Tablet: Continuous-Cyclic	conjugated equine estrogens and medroxyprogesterone acetate	Premphase*
Oral Tablet: Continuous-Combined	conjugated equine estrogens and medroxyprogesterone acetate	Prempro* Premplus**
	ethinyl estradiol and norethindrone acetate	Femhrt
	17beta-estradiol and norethindrone acetate	Activella*
Oral Tablet: Intermittent-Combined	17beta-estradiol and norgestimate	Prefest*
Skin Patch: Continuous-Combined	17beta-estradiol and norethindrone acetate	CombiPatch* Estalis**
Skin Patch: Continuous-Cyclic	17beta-estradiol and norethindrone acetate	Estalis Sequi** Estracomb**

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- Continuous-combined EPT provides both estrogen and progestogen every day. With this EPT regimen, less uterine bleeding occurs (40% of women during the first 6 months), but the timing is less predictable. After 1 year of therapy, uterine bleeding stops in nearly 90% of women.
- Intermittent-combined EPT is a newer regimen that provides estrogen every day, and then adds progestogen intermittently in cycles of 3 days on, 3 days off. Bleeding and endometrial protection are similar to that with a continuous-combined regimen.

These regimens can be used by taking estrogen and progestogen separately or through convenient combination products (see Chart).

### Women Who Should Not Use ET/EPT

Some women have risk factors that are “contraindications” to ET/EPT use. Contraindications are reasons not to use treatment. In a few cases, the potential benefits may outweigh the potential risks, leading women to accept therapy after careful consideration. In general, women who have the following should not use ET/EPT:

- Known or suspected pregnancy;
- History of breast cancer;
- History of hormone-sensitive cancer;
- Unexplained uterine bleeding;
- Liver disease (this especially applies to oral ET);
- History of blood-clotting disorders;
- Confirmed cardiovascular disease.

Cigarette smoking is not a contraindication for ET/EPT, as it is with oral contraceptive use in women over 35, but smokers are urged to stop before treatment starts for general health reasons.

### ET/EPT Side Effects

Potential side effects (adverse effects) of estrogen are listed below. Many of these side effects can be managed using a variety of techniques.

- Uterine bleeding (starting or returning);
- Breast tenderness (sometimes enlargement);
- Nausea;
- Abdominal bloating;
- Fluid retention in arms and legs;

- Hair loss;
- Headache (sometimes migraine);
- Dizziness;
- Changes in the shape of the cornea of the eye (sometimes leading to contact lens intolerance).

Potential progestogen side effects include uterine bleeding and some effects similar to PMS, including fluid retention, headache, breast tenderness, and mood changes.

ET/EPT does not cause permanent weight gain. However, some women may experience temporary weight gain from water retention in the hands and feet. ET can also cause abdominal bloating, with gaseous bowel distension. Increasing fluid intake, limiting salt consumption, and participating in regular exercise will help reduce water retention. Adjusting the dose, dosage form, or estrogen type may also be necessary.

There is one “side effect” issue that is important to keep in mind when ET/EPT is to be discontinued – stopping all at once often results in hot flashes. Gradually tapering the dose may be helpful. Experts don’t agree on the best way to stop ET/EPT.

### *Dealing with ET/EPT Side Effects*

There are various strategies that women and their clinicians can use to deal with the side effects that may occur with the use of ET or EPT (see Box on page 52). However, in general, they have not been proven effective in clinical trials. Many side effects are temporary until a woman adjusts to the hormonal changes. Unless side effects are severe, a trial of 3 months of any hormone therapy is advised to see if side effects resolve. One strategy is appropriate for any side effect: stop hormones (by tapering

slowly) to see if hormones are the cause, because side effects could be the result of something else.

### *ET/EPT Risks*

It is well documented that using estrogen alone can dramatically increase the risk of developing cancer of the uterus. However, it is also well known that using another prescription hormone, progestogen, with estrogen therapy reduces that risk to the level of taking no hormones.

