

CONSENSUS OPINION

Clinical Challenges of Perimenopause: Consensus Opinion of The North American Menopause Society

ABSTRACT

Objective: Perimenopause refers to the time period around menopause. The clinical goal of perimenopause therapy is to optimize the woman's health during and after this transitional period. However, clinical trial data are insufficient to establish evidence-based treatment standards regarding the diagnosis and treatment for both acute and chronic symptoms and conditions of perimenopausal women. Accordingly, The North American Menopause Society (NAMS) sought to develop a consensus opinion on clinical approaches to perimenopause.

Design: NAMS held a closed conference of experts in the field to review the current literature, share clinical experience, and make recommendations about how to help women achieve optimal health throughout perimenopause. The proceedings of the conference were used to assist the NAMS Board of Trustees in developing this consensus opinion of the Society.

Results: On the basis of the conference proceedings, NAMS established the following recommendations for the treatment of perimenopausal women: (1) The annual health examination is valuable in the perimenopausal woman and should include comprehensive screening for physical and psychological problems as well as for appropriate lifestyle counseling. (2) Sufficient clinical data exist to provide recommendations for developing management plans for acute perimenopausal symptoms, as well as counseling for potential chronic diseases related to postmenopause. (3) The importance of individualized screening and management approaches for each woman is evident, as is the need for including the woman in the management decision-making process. (4) Because clinical research data on women in perimenopause are limited, healthcare providers may consider extrapolating data on postmenopausal women, as well as relying on clinical experience when considering management options. (5) Management of perimenopausal symptoms may include doing nothing (many symptoms may be self-limiting) or recommending a combination of treatments.

Conclusions: Although perimenopause is largely unstudied, many therapeutic approaches to the management of perimenopause disturbances exist, both prescription and nonprescription. NAMS established these consensus opinions to be a resource for clinicians when designing a healthcare plan for a perimenopausal woman. The perimenopausal woman's health and quality of life can be maintained and improved through preventive care, lifestyle modifications, early diagnosis of disease or increased risk for disease, and interventions when appropriate. However, more research is needed in all areas concerning perimenopausal women. (*Menopause* 2000;7:5–13. © 2000, The North American Menopause Society.)

Key Words: Menopause transition – NAMS consensus opinion – Perimenopause.

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The North American Menopause Society (NAMS) held a consensus conference to address the clinical challenges of perimenopause. The primary conference agenda included the definition and diagnosis of perimenopause, signs and symptoms, and treatment options for conditions related to perimenopause; subsequently, this information has been updated and approved by the NAMS Board of Trustees. The consensus conference did not include a discussion of women who have medically induced menopause, women who are menstruating irregularly before perimenopause, or women who are already receiving hormone therapy. Because standards of care and available treatment options differ throughout the world, the participants limited their focus to patients and perimenopause therapies available in North America. The NAMS consensus-building process is described in a previous issue.¹

DEFINITION

Menopause is defined as the point at which menstruation ceases, and it is usually confirmed when a woman has not had a menstrual period for 12 consecutive months in the absence of any other obvious biological or physiological cause. Natural menopause occurs as part of the aging process. In contrast, induced menopause occurs as a result of medical interventions, such as bilateral oophorectomy (immediate menopause), or ovarian damage from other medical means, such as chemotherapy. In this consensus opinion, all references to menopause relate to natural menopause.

Estimates of the median or mean age at menopause have been inconsistent, but they generally range from 48 to 52 years. Factors that may contribute to the timing of menopause include cancer chemotherapy,^{2,3} cigarette smoking,^{4,5} and surgical trauma to ovarian blood supply.⁶ A link between hereditary factors and age at menopause also has been suggested. The specific role for each of these factors, however, has not been established conclusively.

The World Health Organization defines perimenopause as the 2–8 years preceding menopause and the 1 year after final menses.⁷ Initiation of perimenopause is when the endocrinological, biological, and clinical changes of menopause are noticed. Typically, perimenopause begins in a woman's 40s, although it may start in her 30s. Subtle hormonal changes usually commence in a woman's 30s; however, the clinical significance of these changes is not known.

DIAGNOSIS

During perimenopause, oocytes undergo accelerated depletion, which leads to eventual cessation of ovulation

and significant changes in serum and hormonal levels, especially estrogen.⁸ As ovarian estrogen production decreases, the pituitary gland increases follicle-stimulating hormone (FSH) production to stimulate the ovary to secrete estrogen.

