

Menstrual Calendar

Name _____ Year _____

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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25												
26												
27												
28												
29												
30												
31												
# of days between periods												

- Exceptionally heavy flow
- X Normal flow
- L Exceptionally light flow
- Spotting

A woman has reached menopause when she has gone 12 months in a row without a period. During the transition to menopause (called perimenopause), various changes in menstrual patterns are common and normal. But some menstrual changes should be checked out by a healthcare provider to rule out causes other than menopause.

Keep track of your menstrual pattern here. Each day, evaluate your menstrual flow, using the symbols above. If you have no flow that day, leave the block blank. Also record the number of days between your periods (the number of days from the start of one period to the start of the next).

- Call your healthcare provider if you have:
1. Periods that are heavier than usual.
 2. Periods that last longer than 7 days or 2 more days longer than usual.
 3. Frequent periods (with fewer than 21 days from the start of one period to the start of the next).
 4. Spotting or bleeding between periods.
 5. Bleeding from the vagina after intercourse.
 6. Bleeding after reaching menopause, if you are not using hormones.



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Calcium Tips

The body's most abundant mineral is calcium, with about 99% contained in the skeleton. Maintaining an adequate intake of calcium helps keep bones strong and has many other health benefits as well. After menopause, more calcium is needed. Plus, if a woman is taking medication for osteoporosis, adequate calcium is essential for this therapy to work.

Ideally, calcium requirements should be met by food sources, but most women aged 50 to 65 consume only 700 mg of calcium daily – much less than the recommended level of 1,200-1,500 mg. Calcium intake can be increased by consuming more dairy products (low-fat or no-fat preferred); each serving provides about 300 mg. Other good sources are leafy green vegetables and calcium-fortified foods and juices. If sufficient calcium is not obtained in the diet, a calcium supplement may be necessary.

Probably every woman could benefit from taking a good quality daily multivitamin/mineral supplement. These “multi” supplements typically provide about 50 mg of calcium (check the label – each product is different). An additional supplement may be needed to reach the recommended calcium intake. Many kinds of calcium supplements are available, varying in type of calcium, dosage form (such as tablet, chewable tablet, dissolvable tablet, and liquid), size of tablet, and price. The two most common calcium supplements contain calcium carbonate (such as Caltrate, Os-Cal, Roloids, Tums, or Viaactiv) or calcium citrate (Citracal). Both are equally well absorbed if taken with meals.

Total daily intake should be 1,200-1,500 mg of elemental calcium. Calcium from the diet provides 100% elemental calcium, but not supplements. For example, calcium carbonate contains 40% elemental calcium (the highest percentage available in a supplement), so 1,250 mg of calcium carbonate provides 500 mg of elemental calcium ($1,250 \times 0.40 = 500$). It's important to read the labels. Look for the “percentage daily value” or “recommended daily allowance.” Whatever this percentage is, add a “0” to find out how much elemental calcium is in the serving. For example, if the label says 50% daily value or recommended daily allowance, that means 500 mg of elemental calcium per serving (50, then add 0 = 500).

A “one-a-day” schedule doesn't work with calcium supplements. This mineral must be taken in small divided doses throughout the day, as only about 500 mg can be absorbed at one time. Absorption is improved by taking the supplement with meals, but not with large amounts of grains (such as wheat bran). Magnesium supplements are not needed for women who eat a balanced diet. Women who take an iron supplement should take it separately from calcium, as calcium limits the absorption of iron. Certain medicines also need to be taken separately from calcium (check with healthcare provider or pharmacist). Recommended doses of calcium supplements don't have serious side effects if taken with a large glass of water, but daily intakes over 2,500 mg should be avoided. For women at high risk for kidney stones, food may be the best source of calcium.