Many clinical trials have provided evidence regarding the effects of ET/EPT on relieving menopause symptoms and reducing risk of bone fracture from osteoporosis. A recent, large-scale, high-quality trial – the Women’s Health Initiative (WHI) – has given healthcare providers more accurate evidence regarding the effects of ET/EPT on various risks in older women (see Box on page 53). After 5 years, women taking the type of EPT used in the trial (Prempro) had increased risks for heart disease, stroke, blood clots, and breast cancer and decreased risks for colorectal cancer and hip fractures. However, little is known about the effects of ET/EPT in women with early menopause.

The WHI study reported the following increased risks for women (average age 63) taking this form of EPT, compared with women taking a placebo:

- 29% increased risk of heart disease events, such as angina and heart attacks; this translates to 7 more heart disease events in 10,000 women per year.
- 41% increased risk of stroke (blood clots in the brain); this translates to 8 more strokes in 10,000 women per year.



*When stopping estrogen therapy, taper the dose to help avoid hot flashes.*



## Strategies That May Help Relieve ET/EPT Adverse Effects

**FLUID RETENTION.** Restrict salt intake, maintain adequate water intake, exercise, try a mild diuretic (either herbal or prescription).

**BLOATING.** Lower the estrogen dose, switch to another estrogen, switch from oral estrogen to a skin patch or gel, lower the progesterone dose, or switch to progesterone or another progestin.

**BREAST TENDERNESS.** Restrict salt intake, cut down on caffeine and chocolate, lower the estrogen dose, switch to another estrogen, switch to progesterone or another progestin.

**HEADACHES.** Restrict salt, caffeine, and alcohol intake, ensure adequate water intake, lower the dose of estrogen and/or progesterone, avoid medroxyprogesterone acetate, switch to progesterone, switch to a continuous dosage schedule or a skin patch or gel to avoid hormone fluctuations.

**MOOD CHANGES.** Restrict salt, caffeine, and alcohol intake, ensure adequate water intake, lower the progesterone dose, switch to progesterone, switch to a continuous dosage schedule or to a skin patch or gel to avoid hormone fluctuations, exercise regularly.

**NAUSEA.** Take oral estrogen tablets with meals or in the evening with a snack, lower the estrogen and/or progesterone dose, switch to another oral estrogen, switch from oral estrogen to a skin patch or gel.

**SKIN IRRITATION UNDER PATCH.** Keep site very clean, switch to a patch with a different adhesive, apply patch to a different area, change to oral estrogen or skin gel.

- 111% increased risk of blood clots in the lungs (called pulmonary emboli) or legs (deep vein thrombosis); this translates to 18 more blood clots in 10,000 women per year.

- 26% increased risk of breast cancer; this translates to 8 more breast cancers in 10,000 women per year.

On the positive side, the study reported the following decreased risks for women taking this form of EPT, compared with women taking a placebo:

- 37% decreased risk of colorectal cancer; this translates to 6 fewer colorectal cancers per 10,000 women per year.
- 34% decreased risk of hip fractures; this translates to 5 fewer hip fractures per 10,000 women per year.

As a result of the WHI data, the FDA requires all estrogen-containing prescription therapies to carry a warning in their prescribing information about the increased adverse risks of Prempro. Furthermore, in the absence of data on other hormone products, their risks should be assumed to be similar. The required language also includes that, because of these risks, estrogen with or without progestogens should be prescribed at the lowest effective doses and for the shortest duration consistent with treatment goals and risk for the individual woman.

It is important to recognize that the WHI was designed to evaluate the effect of ET/EPT in the prevention of several diseases. The trial was not designed to measure how well ET/EPT relieves hot flashes or symptoms of vaginal atrophy, which are the primary reasons women use ET/EPT. Women with moderate or severe menopausal symptoms were discouraged from participating in the study. Thus, the overall analysis of ET/EPT benefits and risks should not be based solely on the WHI results. Also, women who experience early menopause are a different population than the older women studied in the WHI. Since women with early menopause

have a greater risk for earlier onset of osteoporosis and cardiovascular disease, their benefits from hormone therapy initiated at a younger age may be greater than those shown in the WHI study.

