
MENOPAUSE

Table of Contents:

What Is Menopause……..…3
Symptoms……..…10
Hot Flashes……....16
Weight Gain……..…30
Cultural Silence……..……...34
PCOS……..…39
Menopause And Panic Attacks….45
Menopause And Evolution……52
The Brain And Menopause……...61
Alcohol Use And Menopause…....68
Hair Loss……..…73
Insomnia……..…77
Diet……..…80
Vasomotor Symptoms And Health Outcomes……..…..81
Testosterone And the Voice…….82
CBT And Hot Flashes……..…..83
Find a Menopause Expert!.....85

What Is Menopause

Understanding the Menopause Transition

Menopause Demographics

Menopause

- A normal, natural event, defined by the final menstrual period (FMP) and confirmed after 1 year of no menstrual bleeding.
- Represents the permanent cessation of menses resulting from loss of ovarian follicular function, usually because of aging.
- Normally occurs between the ages of 40 and 58 years.

Women worldwide are living longer

- Many women will spend nearly 40% of their lives in postmenopause.
- More than 60% survive at least until aged 80 years.

Arias E, et al. United States Life Tables, 2015. *Nat Vital Stat Rep* 2018;67:1-64.

Definitions and Terminology

Natural menopause	Permanent cessation of menses for 12 months from loss of ovarian follicular activity.[a]
Induced menopause	Surgical or iatrogenic loss of ovarian function (eg, bilateral oophorectomy, chemotherapy, pelvic radiation, other forms of ovarian toxicity).
Primary ovarian insufficiency	Loss of normal ovarian function before age 40 y, resulting in irregular menstrual cycles and reduced fertility.
Premature menopause	FMP before age 40 y.
Early menopause	FMP before age 45 y.
Late menopause	FMP after the age 55 y.
Perimenopause/Menopause transition/Climacteric	The time frame “around menopause” marked by intermenstrual cycle irregularities or other menopause-related symptoms (hot flashes, sleep problems, vaginal dryness); ends after 1 y of amenorrhea.
Postmenopause	Stage of life after FMP.

[a]Assessed by symptoms or measurement of endocrine markers in those without a uterus, using hormone contraceptives, or with history of uterine ablation.
Crandall CJ, et al, eds. *Menopause Practice: A Clinician’s Gui*de, 6th ed. The North American Menopause Society; 2019.

Primary Ovarian Insufficiency and Early Menopause

Primary ovarian insufficiency (POI)

- Final menstrual period before 40.
- Affects 1% of women aged younger than 40 years.
- May be transient (i.e. periods may eventually come back)

Early menopause

- Occurs between the ages of 40 and 45 years in approximately 3% of the population.

What is the cause of POI, premature menopause, and early menopause

- A cause never found in most cases. However, other causes may be: genetic, autoimmune, radiation, infectious (mumps), and metabolic (diabetes)

European Society for Human Reproduction and Embryology (ESHRE) Guideline Group on POI, et al. *Hum Reprod* 2016;31:926-937. doi: 10.1093/humrep/dew027

What is “perimenopause”?

- Can be confusing, but:
  - **Perimenopause** = the menopause transition *plus* 1 year…
  - Begins *before* the final menstrual period (FMP)
  - Lasts until **one year after the FMP**

Reproductive Stages

The rest of life

Birth- Puberty

Reproductive age
- Early 13 - 18
- Peak 18 - 35
- Late 35 - 40 or 45

Menopause Transition
- Early (40-46is)
- Late (1-3 yrs before final period

Post-Menopause

First Period / Final Menstrual Period										
Stage	-5	-4	-3b	-3a	-2	-1	0/+1a	+1b	+1c	+2
Terminology	REPRODUCTIVE				MENOPAUSAL TRANSITION		POSTMENOPAUSE			
	Early	Peak	Late		Early	Late	Early			Late
					Perimenopause					
Duration	*Variable*				*Variable*	1-3 years	2 years (1+1)	3-6 years		*Remaining lifespan*

FINAL PERIOD

4 STAGES OF MENOPAUSE

PREMENOPAUSE — 30-40 yrs — **PERIMENOPAUSE** — 8-11 yrs — **POST-MENOPAUSE**

CHILD — **OLD WOMAN**

MENARCHE
12 yrs

40 yrs

MENOPAUSE
51 yrs

NOT - FERTILE
no periods

FERTILE
menstrual cycle

POOR FERTILITY
irregular periods

NOT - FERTILE
no periods

What Are the Symptoms of Menopause?

How Menopause Affects the Body

EVERYDAY HEALTH

You may have any or all of these symptoms when going through menopause.

“Perimenopause”, “Menopause Transition”

Often marked by:

1. Irregular periods
2. Hot flashes
3. Mood changes
4. Sleep disturbances

Note: *It’s sometimes (incorrectly) used interchangeably with “premenopause”—which refers to the full reproductive years before any transition starts.*

The Experience - Highly Unpredictable

- No set start date—some women notice symptoms years before periods stop
- “False finishes” are common (you think it’s your last period… and then, surprise!)
- For many, it feels like a meandering journey rather than a single event

➢ 🗨 *“The only predictable thing about the menopause transition is its unpredictability.”*

Terminology

Menopause *vs* Perimenopause

Perimenopause	Hormonal fluctuations leading up to and including the year after FMP
Menopause	Technically = 12 months after FMP Lasts 3-8 years (variable)
Postmenopause	Time after menopause
“Going through menopause”	Common phrase = usually means perimenopause

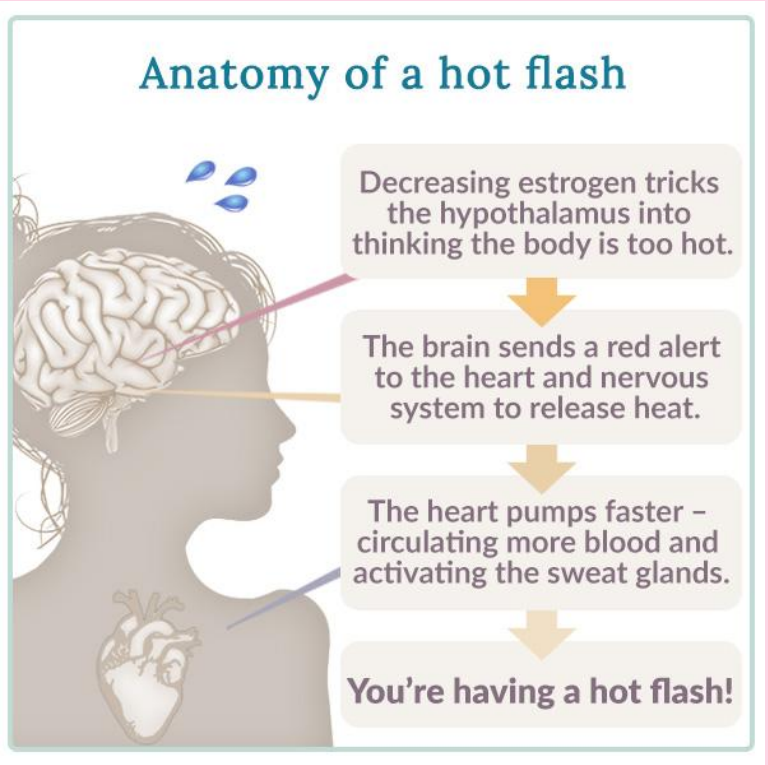
What to Remember About Perimenopause

1. It's a *natural*, though often confusing, life stage
2. Can last several years—each woman's experience is different
3. Understanding it can help with symptom management, and emotional wellbeing
4. Don't worry about getting the terminology perfect—focus on how you *feel*, and communicate clearly with your provider