Vitamin D plays a major role in helping the body absorb calcium. The recommended intake for vitamin D is 400 IU/day for women aged 51-70 and 600 IU/day for women over 70. (Canadian guidelines call for 800 IU/day for women over 50.) These requirements can usually be met with at least 15 minutes of sun exposure daily (without a sunscreen) plus taking a daily “multi” supplement (typically containing 400 IU). For women who always use sunscreen or are never in the sun, 600-800 IU each day is recommended. Certain foods, such as fortified milk, liver, and tuna, can also provide vitamin D.



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Treating Hot Flashes

The most common menopause-related discomfort is the hot flash. Most women have them off and on for only a few years, but a small percentage of women have them for life. Good news! Hot flashes can usually be reduced or eliminated completely through one or more of the following options.

Lifestyle changes

Although the following approaches are currently not well supported by research, they will do no harm, cost nothing, and may offer some women relief for mild hot flashes.

- Avoid any personal hot flash triggers, which may include external heat, strong emotions, hot drinks or foods, alcohol, caffeine, and cigarette smoking.
- To reduce stress and promote more restful sleep, exercise regularly, but not too close to bedtime. Meditation, yoga or tai chi/qi gong, biofeedback, positive visualization, acupuncture, or massage will also help keep stress levels low.
- When a hot flash is starting, try “paced respiration” (slow, deep, abdominal breathing in through your nose and out through your mouth).
- Try different strategies to stay cool while sleeping. Dress in light nightclothes. Use layered bedding that can be easily removed during the night. Cool down with an electric fan. Keep a frozen cold pack under the pillow, and turn the pillow often so that the head is always resting on a cool surface. If you awaken from sleep, sip cool water. Learn effective techniques for getting back to sleep. For instance, don’t just lie there, but get up and read until you become sleepy.

Nonprescription remedies

Although some women report that various nonprescription remedies help relieve their hot flashes, scientific studies are lacking to support their use. Many experts believe that hot flash relief reported while using these remedies can be attributed to the “placebo effect.” Many times, a placebo (dummy medication) has been found to be effective in a scientific study. In studies about hot flashes, a placebo has been found to be effective up to 40% of the time.

Nonprescription options used for hot flash relief include the following:

- Consuming isoflavones, most commonly found in soy foods, has been found in some studies to reduce mild hot flashes by 15%, but many other studies show no effect at all. Eating one or two servings of soy foods daily (25 grams of soy protein) may bring greater benefits than dietary supplement pills. Low-fat varieties of tofu, tempeh, soymilk, or roasted soy nuts are good choices. Results, if any, may take weeks.
- In some studies, use of Remifemin (a brand of dietary supplement pill containing the herb black cohosh) decreased hot flashes. Women taking two 20-mg tablets per day for 8-12 weeks reported improvement in mild hot flashes. However, not all studies show this positive effect. Again, it may take weeks to see results.
- Other nonprescription remedies, including topical progesterone cream, have not been found to be effective in relieving hot flashes.

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(continued NAMS MenoNote, “Treating Hot Flashes”)

Prescription therapies

The following prescription drugs have the greatest chance of relieving very bad hot flashes. They all have contraindications and side effects, so not all are appropriate options for all women.

- Multiple studies have proven that prescription hormone therapy with estrogen remains the most effective treatment for hot flashes, and often with lower doses than those used in the past. Systemic estrogen therapy is the only government-approved therapy for treating hot flashes, and the approved indication is for moderate to severe hot flashes.
- During perimenopause, a woman who needs contraception plus hot flash relief can choose a combination estrogen-progestin birth control pill, provided she is healthy and doesn't smoke. Progestin-only contraceptives are available for women who can't use estrogen.
- When hormones are not an option, some women may try the following nonhormonal prescription medications. Some research supports their use.
 - Drugs approved to treat depression: paroxetine (Paxil, 10-20 mg/day), fluoxetine (Prozac, 20 mg/day), and venlafaxine (Effexor, 25-150 mg/day)
 - A drug approved to treat epilepsy and migraine: gabapentin (Neurontin, 300-900 mg/day)



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Understanding Osteoporosis Tests

Postmenopausal osteoporosis is a disorder in which the strength of bone gradually decreases until the bone becomes more fragile and at higher risk for fractures. Getting older is a risk factor for this disorder, but other factors contributing to osteoporosis include family history, race, low body weight, smoking, and menopause, especially if it was premature (at or before age 40).