### *Weighing Benefits & Risks of ET/EPT*

Many women use systemic ET/EPT for a few months or years for relief of moderate to severe hot flashes and vulvovaginal atrophy, for which there is no other comparable effective treatment. Persistent vulvovaginal atrophy can most likely be treated longer with vaginal estrogen, although the safety of long-term use of vaginal estrogen is not known. The decision to continue systemic forms of ET/EPT over the long term, to treat lingering hot flashes or lower osteoporosis risk, is more complicated.

Many factors will be part of a woman's decision to use a particular hormone product – her age, her risks, her preferences, and the cost of the product. When treating symptoms, one good general principle for hormone therapy is to use the lowest dose needed to get relief. Another principle to remember is that different estrogens and progestogens affect women differently. If one hormone regimen is not working, it is often worth trying another regimen.

Each woman must decide if the potential benefits outweigh the potential risks. Only after examining and understanding her own situation and after a thorough consultation with her healthcare provider can a woman make the best treatment choice. A woman's decision about hormone therapy may also change as more is learned through clinical trials and as personal situations and risk factors change. Re-evaluation on a regular basis is recommended.



## Women's Health Initiative – An Overview

Although many studies have examined the benefits and risks of postmenopausal hormone therapy, as either estrogen alone (ET) or estrogen plus a progestogen (EPT), the Women's Health Initiative (WHI) is the largest randomized, controlled clinical trial in healthy postmenopausal women ever conducted, enrolling more than 161,000 women. This type of trial is considered the “gold standard” for scientists. Thus, the study has made significant contributions to the understanding of ET/EPT use in postmenopausal women. However, the women studied in WHI were older (average age was 63).

Women were randomly assigned to either ET (Premarin) or EPT (Prempro) or a placebo (inactive medication that looks identical to the other product). The study made major news headlines in mid-2002 when the EPT part of the study (16,000 women) was stopped early because potential risks to participants substantially outweighed potential benefits. The part of the study evaluating women taking ET did not show significantly increased risks, so it has continued. Results from it are expected in 2005. Other evaluations are also part of the WHI, and results should be available in the near future.

### *Androgen Therapy*

Many women are surprised to learn that androgen, which is considered primarily a male hormone, is also produced in females, although levels found in females are about 10% of those found in males. In women, androgen is secreted by the ovaries and adrenal glands. Aging ovaries produce less androgen, although the decline is not as steep as with estrogen. Conditions that accelerate the decline of androgen levels include surgical removal of one or both ovaries prior to natural menopause, pituitary and adrenal insufficiency, corticosteroid therapy, and some chronic illnesses.

In women, insufficient androgen may cause three primary symptoms – fatigue, mood changes, and lowered sex drive – a condition recently named “female androgen insufficiency.” Lab tests can reveal a low androgen level, but they are not reliable in confirming female androgen insufficiency.

If androgen insufficiency is suspected, supplemental androgen therapy may help. Androgen therapy may be more important for women with surgical menopause, because of the loss of ovarian androgen. However, there are many uncertainties about the role of androgens in female health. One thing is certain: androgen therapy is appropriate only in combination with estrogen (ET or, for women with a uterus, EPT) – never alone. Women who use androgen alone may suffer adverse side effects related to an imbalance in the ratio of the levels of estrogen and androgen.

Currently, the only androgen-containing product that is available for use in US women is Estratest, a prescription oral tablet containing an androgen (methyltestosterone) and an estrogen (esterified estrogens). In Canada, two androgen products are used by women: oral testosterone undecanoate (Andriol) and injectable testosterone enanthate combined with estradiol (Climacteron). However, no androgen product is government approved in North America for boosting sex drive in women. For example, Estratest is marketed for the treatment of hot flashes that are unresponsive to ET alone. Some women, however, find that their sex drive is improved by using one of these products. Several androgen products are being studied for use in postmenopausal women, and they may be available in the near future.

Custom androgen preparations can be made by a compounding pharmacist following a

healthcare provider’s prescription, although studies are lacking to confirm safety or effectiveness. As with all custom formulations that are not government approved, therapy should be used with caution.

DHEA, an androgen product available without a prescription in the United States (but banned in Canada), is touted for many health benefits, including improving sex drive. However, NAMS does not recommend DHEA for any use, not only due to lack of government regulation, but also proof of effectiveness and safety (see Complementary & Alternative Medicines).