Quenching the Fire

When Your Brain Cries Fire for No Reason

- 80% of women experience vasomotor symptoms (hot-flashes, night sweats); average duration is **7 years**
- **Symptoms often start before menopause and can persist long after**



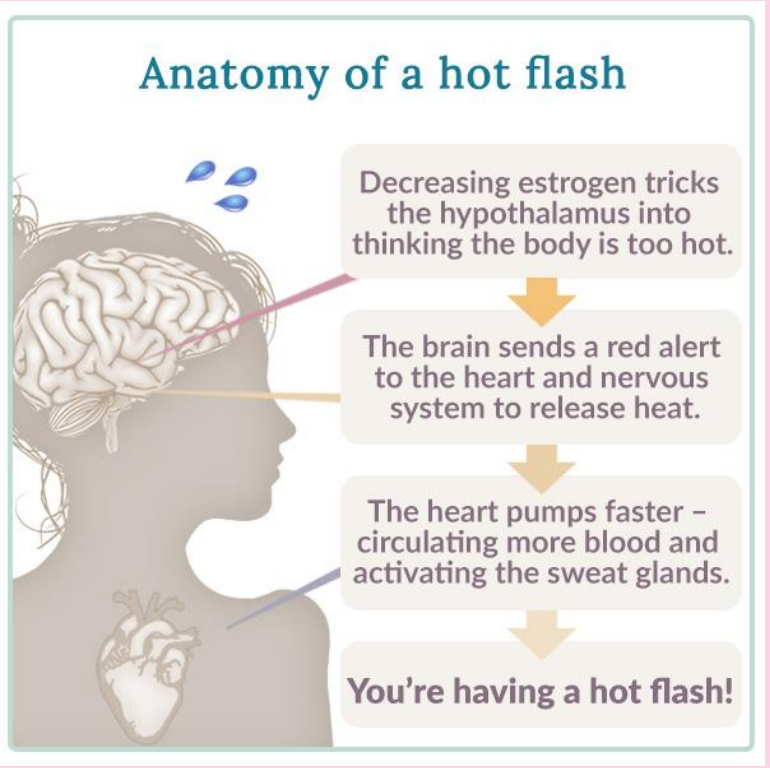
When Your Brain Cries Fire for No Reason

Thermoregulation = how your brain keeps your body temperature steady

Happens in **the hypothalamus**, the brain's temperature control center

Estrogen helps regulate this "thermostat"

Think of reproduction and temperature sharing the same motherboard



Anatomy of a Hot Flash

- The brain shouts: “You’re too hot!” even when you’re not
  - Blood rushes to skin = flushed face, chest, arms
  - Sweat glands turn on
  - Heart rate speeds up
  - Blood flow to brain decreases
  - Cooling overshoots the mark

→ chills or even shivering may occur

Why the Drop in Estrogen Matters

❖ It’s the Fall, Not the Low

- Hot flushes aren’t caused by low estrogen alone
- It’s the **sudden withdrawal** that triggers the symptoms
- Gradual drops (like natural menopause) = milder symptoms
- Sudden drops (like ovary removal) = more intense symptoms

The Impact: More Than Just a Sweat

- It’s Not Just Annoying—It’s Exhausting
  - Hot flushes can happen 20–30 times a day
  - Affect sleep, concentration, mood
  - For some, the chills after the flush are worse than the heat

It’s real. It’s disruptive. And you’re not imagining it.

Treatment With More Than A Fan

Dressing in layers? Fine—but it’s not a cure

Symptom severity = reason enough to seek treatment

Wardrobe Hacks

Breathable fabrics, sleeveless tops, easy-to-remove layers

Short sleeves, **ponytails**, and minimal skin contact can help

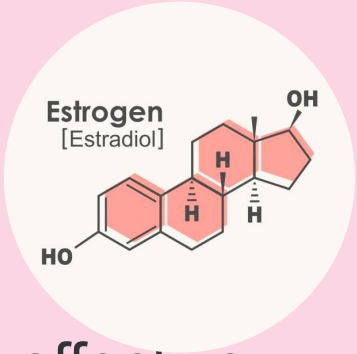
Feeling cooler = feeling less irritated

Cooling fabrics? Maybe helpful—but more about comfort than science

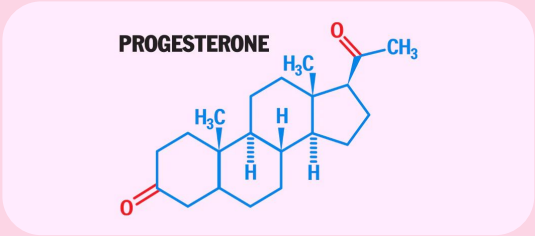
CBT (Cognitive Behavioral Therapy):

- **Mental Shifts** That Cool the Body
  - Changing the thoughts that worsen our perception of a flush
  - Helps to reframe ("This is unbearable") and avoid catastrophizing
  - Combined with **deep breathing** to manage stress response

Medical Therapy



- Estrogen is the gold standard
  - Menopausal Hormone Therapy (MHT) is most effective
  - Smallest effective dose = starting point (e.g., 0.025 mcg patch)
  - Progesterone may help when estrogen isn't an option
  - Oral progesterone (300 mg) can aid hot flushes and sleep



Medical Therapy - Non-hormonal

- SSRIs/SNRIs: Paroxetine, citalopram, escitalopram, venlafaxine
- Gabapentin/Pregabalin: Especially for night sweats & sleep issues
- Clonidine: Modestly effective, more side effects
- Side effects are often mild at low doses

Botanicals & Homeopathy: What to Know

- *Not All Natural Options Are Created Equal*
- **Black Cohosh**:No proven benefit; contamination concerns; reports of liver damage
- **Flower Pollen Extract** (Relizen): One small study shows short-term benefit
- **Homeopath**y: Based on pseudoscience; lacks evidence or biological plausibility

Other Popular Remedies

- Vitamin E: Mild benefit at best; there is evidence that doses ≥400 IU/day may increase mortality risk
- Dong Quai: Not effective; risks include interactions with blood thinners and potential cancer concerns
- Evening Primrose Oil: Popular but unsupported by quality data