Testing bone strength

Bone density accounts for about 70% of bone strength. There are many tests to measure bone density. The preferred and most often used test is dual-energy x-ray absorptiometry – called DXA for short. It uses very low doses of radiation to measure the most common osteoporosis fracture sites, such as the spine and hip. It's quick (about 15 minutes) and painless, and you don't even have to undress. Usually your health insurance will cover the costs.

The DXA test can determine if you have osteoporosis now and, if so, how severe it is. It can also be used to help predict your future risk of developing osteoporosis and fractures. But remember that bone changes very slowly, so bone density tests do not need to be done too often. Every test should ideally be performed at the same place and on the same machine to make comparison between tests reliable.

What's a T-score?

Bone density test results are expressed as a T-score. Your T-score reflects how your bone density compares to a standard – the average value in women aged 20-30, the time of peak bone density. Each bone measured will have its own T-score. Remember that most older women will have a T-score below the standard.

- If your T-score is 0, then it's no different from the standard.
- If your T-score is above 0 (such as +0.5 or +1.0), your bone is more dense than the standard.
- With a T-score of -0.5, your bone density is approximately 5% below the standard.
- If your T-score is -1.0, then your bone density is about 10% below the standard.
(The bigger that negative number, the more below standard and the more porous your bone.)
- A T-score between -1.0 and -2.5 is called "low bone density" (sometimes called "osteopenia").
- A T-score of -2.5 or lower (25% or more below average) is called osteoporosis.

Understanding your T-scores

Discuss your T-scores with your healthcare provider. If your bone density test – alone or in combination with other bone health factors (such as being very thin) – indicate that you are at high risk for bone fractures, it's time for action. Good news! There are many changes women can make to improve their bone health – from adopting a healthy lifestyle, making weight-bearing exercise routine, getting enough calcium and vitamin D, to medication. You and your healthcare provider can devise a plan just for you.



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Bio-identical Hormones

The term “bio-identical hormones” (sometimes referred to as “natural hormones”) is used differently by different people. To scientists and healthcare providers, bio-identical hormones are those that are chemically identical to the hormones produced by women (primarily in the ovaries). A woman’s body can make various estrogens (such as 17-beta-estradiol, estrone, and estriol) as well as progesterone, testosterone, and other hormones. Thus, bio-identical hormone therapy can mean a medication that provides one or more of these hormones as the “active ingredient.”

Hormones have been produced commercially to be chemically exact duplicates of some of these naturally-occurring, bio-identical hormones. These hormones are made available in well-tested, government-approved, brand-name prescription drugs. Several drugs contain 17-beta-estradiol (Estrace and generic oral tablets, Estrace vaginal cream, all the estrogen skin patches, and now topical gels). There is one progesterone product (Prometrium oral capsules).

Custom-compounded hormones

Many consumers and some healthcare providers believe that the term bio-identical hormone refers to a custom-mixed (“custom-compounded”) recipe containing one or more of various hormones in differing amounts, depending on an individual prescriber’s order. The recipe not only contains the active hormone (or hormones), but also other ingredients that either holds everything together (in the case of a rectal suppository, an under-the-tongue tablet, or an under-the-skin pellet) or provides a vehicle for applying the product onto the skin (such as a cream or gel) or into the body (such as a liquid for a nasal spray).