**Androgen risks and side effects.** Because scientific evidence is lacking, the potential risks of androgen therapy for women are relatively unknown. When women use androgen, the dose is very important. High doses not only don’t improve sex drive, but they may cause feelings of agitation, aggression, or depression as well as facial and body hair growth, acne, an enlarged clitoris, adverse changes in cholesterol, muscle weight gain, and permanent lowering of the voice. These effects are rare if the correct androgen dose is used. Estrogen-type side effects are also possible, because androgens are converted in the body to estrogens.

Androgen products available for men (such as Androderm, Testoderm, and AndroGel) should not be used by women, as these contain very high doses that may have harmful effects in women.

## Complementary & Alternative Medicines

Also referred to as integrative medicine, complementary and alternative medicine (CAM) includes a broad range of healing philosophies and approaches that

conventional medicine does not commonly use, study, understand, or provide. A therapy is called “complementary” when it is used in addition to conventional medicine, whereas it is called “alternative” when it is used instead of conventional treatment. Therapies called “conventional” are those that are widely accepted and practiced by the mainstream medical community in North America.

Some CAM therapies utilize “traditional” medicine, practices that have been used for centuries (such as Traditional Chinese Medicine). Other CAM therapies include naturopathy, homeopathy, and acupuncture, each practiced by specialists in the field, as well as mind-body interventions and biologically based treatments, such as phytoestrogens and herbs. Some CAM therapies are called “holistic,” which generally mean they consider the whole person, including physical, mental, emotional, and spiritual aspects.

Many women who use CAM therapies do so because these healthcare approaches mirror their own values, beliefs, and philosophical orientations toward health and life. Others are attracted to CAM therapies because many are “natural” and, therefore, are perceived as safer than conventional treatments. Some women turn to CAM therapies because of their dissatisfaction with conventional medicine, but most CAM users also use conventional medicine.

Despite the broad use of CAM therapies, more substantial scientific information is needed to demonstrate convincingly that they are effective and safe. The following are points about CAM therapies to keep in mind:

- CAM therapies are not necessarily safer than conventional treatments and may, in fact, be more risky;



## Government Regulation of Dietary Supplements

In early 2000, the FDA began allowing dietary supplement marketers to make health claims for treating certain “natural conditions,” such as hot flashes and age-related memory loss, without providing studies for effectiveness or safety. However, the FDA did not allow claims that these products prevent diseases, such as osteoporosis and heart disease.

Regulations regarding whether a dietary supplement is safe are opposite to those for prescription drugs. Demonstrating safety is not required before a dietary supplement is approved for the market, and the FDA (not the marketer) has the responsibility of proving a dietary supplement is harmful before it can be removed from the market. Under the current law, the marketer (not the FDA) is responsible for ensuring that labels are truthful and not misleading, that the “dosage” is appropriate, that they contain enough information for consumers to make an informed choice, and that all dietary ingredients are accurately listed and safe. In the United States, products with better quality control have USP or NSF on their labels. In Canada, consumers are advised to purchase only the brands displaying DIN or GP. It is also preferable to choose specific brands that have been tested in clinical trials.

In Canada, it is the role of the Natural Health Products (NHP) Directorate to ensure access to safe, effective, high quality “natural health products.” A new NHP regulation will come into effect in January 2004 that will place requirements on companies that manufacture, package, label, import, or distribute natural health products, and they are intended to regulate substances that are safe for over-the-counter use.



*No therapy is without risk, even so-called “natural” botanical therapies.*

- The effect of CAM therapies, if any, may take several weeks to occur;
- Severe menopause symptoms may not respond to these approaches;
- CAM therapies are not meant to be considered for prevention of serious diseases, such as osteoporosis;
- Health claims made by some marketers of CAM supplements may be unsubstantiated, as government regulations regarding CAM products (which are regulated as dietary supplements) are not as rigid or as well enforced as they are with prescription drugs (see Box on page 55).