Menstrual cycle changes that occur in perimenopause are usually marked by elevated FSH levels and decreased levels of inhibin, whereas levels of estradiol and luteinizing hormone (LH) remain normal or may be elevated.^{9–15} However, FSH levels can fluctuate from month to month and from woman to woman during perimenopause, which limits their utility as a predictor.¹⁶ Moreover, finding elevated FSH levels does not predict when menopause will start. Oral contraceptive (OC) use lowers FSH levels, and women may need to stop taking them temporarily (and use a nonhormonal form of birth control) before FSH levels can be measured to help substantiate a presumptive diagnosis of menopause.

Estradiol levels usually remain in the normal range until follicular growth and development cease. However, estrogen levels have been reported to increase occasionally before menopause.¹⁵ Fluctuations of estrogen can become extreme during perimenopause, with occasional elevations to levels similar to those seen during early pregnancy, followed by prolonged low levels.^{15,17} For these reasons, laboratory tests (e.g., blood estradiol, estrone, FSH) are of limited value in confirming perimenopause.

Many clinicians regard the appearance of menstrual cycle irregularity in a previously regularly menstruating woman as confirmation of perimenopause. Menstrual cycle patterns, however, differ widely during perimenopause.¹⁸ Studies have shown that intermenstrual intervals often shorten significantly during perimenopause, and menstrual cycles may become irregular as well.^{9,19} Another study reported that long intermenstrual intervals may be interspersed with very short cycles.²⁰ Studies have shown that the menstrual cycle may shorten by as much as 3–7 days, perhaps as a result of ovulation occurring earlier than day 14 of the cycle.^{21,22} Some women may skip several cycles and then return to regular cycles. Others may have irregular spotting or regular menstrual cycles until the onset of menopause.

Because any menstrual pattern is possible, the perimenopausal woman is not totally protected from an unplanned pregnancy until amenorrhea greater than 1 year occurs or consistently elevated levels of FSH (greater than 30 MIU/mL) can be demonstrated.¹⁰ Sexually active women should be made aware of the possibility of pregnancy; contraception may be needed until menopause is confirmed.

Several hormonal systems manifest age-related changes that may or may not have their onset during the

perimenopausal years. Conditions that are not related to perimenopause, such as obesity, diabetes, thyroid disorders, or hypertension, often develop during midlife. Moreover, physiological changes coupled with cultural attitudes about menopause as well as midlife emotional and social crises affect the overall physical disposition of the perimenopausal woman.

As a result, confirmation of perimenopause usually relies on the woman's medical history and the symptoms that she experiences (e.g., irregular menses, hot flashes), as well as ruling out other causes for those changes. However, the physical symptoms that occur and the pattern of menstrual cycles during perimenopause differ markedly from woman to woman. Thus, clinicians should not assume that irregular menstrual cycles or bleeding indicates the onset of perimenopause without ruling out other causes, including local uterine pathology, pregnancy, and thyroid abnormalities.

Abnormal uterine bleeding

Prolonged intervals of amenorrhea are common among perimenopausal women, and no therapy is usually needed if the woman ovulates periodically. Abnormal uterine bleeding is a more serious concern and requires further investigation. Abnormal uterine bleeding is generally defined as any of the following:

- Heavier uterine bleeding than usual
- Prolonged uterine bleeding
- Menstrual periods occurring more often than every 3 weeks
- Spotting between menstrual periods
- Bleeding after sexual intercourse

The possible causes of abnormal uterine bleeding in perimenopausal women include anovulation, uterine fibroids, uterine lining abnormalities, cancer, and blood-clotting problems. Specific organic causes (neoplasia, complications of unexpected pregnancy, or bleeding from extrauterine sites) must be ruled out.²³ Hormonal contraceptives, particularly progestin-only products and intrauterine devices, can result in abnormal uterine bleeding and should be considered in the differential diagnosis. Women who bleed fewer than nine times each year and have no menses warrant evaluation as well.

An evaluation of abnormal uterine bleeding should include a history and physical examination plus one or more of the following procedures: endometrial biopsy, office aspiration curettage, dilation and curettage, saline sonohysterography, hysteroscopy, or transvaginal ultrasound. As with all invasive procedures, the potential benefits and risks need to be discussed with the patient.