Custom-compounded hormones may provide certain benefits, such as individualized doses and mixtures of products and dosage forms that are not available commercially. However, there may be risks to the consumer. These compounds do not have government approval because individually mixed recipes have not been tested to prove that they are absorbed appropriately or provide predictable levels in blood and tissue. And there is no scientific evidence about the effects of these hormones on the body, both good and bad. Although there is a long history of pharmacies providing a wide range of compounded products, the fact that preparation methods vary from one pharmacist to another, and from one pharmacy to another, means that patients may not receive consistent amounts of medication. In addition, inactive ingredients may vary and there can be batch-to-batch differences. Reliable sterility and freedom from undesired contaminants are also concerns. Expense is also an issue, as many custom-compounded preparations are viewed as experimental drugs and are not covered by insurance plans.

Hormone testing

Saliva testing to determine if a woman has the “right amount” of hormones has not been proven accurate or reliable. Even blood testing of hormone levels has the drawback that levels vary throughout the day as well as from day to day. More important, the desired levels in postmenopausal women have not been established. In addition, an individual woman’s physical comfort may not even be related to her absolute hormone levels.

Recommendations

NAMS does not recommend custom-compounded products over well-tested, government-approved products for the majority of women – and does not recommend saliva testing to determine hormone levels.



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Sexual Desire

Sexual feelings and activities are a natural part of living. In general, sexual desire (sexual drive) slowly declines with age in both sexes, but each individual is different. Some experience a significant decline in desire, a few have increased interest, and others notice no change at all. Research shows, however, that sexual problems are common for both women and men, with women being two to three times more likely than men to be affected by a decrease in desire. Low sexual desire is especially common in relationships of long duration.

The effect of menopause

The relationship between menopause and sexual desire continues to be studied. Reduced ovarian production of estrogen at menopause can contribute to hot flashes and night sweats, robbing a woman of restful sleep and reducing her interest in having sex. Falling estrogen levels can also result in vaginal dryness, making intercourse uncomfortable. At the same time, the body's production of another type of hormone – androgen – lessens with aging, possibly decreasing desire. Women experiencing induced menopause caused by removal of both ovaries or by chemotherapy have an accelerated decrease in both estrogen and androgen levels, thereby resulting in more severe problems than women having natural menopause.

Other factors influencing desire

Hormone changes at menopause are only part of a complex group of factors influencing the sexual function of women at menopause and beyond. Social changes often take place at this time of life, such as children leaving home or the need to care for aging or ill parents. The resulting stress or fatigue can dampen sexual desire. Other factors include changes in a woman's physical and mental health, her self-esteem and feelings about aging, and her feelings about sex in general and sex in a non-reproductive context. Sexual interest also depends on past sexual experience and on the quality and meaning that sexuality had in younger years.

Often a functioning partner is no longer available. If a woman is in a relationship, her sexual desire can be diminished by life stresses, further complicated when they occur at the same time as changes in her own or her partner's physical health. A simultaneous decrease may occur in her partner's sexual desire and ability to function. Communication (or lack of it) between partners can affect the ability to respond positively to life changes. For women to experience sexual desire, a caring relationship is generally required.

Medical problems may also result in low sexual desire. These include poor overall health and well-being or worrying about illness. For example, conditions which cause pain or decreased ability to move (such as arthritis) and mental health problems (such as anxiety and depression) can have a negative effect. Certain medications have side effects that interfere with sexual function, such as those that produce drowsiness or drying of mucous membranes (including the vaginal lining). Many medicines used to treat depression interfere with sexual arousal or response. And substance abuse (with alcohol or marijuana) is known to have negative effects on either partner's sexual function, as well as contribute to other relationship problems.

Seeking help

A clinical evaluation can help to identify any underlying medical or psychological causes of low sexual desire that can then be treated as appropriate for each individual woman. Often, making lifestyle changes, such as exercising or reducing alcohol consumption, will help a woman feel better. Changing medications or lowering doses may be helpful. It's not unusual for the partner's health and sexual function issues to need addressing as well.