The same caution should be used with CAM therapies as with all other therapies. As more research findings support their effectiveness, some therapies now listed as CAM therapies will undoubtedly become more mainstream. CAM therapies that are proven to be ineffective or too risky will not be included among menopause treatment options and may be taken off the market entirely. Still others will remain classified as CAM, since not all therapies can or will be adequately tested. This may be due to a lack of financial backing for studies because many CAM products can't be patent protected and, thus, do not allow marketers to recoup their research investment.

This publication addresses the two most common types of CAM therapies used by menopausal women – hormone therapies available without a prescription and botanical therapies.

#### *Hormone Therapies*

Products containing hormones, such as progesterone and the androgen DHEA, can be purchased without a prescription in drugstores and health food stores in the United States. They are government

regulated as dietary supplements and none are FDA-approved to treat a menopause-related condition.

**Progesterone therapies.** Although progesterone is available in prescription drugs, it is also available without a prescription in skin creams of various strengths. Testing has revealed that some brands contain no progesterone at all. The most often purchased nonprescription progesterone cream product (Pro-Gest Cream) contains 450 mg progesterone per ounce, the same as found in many custom-made prescription creams. Evidence is mixed regarding whether progesterone cream is effective for mild hot flashes during perimenopause. A few progesterone cream marketers claim that their products not only treat menopause symptoms but also protect against osteoporosis and breast cancer. These claims, however, have not been confirmed through clinical studies. More research is needed to document the effectiveness and safety of these products.

Studies with one brand of progesterone cream have shown that after applying the cream on the skin's surface, progesterone is absorbed into the bloodstream, but not in consistently high enough levels high to protect the uterus when using estrogen therapy. A systemic form of progestogen should be used to provide the needed protection for the uterine lining with certainty (see Progestogen & EPT).

**Androgen therapies.** Dehydroepiandrosterone (DHEA) is an androgen hormone made by the human adrenal gland. It is marketed and government regulated as a nonprescription dietary supplement, not a drug. DHEA supplements appear to be effective in women diagnosed with adrenal insufficiency. Some women use DHEA for the marketers' claims

of increased energy, weight loss, improved mood, heightened sex drive, improved cholesterol and immune function, and slowed aging. However, very few clinical trials have been conducted regarding its use in humans, and more are needed to support not only its effectiveness but also its safety.

High doses can produce side effects, such as liver damage and depressed mood. At lower doses, DHEA is converted in the body to more potent androgens, including testosterone. At higher doses, it will be converted to estrogen. Therefore, DHEA is contraindicated in women who have a history of hormone-sensitive cancer. DHEA is banned in Canada due to lack of safety data. NAMS does not recommend its use because it has not been shown to be effective or safe.

### *Botanical Therapies*

Unlike modern plant-derived drugs, botanical therapies are complex mixtures of preparations made from the whole plant or plant part, such as the root. Most botanical therapies are herbs, administered in various ways, such as teas made from the dried plant. A skilled herbalist can provide the best guidance. Herbal therapies are also available in supplements that can be purchased without a prescription in drugstores and health food stores. Some energy drinks as well as vitamin and mineral supplements may also contain botanicals.

**General precautions.** No therapy is without risk, even so-called “natural” botanical therapies. These may interact with prescription drugs, resulting in dramatic changes in the effect of the botanical, the drug, or both. Women who use medications that are necessary for life (such as cyclosporine), have a disease that can be fatal if undertreated (such as epilepsy),

or those with certain medical conditions (including diabetes) must exercise even more caution with botanical therapies.

Women who use ant clotting therapies, such as warfarin (Coumadin) and aspirin (even a “baby” aspirin), may be exposed to additional risks with botanical therapies that affect the ability of blood to clot (including dong quai, evening primrose oil, ginkgo, ginseng, ginger, garlic, and feverfew). These botanicals should also be avoided by women with heavy periods and discontinued 7 to 10 days before any surgery.

To be safe, women must tell their healthcare providers about all CAM therapies they are using, as well as any other therapies, both prescription and nonprescription.

**Types of botanicals.** There are dozens of botanical therapies. This guidebook will feature those most commonly used by women around menopause.