Medical treatment is preferable for anovulatory (i.e., dysfunctional) uterine bleeding. The following therapies have been reported to be efficacious in treating abnormal uterine bleeding:

- Progestogen (progestin/progesterone) therapy²⁴
- Low-dose OCs²⁵
- Danazol²⁶
- A progesterone-releasing intrauterine device²⁷

In addition, nonsteroidal anti-inflammatory drugs reduce heavy menstrual bleeding (i.e., menorrhagia) in ovulating patients.²⁶

Amenorrhea

Amenorrhea should not be ascribed automatically to perimenopause in women who are younger than 50 years. Pregnancy must be ruled out as a cause of amenorrhea.²⁸ Excessive dieting (including the eating disorders anorexia and bulimia) or exercising can cause hypothalamic amenorrhea; in these women, FSH levels will be normal or low rather than increased.

Thyroid abnormalities

Thyroid dysfunction can affect the menstrual cycle. Hypothyroidism is generally associated with menorrhagia but may result in amenorrhea; hyperthyroidism may be associated with amenorrhea. Although the signs and symptoms of these conditions may be subtle, the functional impairment can be great. Perimenopausal women should be screened for thyroid dysfunction. A thyroid-stimulating hormone (TSH) level using a "sensitive" TSH assay is the initial screening test. If the TSH level is abnormal, then thyroid function should be evaluated further.²⁹

Premenstrual syndrome

A constellation of symptoms that recur in the luteal phase of each menstrual cycle may be sufficiently severe to negatively affect the quality of life. This complex has been variously defined as premenstrual syndrome (PMS) or premenstrual dysphoric disorder.³⁰ Although most women who seek help for PMS most often are in their mid-30s, it is not uncommon for perimenopausal women to present with new onset premenstrual symptoms. Most women with PMS report six or more symptoms.³¹

Because symptoms are restricted to the premenstrual phase, timing is important in differentiating PMS from other conditions. Normal symptoms reported by menstruating women are similar to those who experience PMS; they typically are present for a few days before the

onset of menses but do not interfere with daily functioning. PMS is confined to the luteal phase, approximately 14 days before the onset of menses, and symptoms interfere with daily functioning. Age of onset and prospective timing of symptoms should be assessed. Women in their 40s commonly assume that the onset of perimenopause is PMS because the symptoms are so similar.

ACUTE PERIMENOPAUSE SYMPTOMS

Data support the association of various acute symptoms with perimenopause. In addition, data confirm that perimenopausal physiological changes may be associated with long-term problems. Acute symptoms in perimenopause initiated by altered secretion of ovarian hormones include menstrual irregularities (as previously described), vasomotor symptoms, and sleep disturbances. Behavioral changes have been variously ascribed to psychosocial/cultural factors and may possibly be affected by endocrine factors.

Vasomotor symptoms

The hot flash or flush is the most frequent perimenopausal vasomotor symptom, experienced by up to 85% of women.^{32,33} A few women will have hot flashes years before menopause; others experience them for years after menopause.³⁴ Hot flashes that occur with perspiration during sleep are termed night sweats.

The perimenopause experience is perceived differently among women of different cultures. For example, between 75% and 85% of perimenopausal women in North America and northern Europe have reported hot flashes, in contrast to 25% of women in Japan.³⁵ In the United States, the prevalence of vasomotor complaints did not differ in a survey of African American and Caucasian women.³⁶

The cause of menopause-related hot flashes is still a matter of speculation.³⁷ Although it may not be accurate to say that hot flashes are caused by low estrogen levels, consistent evidence suggests that estrogen administration diminishes the frequency of hot flashes in a dose-dependent manner.³⁸⁻⁴¹ Few studies have produced quantitative estimates of the effect of hot flashes on quality of life, even though the potential for hot flashes to disrupt daily activity and sleep quality is widely known. In addition, there are other potential causes of hot flash-like phenomena that are unrelated to menopause. These include hyperthyroidism, pheochromocytoma, carcinoids, leukemia, and pancreatic tumors.³⁷

Hot flashes can be associated with palpitations and feelings of anxiety. The unsettling feeling that precedes a hot flash can trigger an anxiety (or panic) attack. Clin-

icians should rule out cardiovascular causes when these symptoms are observed.

Sleep disturbances

Sleep disturbances of varying degrees of severity are frequently reported by perimenopausal women.⁴² The extent to which sleep disturbances are due specifically to the hormonal changes of perimenopause is uncertain. Sleep disturbances may vary widely and may be chronic or transient. Several common patterns have been reported, including difficulty falling asleep, awakening in the middle of the night with trouble resuming sleep, and early morning awakening with an inability to resume sleep. Sleep disturbances can seriously affect quality of life, resulting in fatigue, irritability, and inability to concentrate.