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(continued NAMS MenoNote, “Sexual Desire”)

Unfortunately, knowledge about drug therapy to improve a woman’s sexual function is still in its infancy. The following are current options:

- A vaginal lubricant may be sufficient for women with vaginal dryness, while others may benefit from estrogen-containing hormone therapy (HT) – either directly applied to the vagina or taken systemically to affect the whole body, providing relief not only for vaginal dryness, but also for hot flashes and night sweats.
- In some cases, androgen therapy may be added to HT in an effort to boost sexual desire, but no well-tested drug product is government-approved for this indication (there is one available combination estrogen-androgen medication for women that is government-approved for treating hot flashes). Using products available over the counter or drugs designed for men is not recommended to improve a woman’s sexual desire because of a lack of data on safety and effectiveness in women.

Couples are urged to make time for quality sexual encounters. Sex devices or “toys” such as a vibrator or dildo, or warming vaginal lubricants, may enhance sexual pleasure. More attention can be directed to means of sexual gratification other than intercourse, such as oral sex, manual stimulation, massage, and caressing. Masturbation is a satisfying option for some women without partners.

Psychological counseling can help in coping with difficult medical or family issues, and can also improve communication between partners. Consulting with a specialist for sexual counseling is sometimes beneficial, especially when other options have not been successful.



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Birth Control during Perimenopause

Perimenopause – the transition to menopause (the final menstrual period) – can last 6 or more years. Despite a decline in fertility during perimenopause, pregnancy is still possible until menopause is reached, even if a few months have passed without a period. Menopause (and infertility) is not confirmed until a woman has had no uterine bleeding for at least 12 consecutive months.

Many perimenopausal women are interested in avoiding pregnancy. There are many effective options available. A woman should consult with her healthcare provider to determine which is most appropriate for her.

Estrogen-progestin contraceptives

One popular birth control option is the oral contraceptive (OC), often called the birth control pill. OCs containing a combination of the hormones estrogen and progestin are both effective and safe for healthy perimenopausal women who don't smoke. Besides preventing pregnancy, OC use provides multiple health benefits, including more regular menstrual cycles, decreased menstrual bleeding (and decreased iron deficiency anemia as a result), decreased ovarian and uterine cancer risk, reduced hot flashes, and maintenance of bone strength.

Several OC options are available. Other combination hormonal contraceptives include the new skin patch and vaginal ring. These work in the same way as OCs and have the same benefits and risks. Common side effects include nausea and breast tenderness, which tend to resolve as use continues. Use of any combination hormonal contraceptive results in withdrawal uterine bleeding – even after reaching menopause, a time when periods normally cease.

Perimenopausal women who should not use estrogen-containing contraceptives are those who smoke or have a history of estrogen-dependent cancer, heart disease, high blood pressure (even if controlled), blood clots in the legs or lungs, or diabetes.

Progestin-only contraceptives

Hormonal contraception that contains only progestin may be appropriate for women who cannot use estrogen-containing therapies. Progestin-only contraceptives are available in the form of a daily tablet, as an injection given every 3 months, and in an intrauterine device (IUD).

- *Daily tablet.* Effectiveness of the progestin-only contraceptive tablet is dependent on taking it at the same time daily. Breakthrough bleeding and spotting are common side effects.
- *Injection given every 3 months.* Using the progestin injection long-term can result in decreased or stopped menstrual bleeding. Common side effects are weight gain and depression. Concerns have recently been raised about its effects on bone.
- *Hormonal IUD.* Any type of IUD can be a safe, effective, and convenient type of birth control for the perimenopausal woman who has had children. One type of IUD releases tiny doses of the progestin hormone. Its advantages are that it may provide decreased menstrual bleeding and has to be changed only every 5 years. Risk for infection or having complications at the time of insertion is low.

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Nonhormonal methods

The following birth control methods do not contain hormones; however, not all are good choices for perimenopausal women.

- A nonhormonal IUD is available, providing another effective and safe birth control option for perimenopausal women.
- Barrier methods include condoms (male and female), diaphragm plus spermicide, spermicide-containing sponge, and spermicide alone. Barrier methods are effective, although not as effective as hormonal contraception or the IUD. The condom is the only proven effective protection against pregnancy and sexually transmitted infections, and can be used in combination with other birth control methods.
- Natural family planning (the “rhythm method” or periodic abstinence) is not recommended for perimenopausal women because irregular periods make predicting ovulation difficult.