- **Phytoestrogens and soy.** The most studied of the botanicals for menopause-related conditions are phytoestrogens (plant estrogens), such as isoflavones. These are naturally occurring compounds found in rich supply in soybeans, soy products, and red clover. They are similar in chemical structure to estrogen and can produce weak estrogen-like or antiestrogen effects, depending on the amount and the human organ involved.

Commercial preparations containing isoflavones – including over-the-counter supplements, additives to “multi” supplements, and fortified foods (such as candy bars) – are marketed to provide a variety of health benefits.



## Isoflavone Content of Foods

Food (100 g)	Average Isoflavone Amount (mg) in Food
Soybeans, green, raw	151
Soy flour	149
Soy protein isolate	97
Miso soup	60
Tempeh	43
Soybeans, sprouted, raw	41
Tofu, silken	28
Tofu yogurt	16
Soy hot dog	15
Soy milk	10
Soy sauce, shoyu	2

There is some evidence that eating isoflavone-containing soy foods (such as tofu, tempeh, soy milk, or roasted soy nuts) or using a commercial isoflavone preparation may reduce mild menopause hot flashes about 15% better than a placebo (inactive medication), but there are no conclusive recommendations. There is no good evidence that these botanicals reduce vaginal dryness or osteoporosis. The benefits and risks of isoflavone use by women with hormone-sensitive cancer is unknown.

The most convincing beneficial health effects have been attributed to the actions of soy on fats in the blood, stimulating the FDA to recommend eating a daily serving of soy foods (25 grams of “soy protein”), as part of a diet low in saturated fat and cholesterol, to help lower the risk of heart disease.

It is not clear, however, whether the observed health benefits sometimes seen with soy foods are caused by the isoflavones alone or by isoflavones plus other components in whole foods. Until the effectiveness and long-term safety of isoflavone supplements have been clearly established, eating reasonable amounts of soy food is probably a better choice than taking a supplement. Foods have widely different amounts of isoflavone (see Box), and there is great variability within the same food type, depending on many factors, such as growing conditions.

- Black cohosh. The most widely studied herb in menopause treatment is black cohosh (botanical name *Cimicifuga racemosa*). The most studied brand of supplement is Remifemin, marketed in the United States and Canada as a dietary supplement. In some clinical trials, women reported improvements in hot flashes with a dose of 40 mg/day for 8 to 12 weeks, but other results differ. Side effects are rare and include gastrointestinal upset, typically with first-time use. Safety beyond 6 months of use is unknown.

Some preparations made with black cohosh have estrogen-like effects, although the current formulation of Remifemin has not exhibited these actions. Whether black cohosh products can be safely used to treat hot flashes by women with hormone-sensitive cancer is unknown.

- Dong quai. Among Chinese therapies, dong quai (*Angelica sinensis*) is the most used herb in treating female health disorders, including easing menstrual cramps and menopausal symptoms such as hot flashes. However, one high-quality study showed it was not effective in relieving hot flashes.

Chinese herbalists note that dong quai is not meant to be used alone, but within an individually tailored mixture of herbs.

Dong quai is available in supplements that can be purchased in drugstores or health food stores. Research to document effectiveness and safety are lacking. Side effects include sensitivity to sunlight (resulting in skin rash) and counteracting the blood's ability to clot. Dong quai can trigger heavy uterine bleeding and should never be used by women who have fibroids, hemophilia, or other blood clotting problems, or by those who are using anticlotting drugs (such as Coumadin or aspirin).

- Evening primrose oil. Preparations made from the oil of seeds of evening primrose (*Oenothera biennis*) are reported to have various health effects, including relief of menopausal hot flashes. However, there is no scientific evidence that its effectiveness is better than a placebo (inactive medication). Evening primrose oil is also available in some supplements.

Reported side effects include nausea and diarrhea, as well as some life-threatening effects. Women with epilepsy or serious mental health disorders should not use evening primrose oil, nor should it be used by women using anticlotting drugs (such as Coumadin or aspirin) or certain anxiety-treating drugs (phenothiazines).