Bottom Line: Here Are The Facts

- Estrogen is the most effective treatment
- Best nonmedication therapies: CBT and possibly hypnosis
- Effective nonhormonal prescriptions: Paroxetine, escitalopram, low-dose gabapentin
- Phytoestrogens and black cohosh: no proven benefit in studies

Weight Gain In Menopause

It‘s Not Just A Vanity Issue

Why Weight Gain Happens in Midlife

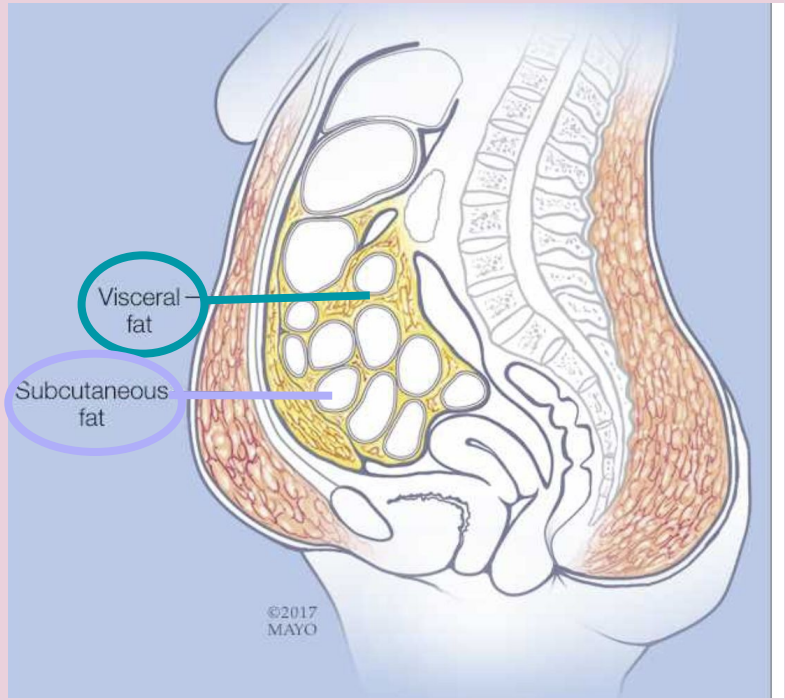
- Midlife = Change
- Ages 40–65: hormone shifts + natural aging
- Menopause → more belly fat, even without eating more
- What's Behind the Gain?
  - **Muscle loss**: 3–8% per decade after 30 = slower metabolism
  - **Estrogen drop:** encourages fat storage in the abdomen
  - **Lifestyle shifts**: Less movement, poor sleep, more stress

Bottom Line:

Weight gain isn't just about willpower—it's physiology, hormones, and life transitions rolled into one.

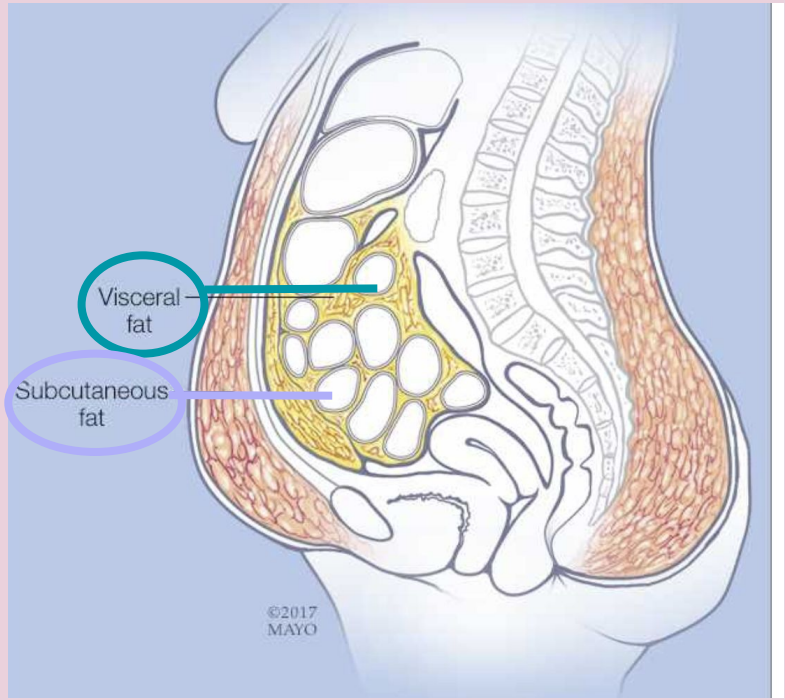
Weight Gain: Why It Matters

- Where fat lands matters.
  - Abdominal fat (a.k.a. visceral fat) is more dangerous than extra pounds elsewhere.
  - Subcutaneous fat is the belly fat you can feel if you pinch excess skin and tissue around your middle
  - Visceral fat is belly fat that accumulates in your abdomen in the spaces between your organs. Too much visceral fat is strongly linked with a greater risk of serious health problems.