There are other situations associated with sleep disturbances. These include hypothalamic disturbances; habits such as daytime naps and an irregular sleep schedule; stimulants such as caffeine, alcohol, nicotine, and some prescription drugs; illnesses; anxiety or emotional concerns; physical discomfort such as pain from arthritis; and nocturia.

Genitourinary effects

As women make the transition from late perimenopause into early postmenopause, vulvovaginal atrophy and urinary tract conditions may manifest. These conditions are not in the scope of this article, and discussion of these issues can be found in published reviews of the treatment of the postmenopausal woman.⁴³⁻⁴⁸

THERAPEUTIC OPTIONS

The majority of women do not require specific medical management. However, screening, counseling, and lifestyle changes are advisable for all.

Various treatment options are available for the symptoms associated with perimenopause—both acute conditions and potential chronic diseases—including lifestyle changes, prescription and nonprescription therapies, and alternative/complementary approaches. In selecting the optimal treatment plan, the clinician needs to discuss in depth the pros and cons of each option with the woman, with the goal of fully involving her in the decision-making process.

The healthcare provider can use the woman's concern about perimenopausal changes, such as irregular menses, as a forum to initiate a discussion of lifestyle modification. Although these recommendations are not specific to perimenopause, this transition period is a good time to assess each patient's lifestyle habits.

PREVENTIVE SCREENING

The annual health examination is valuable for the perimenopausal woman and should include comprehensive screening for physical and psychological problems as well as for appropriate lifestyle counseling. The annual physical examination provides clinicians with the opportunity to address disturbances that cause women to seek medical care, screen for disease risk factors, and assess the woman's perimenopause status. It is recommended that the physical examination include the following:

- Complete medical and personal histories (especially for cardiovascular disease, osteoporosis, cancer, health status, diet/nutritional assessment, and physical activity)
- Complete physical examination, including breast, pelvic, and rectovaginal examinations as well as standard measurements (e.g., weight and height, blood pressure)
- Laboratory testing, such as standard blood/urine screens, Papanicolaou test, stool guaiac, mammography, serum cholesterol levels, thyroid testing, and, when indicated, screens for sexually transmitted diseases
- Appropriate testing for specific chronic conditions
- Counseling regarding health changes related to menopause, including acute symptoms (e.g., hot flashes, sleep disturbances), sexuality (e.g., contraceptive options, high-risk sexual behaviors, sexual function), hygiene (e.g., dental care), psychosocial concerns (e.g., family relationships, job/work satisfaction), cardiovascular and osteoporosis risk factors (e.g., hypertension, obesity), health/risk behaviors (e.g., smoking, exercise, proper diet, nutrition), and treatment options, both nonprescription and prescription
- Encouraging the patient to keep a personal health maintenance schedule

Lifestyle modifications should include smoking cessation, physical exercise, proper diet and nutrition (especially regarding adequate intake of calcium and vitamin D), weight maintenance, and stress reduction.

Because clinical research data on women in perimenopause are limited, healthcare providers may consider extrapolating data on postmenopausal women as

well as clinical experience when considering management recommendations.

Vasomotor symptoms

Behavioral changes, such as moderate exercise and avoidance of potential hot-flash triggers (e.g., caffeine, spicy foods, alcohol, warm room) may prevent some hot flashes. However, only anecdotal data support the efficacy of these measures.⁴⁹ The efficacy of paced respiration—deep, slow abdominal breathing—as a modality to lessen hot flashes has been shown in a small trial.⁵⁰ Various alternative therapies, such as botanicals, acupuncture, massage, meditation, and some soy products, also may provide benefits, although efficacy has not been documented in clinical trials, except for moderate quantities of soy products.^{50–54} Healthcare providers should query women about their use of alternative therapies and over-the-counter medications. At this time, although the use of these substances is becoming more widespread, clinical trials have not confirmed their effectiveness.

Few data are available on the effects of estrogen replacement therapy (ERT) or hormone replacement therapy (i.e., estrogen plus progestogen, or HRT) on perimenopausal women; most ERT/HRT studies to date have been on postmenopausal women. Until more studies are available, data from postmenopausal women may serve as general guides to cautious decision making, combined with the healthcare provider's clinical experience. Therefore, prescription ERT may be considered for perimenopausal women. For almost all women with an intact uterus, clinicians should add progestogen to ERT (i.e., HRT) to guard against an increased risk of endometrial carcinoma from unopposed estrogen.^{55,56}

For perimenopausal women who are prescribed ERT/HRT, it is important to use the lowest possible effective dosage. If ERT/HRT is contraindicated and nonprescription remedies fail to control the vasomotor symptoms, then other prescription medications can be used, such as clonidine, progestogen alone, or megestrol acetate.