- Ginkgo. The medicinal uses of ginkgo (*Ginkgo biloba*) go back to about 3000 B.C. Preparations made from the leaf of the ginkgo tree are used for a wide range of health effects. Dietary supplements containing ginkgo are also available. Acting as an antioxidant and blood thinner, ginkgo is thought to increase blood flow through small vessels, including arteries in the brain.

Some studies show a minimal beneficial effect for improving memory or for individuals with severe cognition problems, such as Alzheimer's disease.

Because it is a blood thinner, bleeding is a serious side effect. Women using other anticlotting drugs (such as Coumadin or aspirin) should not use this product. With standard doses, the most common side effects are stomach distress and headache. NAMS does not recommend its use for menopause-related conditions.

- Ginseng. The most common type of ginseng is Oriental ginseng root (*Panax ginseng*), an important herbal remedy used in Traditional Chinese Medicine (TCM) for thousands of years. Recently, marketers of ginseng supplements have promoted the products to build stamina and resistance to disease, although there is no strong documentation for these claims.

The estrogen-like effects associated with ginseng may be responsible for the uterine bleeding that can occur after ginseng use. Yet, unlike estrogen, studies have shown that ginseng does not relieve hot flashes and may make them worse. Side effects include high blood pressure, low blood sugar, headache, aggressive behavior, mental disturbances, and insomnia. Women with heart disease, diabetes, or bipolar disorder should use ginseng with caution. Ginseng should not be used with anticlotting drugs (such as Coumadin or aspirin), drugs that lower blood pressure, or stimulants (including diet remedies containing ma huang, ephedrine, or guarana).

- Kava. The kava used in medicinal treatments comes from the rhizome of the kava shrub (*Piper methysticum*). It is ingested in teas and as dietary supplements for soothing mild anxiety, hot flashes, and

sleep disturbances. Recently, this addictive herb has been linked with severe liver damage. Some countries (including Canada) have banned its use. Given this concern, it is advisable to avoid using kava until more is known.

- Licorice. The root of the licorice plant (*Glycyrrhiza glabra*) is used for various health reasons. In TCM, licorice preparations are used for postmenopausal symptoms, due to its estrogenic activity. However, it is a potent herb with potentially severe side effects that should be prescribed only by a TCM practitioner. This type of licorice is not usually found in candy called “licorice” sold in North America.
- Sage. Some women use sage (*Salvia officinalis*) to help with menopausal hot flashes and night sweats. However, it is not recommended due to the possibility of seizures and other severe neurological symptoms.
- St. John’s wort. Women take preparations made from the perennial St. John’s wort (*Hypericum perforatum*) to ease mild to moderate depression. Supplements have been found to be as effective as conventional antidepressant drugs, but with fewer side effects. St. John’s wort is not effective for treating major depression. Many CAM practitioners avoid using this herb longer than 2 years. Side effects include gastrointestinal upset, fatigue, and increased sensitivity to sunlight. When taking this herb, wearing sunscreen, a hat, and wraparound sunglasses is advised when in the sun, and sunbathing must be avoided. St. John’s wort should not be used with anticlotting drugs (such as Coumadin or aspirin), drugs for psychological problems or HIV, or after organ transplant.
- Valerian. Preparations made from this plant (*Valeriana officinalis*) are used to treat nervousness and sleeping difficulties. Supplements have been found to improve sleep quality. No substantial side effects of valerian have been noted with standard doses, and it can be used for as long as required to develop better sleep patterns. However, a woman who suffers from stress or long-term sleep problems should be examined by her healthcare provider and treated for the underlying cause.
- Vitex. There are no studies regarding the effect of vitex (*Vitex agnus castus*) on menopausal symptoms, yet some CAM practitioners recommend it to regulate heavy menstrual bleeding during perimenopause, probably due to its progesterone-like effects. Although often thought of as an herb to increase sex drive, it is not recommended for this use.

## Different Women, Different Needs

There is no single way to ensure the best possible quality of life through menopause and beyond. Each woman is unique. It is beneficial for a woman experiencing early menopause to invest time working with her healthcare professionals to create an individual health plan and to make therapeutic adjustments that are required over time, not only as new therapies and guidelines are available, but also as a woman’s body continues to change in its own individual way. ✨