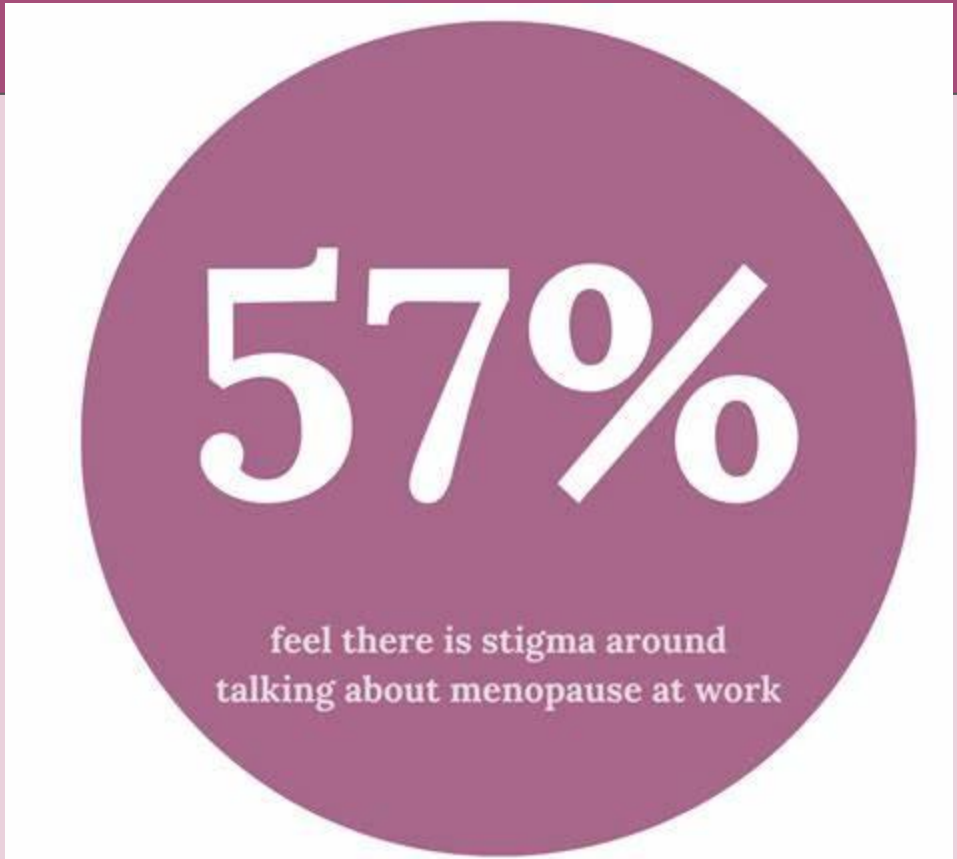


Weight Gain: Why It Matters

- Visceral fat raises the risk of:
  - ❤️ Heart disease & diabetes
  - 🧠 Cognitive issues & depression
  - 🦴 Joint pain & arthritis
  - 🦠 Cancer (esp. breast & colon)



Why the Cultural Silence?


57%
feel there is stigma around
talking about menopause at work
2021 Vodafone Menopause Research facilitated by Opinium Research

Culture Contributes to Cognitive Distortions

It’s just aging.

Not a big deal.

It’s a failure of your ovaries.

Keep it to yourself.

Menopause: The Unspoken Transition

1. **Fear? Check.** Many women approach menopause with anxiety due to a lack of information.
2. **Uncertainty? Check.** The **unpredictable** nature of symptoms leaves many unprepared.
3. **Medical ramifications? Check.** Symptoms can impact daily life, yet are **often dismissed**.
4. **Unpleasant symptoms? Check.** Hot flashes, mood swings, and sleep disturbances are common.
5. **Societal irrelevance? Check.** Aging women often feel invisible in media and society.

Menopause is Not a Disease

Despite being a universal experience, menopause remains shrouded in silence, leading to misinformation and neglect.

PCOS And Irregular Periods

When Your Cycle Doesn’t Follow the Script

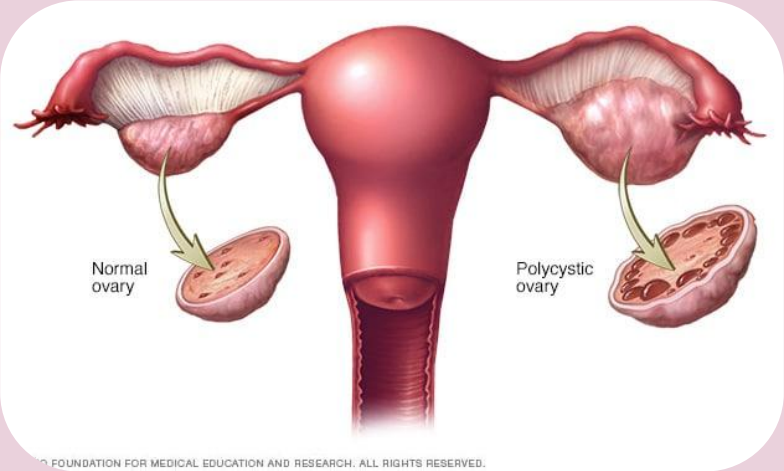
When Periods Aren’t a Helpful Clue

- Not Everyone Gets the “12-Month Countdown”
  - Women with PCOS
  - Those with a hormonal IUD
  - Women post-endometrial ablation
  - Women post-hysterectomy

Menopause symptoms (e.g., hot flashes, sleep changes) may still occur—and can be treated!

PCOS

Polycystic ovary syndrome (PCOS) is a condition characterized by **irregular menstrual cycles**, **challenges with weight loss**, and elevated levels of androgenic hormones, such as testosterone. This can result in symptoms like acne, excess facial or body hair, and **thinning hair** on the scalp.
Many of these symptoms are harbingers of menopause



FOUNDATION FOR MEDICAL EDUCATION AND RESEARCH. ALL RIGHTS RESERVED.

Symptom Similarity

Symptom	PCOS	Menopause
Missed periods, irregular periods, or very light periods	Yes	May present this way
thinning hair	Yes	Yes
Weight gain, especially around the belly	Yes	Yes
Acne or oily skin	Yes	Maybe
Infertility	Yes/not always	Yes
Ovaries that are large or have many cysts	Yes/not always	No (unless already have PCOS)

Tracking Symptoms Beyond Bleeding

- Common perimenopause symptoms still apply:
- Hot flashes
- Sleep disruption
- Mood swings
- Vaginal dryness or libido changes
- Treatment decisions can be made based on symptoms and risk factors, even without cycle tracking
- Advocate for your care—bring symptoms up with your provider

PCOS & Menopause: A Research Gap

- There’s limited research on how menopause uniquely affects women with PCOS
- More studies are needed to:
  - Refine diagnostic tools for aging women
  - Understand long-term cardiovascular & metabolic risks
  - Tailor hormone therapy guidelines

If you're not sure whether you're in perimenopause—you're not alone. The key is to track changes and get support from a provider who understands PCOS and midlife health.

Menopause and Panic Attacks: Is There a Connection?

What is a Panic Attack

- Sudden wave of fear or dread
- Racing heart, chest tightness, feeling faint
- Shortness of breath, sweating, chills
- Feeling like you're "losing control"

🧠 *They're real, physical experiences—often triggered by stress or body changes.*

Why Menopause Can Be a Trigger

- Hormones like estrogen and progesterone affect brain chemistry
- Their decline can mess with mood, sleep, and stress regulation
- Some women feel more emotionally vulnerable
- Menopause = a perfect storm of physical, mental, and emotional shifts

🧪 Lower levels of a calming brain chemical called allopregnanolone may play a role.

25%

- *Anxiety affects 1 in 4 women with menopause symptoms*

What Does Research Say?