Surgical sterilization

Tubal ligation (female sterilization) and vasectomy (male sterilization) are appropriate and popular options for perimenopausal women (or their male partners) if they are in a mutually monogamous, long-term relationship and desire permanent contraception. Disadvantages include the risk of anesthesia and the surgical procedure as well as cost.



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Deciding about Hormone Therapy Use

Many women experience hot flashes, vaginal dryness, and other physical changes as they reach menopause and beyond. For some women, the symptoms are mild and do not require any form of treatment. For others, symptoms are severe and interfere with daily activities. Fortunately, most symptoms last only a few years, but some women continue to have symptoms for several years after menopause. Lifestyle changes and nonprescription remedies are treatment options for these symptoms, but these may or may not be effective – especially when symptoms are moderate to severe. Prescription hormone therapy (HT) containing estrogen may then be considered. Estrogen is the only treatment that is well-tested and government-approved for relief of hot flashes and vaginal dryness.

Potential benefits

In the past, HT was recommended for most women at menopause to relieve symptoms and to reduce risk of serious disease as they got older, including osteoporosis and heart disease. Many women stayed on HT for life. Newer research has resulted in a different practice. HT is no longer thought to be needed by all women and does not help reduce heart disease risk. Importantly, however, HT is an effective option for treating symptoms such as hot flashes and vaginal dryness and, in some cases, for use long-term to keep bones strong. Each woman is different – and must make a decision based on an individualized treatment plan.

Potential risks

Just as with all prescription drugs, HT is associated with a number of potential risks. For example, one large study compared the effects of using a certain type of oral HT (Prempro) to women not using hormones. It found that HT increased the risk of blood clots (34 cases per 10,000 women per year when using HT versus 16 cases per 10,000 women per year when not using HT), stroke (29 versus 21 cases), and breast cancer (38 versus 30 cases), but decreased the risk of hip fracture (10 versus 15 cases). Although some experts disagree, the NAMS position is that all types of HT should be considered to have similar risks and benefits.

A decision must then be made by each woman in consultation with her healthcare provider. Do her potential benefits from HT outweigh the potential risks? If the answer is yes, then the next step is to select the right HT therapy for her.

Selecting the right HT

Prescription estrogen therapy (ET) – whether an oral tablet, skin patch, or skin gel – remains the most effective treatment for hot flashes. When this type of “systemic” (circulated through the body) ET is chosen, women with a uterus must also use another prescription hormone, progestogen, to protect the uterus. This combined estrogen-progestogen therapy is called EPT. If hot flash relief is the goal, systemic ET or EPT is an appropriate choice.

ET (in oral tablet, skin patch, skin gel, or vaginal dosage form) is also the most effective treatment for moderate to severe vaginal dryness. Most of the vaginal forms of ET provide estrogen “locally” (not circulated through the body); in this case, progestogen may not be required. If vaginal symptoms are the only reason to consider hormone therapy, vaginal (local) ET is the most appropriate choice.

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One way to lower potential risk with ET or EPT use is to lower exposure to hormones by starting with a low dose. Research has shown that “lower than standard” doses of estrogen are almost as effective for symptom relief as standard doses. HT, even at the lowest dose, should always be used for the shortest duration possible.

Follow-up important

After beginning HT, close follow-up is important to be sure the treatment approach is working. It’s unusual to achieve optimal results in one visit. Also, a woman should eventually attempt to reduce or stop HT when appropriate for her, and always in consultation with her healthcare provider. If bothersome symptoms persist, HT may be resumed.

For the majority of women, a point will be reached when symptoms are gone for good. Other women may decide to continue long-term ET or EPT for other potential or perceived benefits. The decision should be re-visited regularly to re-assess the risk/benefit ratio for each individual.



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