In postmenopausal women, use of ERT/HRT has been shown to be effective for the treatment of hot flashes.³⁴ Low doses of ERT/HRT can be effective in relieving moderate to severe vasomotor symptoms in postmenopausal women⁵⁷ and might be preferentially considered in perimenopausal women.

In a study of perimenopausal women who needed contraception,⁵⁸ vasomotor symptoms were treated with low doses of transdermal estradiol (0.05 mg/day for 21 days) and different oral progestins. This regimen blocked hot flashes and nocturnal sweating and provided contraception. However, this single study has not been confirmed, and the number of women studied was small.

Casper et al.²⁵ also showed a reduction in the incidence and severity of hot flashes with 0.02 mg ethinyl estradiol and 1 mg norethindrone acetate. A low-dose OC can provide needed contraception as well as relieve hot flashes. For women who use OCs and have hot flashes during the placebo week, adding a low dose of supplemental estrogen may help. Other treatment options extrapolated from studies with postmenopausal women include megestrol acetate (20 mg orally twice daily)⁵⁹ and clonidine (0.05–0.15 mg/day orally or transdermally).⁶⁰

Transitioning a woman from combination (estrogen/progestin) OCs to ERT/HRT should be done as soon as is appropriate. Even OCs with very low hormone doses still provide significantly more hormone than in standard ERT/HRT, which may increase exposure to unnecessary risks from long-term use. Timing of the switch is often difficult, because cessation of menses—the hallmark of menopause—is not observed while the patient is taking OCs. Some clinicians choose age 51, the median age of natural menopause in Western women. Clinicians also must consider the woman's need for contraception when making the transition.

Sleep disturbances

Healthcare providers are advised to approach treatment of insomnia through measures that improve the woman's sleep routine, such as keeping a regular sleep schedule; keeping the bedroom cool; and avoiding ingesting alcohol, caffeine, or spicy foods before bedtime.

In postmenopausal women, ERT improves symptoms of insomnia such as restlessness, nocturnal awakenings, and inability to fall asleep.⁶¹ Improved sleep is associated with alleviation of vasomotor symptoms, somatic symptoms, and mood.⁶¹ Anecdotal experience has revealed that this approach also may be effective with some perimenopausal women. As with managing hot flashes, the lowest effective dose should be used. For women who need protection against an unwanted pregnancy, prescribing a low-dose combination OC (estrogen plus progestin) may be a good approach.

Depression-related insomnia may be treated with antidepressants and/or with a referral for specialized psychiatric care. Insomnia from other causes may respond to prescription sleeping aids or may require referral to a sleep disorder clinic.

GENERAL COUNSELING

Perimenopause is an appropriate time to consider other issues: changes in sexual function, psychological effects, and osteoporosis and cardiovascular disease.

Changes in sexual function

An assessment of all potential physical, psychological, or social factors amenable to intervention should be the primary therapeutic consideration for perimenopausal women who express a specific complaint of loss of libido.

In postmenopausal women, estrogen therapy has been shown to improve vaginal health and may improve sexual function by reducing dyspareunia; however, its role in libido is uncertain.^{62,63} There are no studies regarding estrogen's effects on perimenopausal women, yet anecdotal evidence suggests that low doses provide similar benefits.⁶⁴ Another ovarian hormone, testosterone, may play a role in women's sex drive, but there are no published data in perimenopausal women.

Some perimenopausal women report vulvovaginal changes, such as vaginal dryness. Often, the first noticeable change is reduced vaginal lubrication during sexual arousal. All women of perimenopausal age should have a thorough evaluation of vaginal health, regardless of whether they are symptomatic or sexually active. Women who have sexual dysfunction of extended duration or who do not respond to medical intervention and simple counseling should be referred to a specialist in the treatment of sexual problems.

Psychological effects

Healthcare providers can help diminish fear and even help prevent some psychological symptoms by counseling patients on what to expect at menopause, both physically and psychologically. Relaxation and stress-reduction techniques, including lifestyle modification, may help women cope with stress-producing factors in their lives.