- Panic Symptoms Are More Common in Midlife Women
  - **Panic disorder** affects **~3%** of women aged 40–49
  - **Panic attacks** linked to more severe hot flashes, poor sleep, migraine, and life stress
  - HRT? 🤷 Not a clear fix—results are mixed

  Takeaway: *The menopausal brain and body may be more sensitive to panic.*

Managing Panic in Menopause

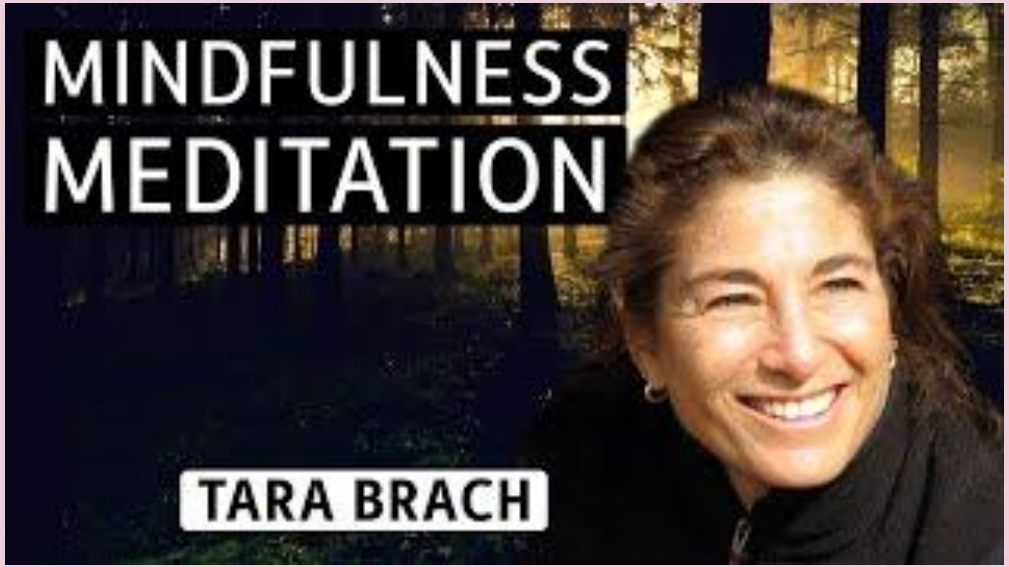
Mind-Body Connection

- Cognitive Behavioral Therapy (CBT)
  - **The 3 C's**:
    - Catch it
    - Check it
    - Change it

- Relaxation & breathing techniques
- Gentle movement like walking or yoga
- Meditation

Don’t Know Where To Start?

A loving-kindness meditation with Tara Brach



A profound transformation can occur just by training your attention in awareness—a practice sweeping the country with its capacity to decrease stress, cultivate inner calm, and expand wisdom and creativity.

Medical Support

- Anti-anxiety meds (if needed) - there are medications that are not linked with dependency
- Hormone therapy in some cases can improve symptoms
- Talk to your healthcare provider

You're not "just anxious"—there are real, treatable reasons behind these symptoms.

Menopause and Evolution

The Grandmother Theory
A Beautiful YouTube video: https://www.youtube.com/watch?v=sQpGT1BgdX4
(can watch on the next slide if you wish)


THE AMAZING GRANDMOTHERS
OF THE KILLER WHALE POD
TED-Ed

Evolutionary Advantage of Menopause: A sign of Strength, Not Weakness

- Fallacy: women were never “meant” to experience menopause.
  - Claims that menopause is an accidental state that resulted from longer life expectancies:
    - Due to modern sanitation and medicine
    - Allowed women to live after ovulation stopped
    - Uncovered the state of being in menopause

- Imagine the following statement: “Through good sanitation and health care, men are now living long enough to develop erectile dysfunction.” (does not quite compute, right?)

Menopause Benefits Society

Truth: Menopause may confer some advantages toward survival

- "Women living beyond their own reproductive fitness may improve maternal-infant care by providing additional hunter-gatherer labor and reliable food and water and by playing midwifery roles that lower infant and maternal mortality rates."

Hawkes K, O'Connell JF, et al. Grandmothering, menopause and the evolution of human life histories. Proc Natl Acad Sci. 1998;95:1336–9. doi: 10.1073/pnas.95.3.1336.

Studies By The Center for Whale Research

Since 1976, they have been studying a single population of whales off the coast of the PNW

Evolutionary Advantage of Menopause: A sign of Strength, Not Weakness - The Vital Roles of Killer Whale Grandmothers

Evolutionary Advantage of Menopause: A sign of Strength, Not Weakness

- Female Killer Whales and Menopause
  - Female Orcas stop reproducing around the age of forty
    - Can live to be ninety yrs old
    - Live approximately half of their lives after menopause.
    - Most male killer whales die in their late 30s or early 40s
    - **The sons and daughters** of killer whales **spend their entire lives with their mother‘s families**

The Killer Whale Grandmother: The Most Knowledgeable Hunter

- Research On Killer Whales in the Pacific Northwest
  - Like humans:
    - Live in small groups
    - Social and intelligent
    - If a grandmother killer whale is present, this increases the likelihood her grandcalf will survive.
    - If a grandmother dies, the grandcalf has an increased risk of dying for two years.
    - When food is scarce grandmother killer whales were best able to locate salmon, leading their pod to food, and they shared their catch.

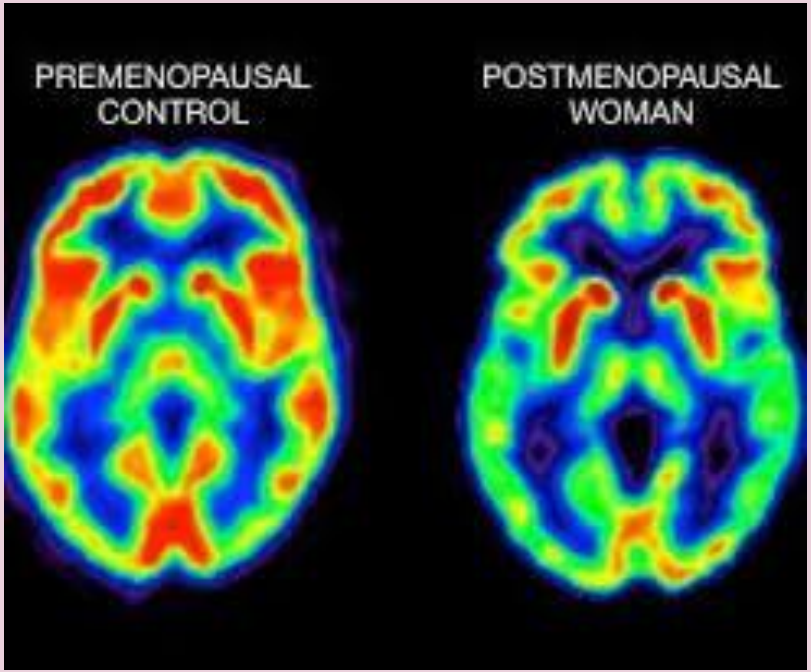

Grandmother taking the lead in the search for salmon.

The Grandmother Theory

- Menopause played an essential role in human evolution.
- Grandmothers confer a survival advantage for their grandchildren, likely by gathering food and assisting with child care and shelter.
- Some toothed whales, most notably killer whales, experience menopause, and grandmother whales are essential for survival of their grand-calves.
- Chimpanzees, our closest relative, also stop ovulating around the same time as humans, but die soon after.
- Women evolved to live beyond their ovarian function because menopause benefits society.