Perimenopausal women who are exhibiting relevant symptoms should be screened for clinical depression.⁶⁵ A medical history, physical examination, and routine laboratory tests should be performed to rule out illnesses that are often associated with depression. Simple tools, such as the Beck Depression Inventory or the Zung Self-Rating Depression Scale, may assist clinicians in identifying depressed women. Symptoms such as prolonged tiredness, loss of interest in normal activities, sadness, or irritability can result from disease. Depression also may be a side effect of medications. Only when the exact cause of depression is determined can an appropriate treatment plan be developed.

In addition, an evaluation of anxiety is needed to differentiate normal day-to-day anxiety from pathological responses that require pharmacological intervention and/or psychotherapy. Anxiety needs to be differentiated from other psychiatric conditions, such as obsessive-

compulsive and posttraumatic stress disorders. Anxiety also can be a warning symptom of psychiatric conditions, such as panic disorder (distinguished by shortness of breath, chest pain, dizziness, heart palpitations, and/or feelings of “going crazy” or being “out of control”).^{66,67}

For perimenopausal women who are moody, tired, and irritable from sleep deprivation as a result of hot flashes and night sweats, clinicians should provide therapies that are focused specifically on those symptoms. Synthetic progestins may worsen mood in some women, particularly those with a history of PMS. In these patients, clinicians can try switching to another progestin, switching to a continuous-combined HRT regimen, or using a natural progesterone.⁶⁵

If psychological disturbances persist after 6–8 weeks of hormone treatment, further evaluation is indicated, perhaps by a mental health professional.

Osteoporosis and cardiovascular disease

When counseling a woman who is in perimenopause, the healthcare provider must consider her risk factors for developing chronic diseases related to estrogen depletion, primarily osteoporosis and cardiovascular disease. For women who are at high risk, ERT/HRT should be considered. However, the decisions of women who choose to make lifestyle changes or take therapies other than ERT/HRT also need to be supported. All women require yearly examinations to identify markers for increased risk for developing cardiovascular disease, osteoporosis, or genitourinary problems.⁶⁸

FUTURE RESEARCH

As unprecedented numbers of women approach their perimenopausal years, the healthcare community needs to increase its understanding of this important transition period. To this end, further research is needed in various areas, which include the following:

- Standardized definitions of perimenopause for clinical studies
- Standardized definitions of the transition from premenopause to perimenopause to postmenopause
- Standardized terminology to describe the phases of perimenopause to enhance between-study comparisons
- Controlled studies to define the effects of perimenopause and to identify predictors of these effects
- Identification of new and better markers for perimenopause and menopause
- Controlled studies to identify prospective predictors of the final menstrual period

- Consideration of the association of steroids and other hormones and cytokines aside from estrogen with menopause events
- Determination of potential confounders and effect modifiers
- Use of sophisticated analytic strategies to account for complex patterns of hormone levels
- Age-matched studies to distinguish aging-related from menopause-related symptoms

CONCLUSIONS

Perimenopause is a largely unstudied and ill-defined period in the lifespan of women. Although the demand for information has been increasing, data are lacking regarding diagnosis, screening, and treatment options for perimenopause and for the effect of physiological, racial, cultural, and socioeconomic factors in this diverse population of women.

Characteristic changes of perimenopause are influenced by the normal aging process, because several hormonal systems manifest age-related changes that may or may not be related to the reproductive changes that occur during perimenopause. In addition, other conditions and diseases (e.g., obesity, diabetes, hypertension) often develop during midlife or may precede the beginning of perimenopause. Perimenopause, therefore, is an ideal time to reinforce or begin a good health program that will serve women well throughout the remainder of their lives. Healthcare providers should follow these perimenopausal women regularly and discuss with each woman the therapeutic options, both prescription and nonprescription, for the management of perimenopausal disturbances.

In selecting a treatment plan, if any, the healthcare provider and the woman must consider the following:

- The woman’s general health status
- The severity of her hormone-related disturbances
- The woman’s risk for developing serious disorders, such as osteoporosis and cardiovascular disease
- The potential risks and benefits of each available treatment
- The woman’s lifestyle
- The woman’s view of each treatment

The healthcare provider also must reassess therapy if the woman’s needs change or if new therapies become available. Most women require reminding that the disturbances of perimenopause are mostly temporary and that “doing nothing” is an option.

The challenges of perimenopause justify further study because women present with real complaints that

healthcare providers need to consider seriously for confirmation and treatment. Until more is known, a combination of preventive care, lifestyle modification, and early confirmation and intervention can play a valuable role in maintaining the overall health and quality of life of the perimenopausal woman.

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