Excerpt from “The Menopause Manifesto” by Jen Gunter,MD

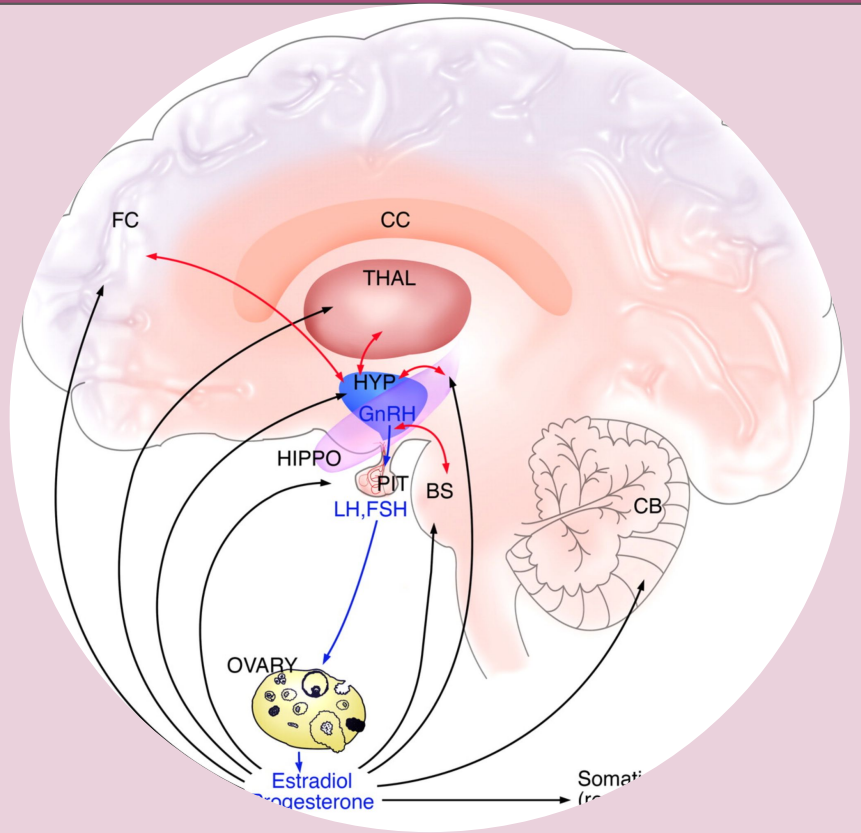
Your Brain On Menopause



From the February 28, 2024 Podcast with Neuroscientist, Lisa Mosconi
WBUR

Menopause Is a Brain Event

- Menopause is a **neuroendocrine transition**—not just about the ovaries.
- The brain and ovaries communicate through a hormone feedback loop.
- Estrogen and progesterone support neurological functions like:
  Memory
  - Mood regulation
  - Energy metabolism
  - Neural connectivity (dendrites)



Experience Shared By Listeners of the Podcast

Brain fog and forgetfulness

Mood swings and “doom drops”

Anxiety and insomnia

Hot flashes disrupting focus

“I forgot where I was going.”

“It hit me like a freight train.”

Menopause: A Window of Vulnerability

- Menopause **doesn't cause Alzheimer's**—but it may uncover pre-existing risks.
- This window of estrogen loss can unmask:
  - Depression
  - Autoimmune disorders
  - Cognitive decline
- For those with genetic or health predispositions, symptoms may appear during menopause.

Estrogen: The Brain's Fuel

- **Estrogen** is not just a sex hormone—it's a **neuroprotective** hormone.
- It increases brain connectivity and energy use.
- During ovulation: peak energy, focus, and resilience.
- During withdrawal from estrogen: fatigue, fog, and vulnerability

"Estrogen is to the brain what fuel is to a car."

- *Dr. Lisa Mosconi*

Rewiring, Not Collapse

- Menopause involves “pruning” of the neurons—similar to puberty and pregnancy.
  - ➢ Some neurons shed as the brain adapts to a post-reproductive phase.
- This may lead to temporary “glitches” in memory, sleep, and mood—but is part of functional adaptation.
- Long-term gains: improved emotional regulation and contentment.

“It’s not decline—it’s redesign.”

- Dr. Lisa Mosconi

Menopause with Power, Not Panic

- Key Points:
- Your brain is changing—and that's real.
- Symptoms deserve recognition and care.
- Positive mindset and lifestyle changes matter:
- Aerobic activity for brain fog
- Strength training for mood
- Plant-forward diet for symptom relief

To listen to the full interview with Dr. Mosconi, visit
https://www.wbur.org/onpoint/2024/02/28/brain-menopause-women-science-reproductive-biology

Alcohol and Menopause

Simply Put…

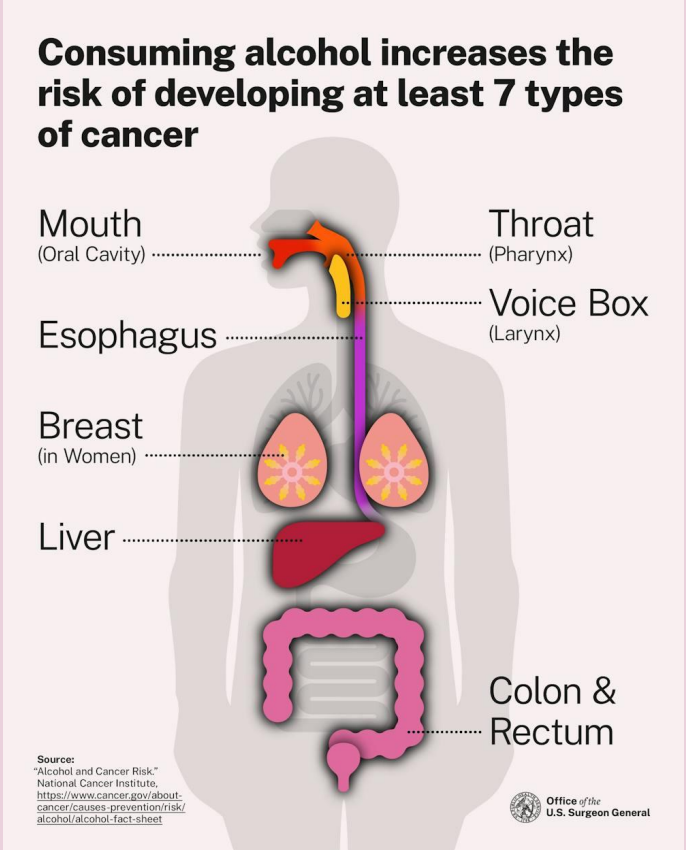
- Alcohol makes menopausal symptoms worse.
- Hot flashes stem from a disrupted thermoregulatory zone in the brain
- Alcohol is a toxin to the brain
- Alcohol acts as a trigger—making hot flashes and night sweats more frequent or more intense

Alcohol and Sleep During Menopause

- Menopause is linked with sleep disturbances.
- Alcohol may feel sedating but reduces sleep quality.
- Nighttime drinking worsens both hot flashes and sleep fragmentation
- That means lighter sleep, more awakenings, and—yes—worsening of night sweats.

Health Risks of Alcohol…Even Just 1 Drink Per Day

- Alcohol contributes to higher risk of:
  - Breast and colorectal cancer
  - Heart disease and stroke
  - Osteoporosis
- It also impairs weight control, which is already challenging during menopause.



Latest Updates

From 2024 Menopause Society Meeting

- Hair Loss
- Testosterone Therapy

Menopause and Hair Loss

No, it's not life-threatening like cancer or heart disease…but hair loss in menopause can be a source of distress and affect our self-esteem.

Menopause and Hair Loss

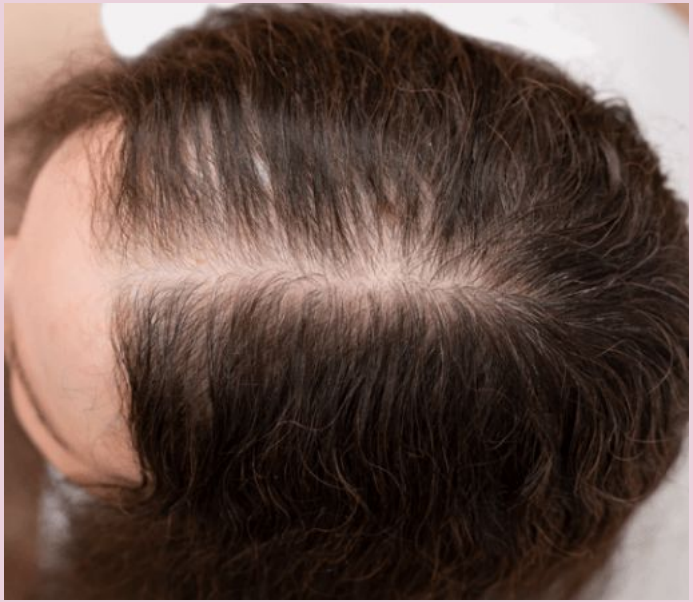
Hair loss #1. If your hair loss issue is that your hairline is receding, you need to see a dermatologist. You must be evaluated for frontal fibrosing alopecia, a type of hair loss that involves scaring, as the hair can't grow back if left untreated. It is often unmasked during the menopause transition or during menopause but can affect people of all ages and genders. For some unknown reason, the incidence is increasing. There are treatments to stop the progression, so if you are concerned your hairline is receding, then please see a dermatologist.

Hair Loss

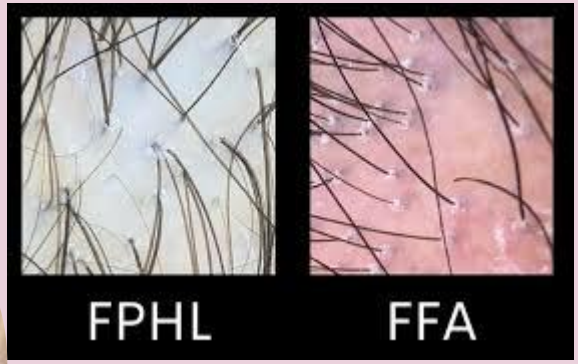
Hair loss #2. The most common type of hair loss during menopause is female pattern hair loss. It typically presents as a thinning part line and/or a thinning ponytail. Hair typically goes through three phases: anagen (growing), catagen (stops growing, starts to detach), and telogen (the hair follicle rests and there is no growth). With female pattern hair loss, more hair enters telogen, so more is lost, and then when the hair follicle wakes back up to start anagen again, the hair follicle has become miniaturized, so the hair is finer and doesn't grow as long. It's important to rule out other causes of hair loss, such as low iron or taking testosterone. When the diagnosis is certain, the first line therapy is either oral or topical minoxidil, and while they are equally effective, topical minoxidil must be used twice a day, and many people can't do that or don't like it (which I totally understand). Oral spironolactone can also be added. There was no mention of supplements, and FYI, there is no data to support biotin. The speaker's go-to starting regimen is oral minoxidil 1.25 mg and spironolactone 100 mg.

Female Pattern Hair Loss (FPHL)

- Thinning of the part-line
- Pony-tail getting smaller



Frontal Fibrosing Alopecia (FFA)



FFA is different from FPHL and can cause permanent scarring and cannot grow back if left untreated.

Bottom line: If your hair-line is receding, you need to see a dermatologist

Insomnia - Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

Sleep #1. Cognitive behavioral therapy for insomnia, or CBT-I, is the most effective therapy, even when there are hot flashes! CBT even outperformed estrogen (although in the study presented, the estrogen was admittedly a lower dose, 0.5 mg oral estradiol). The take-home message here is that CBT-I works whether there are hot flashes or not, and a review of the literature was presented that suggests that menopause hormone therapy only has a modest improvement in sleep quality. Many women have poor sleep, even when hot flashes are improved with therapy, so consider CBT-I as a good add-on or complement to pharmaceutical therapies, and it is also a totally reasonable thing to do as a stand-alone.

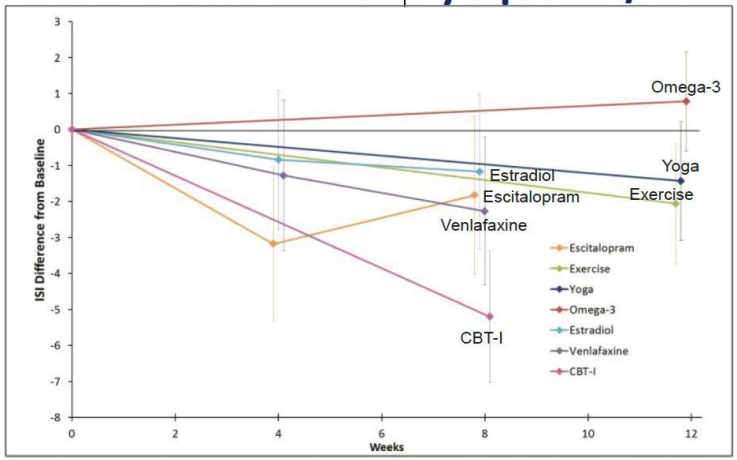
Pro tip: keep this in mind if you have started a moderate dose of estradiol (a 50 mcg patch or 1 mg oral) and are still not sleeping well. Unless you are waking up soaked in sweat multiple times, maybe consider CBT-I as an add-on.

NAMS= North American Menopause Society,
now “The Menopause Society”

Insomnia - Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

I think it’s important to see this slide, which shows that many of the nonhormonal therapies are also good for sleep in menopause for people who have hot flashes. Even more interesting, the CBT-I therapy in this study, as shown in the image below, was delivered by telephone.

Comparison of Effects on Insomnia Severity Among Women with >13 Vasomotor Symptoms/week

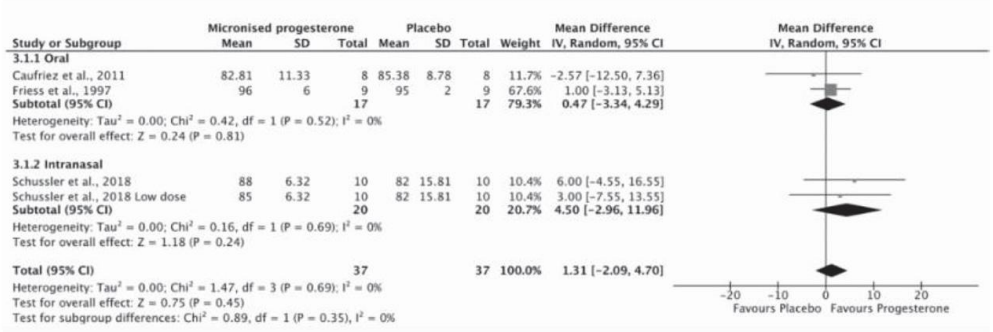


Guthrie KA et al Obstet Gynecol. 2015 Aug;126(2):413-422.

Insomnia - Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

Sleep #2. Progesterone may not be as effective as we think. Many of us have heard that progesterone is sedating and can help with sleep. However, there is a massive placebo response in sleep studies, so that is always important to keep in mind. This is the slide from a recent meta-analysis that was presented. I’m not saying people should stop their progesterone if they are sleeping well, but if it’s not working, maybe consider that it doesn’t have the most robust evidence, and the reason you are still not sleeping well might be because you may not be taking an effective therapy.

Micronized Progesterone and PSG-Sleep Efficiency



“Randomized controlled data demonstrates that micronized progesterone improves various aspects of the sleep cycle and self-reported sleep outcomes, predominantly in studies involving postmenopausal women. However, results are inconsistent between studies.”

Brendan J Nolan, Bonnie Liang, Ada S Cheung, Efficacy of Micronized Progesterone for Sleep: A Systematic Review and Meta-analysis of Randomized Controlled Trial Data, The Journal of Clinical Endocrinology & Metabolism, Volume 106, Issue 4, April 2021, Pages e942–e951,

Diet - Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

The takeaway was that the best diet is likely a Mediterranean diet focusing on lean and more plant-based proteins. No surprise. The lecturer didn’t even mention intermittent fasting, but it came up in the questions. No surprise there either, as there are two books from providers with massive followings on social media that make some pretty bold (and scientifically unverified) claims about intermittent fasting being superior for women. The speaker, Annina Burns, PhD, RD from the Office of Research on Women’s Health at the National Institutes of Health (NIH), said that if you were to design the worst diet for perimenopause, it would be intermittent fasting. The speaker felt that the impacts of hormonal fluctuation in the perimenopause of inflammation could be worsened by time-restricted eating and, in fact, thought scientifically the best diet in perimenopause was more likely to frequent small meals, although admittedly not studied. Look, if intermittent fasting works for you, great, but anyone who is suggesting it is especially beneficial for perimenopause has it wrong.

Health Outcomes: Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

People with more VMS seem to be at higher risk for cardiovascular disease (CVD) and dementia. This doesn’t mean that you will definitely get CVD or dementia if you are a super flasher, nor does it mean that treatment of hot flashes/night sweats will prevent these outcomes.

While one hypothesis is that hot flashes are involved in a causal relationship with CVD and/or dementia, it’s equally plausible that VMS is a marker. For example, it’s possible that people who are destined to get CVD or dementia have more blood vessel stiffness, and the stiffness is also what makes them more likely to get hot flashes.

And there are many other explanations for a correlation between the two instead of a cause and effect. This is an active and important area of research. The take-home is that we don’t want women to suffer, so it’s important to treat hot flashes, and hopefully, over time, we will learn if that treatment also reduces the risk for CVD and dementia for the subgroup with more hot flashes.

Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

Testosterone And the Voice

The voice. Testosterone can lower the voice, even when dosed appropriately, and this is a real risk. While understudied, blood levels can’t predict this. If you use your voice professionally, this should be a consideration, although it should be a consideration for everyone as the changes are largely irreversible.

CBT and Hot Flashes - Latest Information From NAMS - Excerpted from “The Vajenda” By Jen Gunter (Substack)

There is good evidence to support using CBT for hot flashes. This does not mean that everyone needs to try it; it is just one more option as a stand-alone therapy or as an add-on to other therapies. Thoughts and mood affect our physical experience; of course, the reverse is true. I think we can all understand that controlling that response may be beneficial if we feel sad or anxious, embarrassed or angry because of a hot flash.

CBT can help with cognitive distortions that might negatively amplify the hot flash experience. This doesn’t mean the hot flash is made up or in your head; it just recognizes that there is a mind-body connection, and it can be a powerful tool you can use to your advantage.

Also, CBT for hot flashes also focuses on the concept that any improvement is good. I think many of us, myself included, look at therapies in an all or none way, but the reality is many therapies improve things by 50% or 60%, and sometimes cognitive distortions may keep us from appreciating and enjoying that improvement.

CBT = cognitive behavioral therapy

One more thing…

"Side note: I see some healthcare professionals with large accounts disparaging CBT for hot flashes. That tells me they have not bothered to read any of the literature or somehow offering nonhormonal therapies interferes with their bottom line. I simply can't imagine a situation where I would shit on an evidence-based therapy that is safe. More science-backed options are good for women. That is the hill I will die on." - Jen Gunter

The takeaway is that CBT for insomnia is an effective treatment. Dr. C can point you in the direction of CBT-I trained professionals on the island who really know their specialty and can make a difference in your visits to the sandman.

Feel free to ask about a referral if this pertains to you…

Advocating For Your Health and Symptoms in Menopause

Taking Charge of Your Midlife Health

How To Find a Menopause Practitioner

- What Should I Look For in a Provider?
  - **Location** and accessibility
  - Accepts your **insurance**
  - **Offers telehealth** options
  - **Comfort with menopause care and women's midlife health**
  - Specialty training or certification (MSCP = gold standard)😉

Be Prepared and Speak Up

- Be Prepared and Speak Up
  - Write down symptoms and questions in advance
  - Don't wait to bring up hot flashes, sleep changes, libido, or mood
  - You deserve a provider who listens, explains, and respects your voice

What Does “Certified” Mean?

- MSCP = Menopause Society Certified Practitioner
- Credential earned by passing a rigorous competency exam
- Valid for 3 years with continuing education
- It’s your assurance that the provider is truly menopause-savvy

How To Start Your Search

Visit: www.menopause.org

Use the “Find a Menopause Clinician” tool

Look for those with the MSCP credential

Call or email the clinic to ask about insurance, services, and appointment types

Start Your Journey To Wellness

If you are located in Hawaii and would like support in your journey through menopause, please visit me at hinawellness.com.

The Menopause Society™

Attests That

Jennifer Campbell, MD

Has Met All the Criteria to be Credentialed as a Menopause Society Certified Practitioner (MSCP) Through December 31, 2027

Medical Director

Chief Operating Officer