



THE MODERN MENOPAUSE

What You Need to Know in 2026

Pallavi Khanna, MD, MSCP, FACOG

Associate Professor · Department of Obstetrics & Gynecology · UTHSC Memphis

40th Annual Conference on Contemporary Issues in OB/GYN · Destin, FL · July 2026

DISCLOSURES

COMPANY	RELATIONSHIP
Astellas	Speaker

All recommendations in this presentation reflect peer-reviewed evidence and current society guidance. Off-label uses are identified as such.

Generative AI tools were utilized in the drafting and formatting of this presentation. All content has been reviewed and edited for accuracy and intent.

LEARNING OBJECTIVES

By the end of this session you will be able to

- 01** **Summarize** the current evidence for systemic and local hormone therapy.

- 02** **Identify** non-hormonal options for vasomotor and mood symptoms.

- 03** **Discuss** multidisciplinary strategies for long-term health after menopause.

TODAY'S ROADMAP

Eight stops in forty-five minutes

- 1 The modern menopause patient
- 2 Anticipatory guidance
- 3 Hormone therapy: the evidence reset
- 4 Individualizing hormone therapy
- 5 Non-hormonal & lifestyle options
- 6 Cardiometabolic & long-term health
- 7 The empowerment approach
- 8 Teaching the next generation

SECTION ONE

The Modern Menopause Patient

Who she is, what she has read, and what she is asking us for.

A GENERATION IN TRANSITION

Menopause is not an endpoint — it is a third act

1.3M

US women enter menopause
every year

55M

are **postmenopausal** in the US
today

30+

years of life after a median
onset of age 51

Bartz, Tadikonda & Manson, JAMA 2026 · USPSTF, JAMA 2022

WHAT PATIENTS ARE ASKING FOR
NOW

FROM

Reactive symptom control



TO

Anticipatory,
individualized
partnership

FIVE THINGS SHE WANTS

01 Anticipatory guidance

Tell me what's coming

02 Nutrition & lifestyle

Not only a prescription

03 Individualized care

Built around my risks

04 The long view

My heart, bones & brain

05 To be believed

And to share the decision

25%

of women with hot flashes and
night sweats **actually seek help.**

NEJM Clinical Practice, 2020

THE CARE GAP

Under-discussed, under- taught, under-treated

Menopause symptoms have historically been poorly understood by patients and clinicians alike. The highest-yield intervention is often the simplest one—
asking the question.

SECTION TWO

Anticipatory Guidance

Naming the stage and what's normal — the most therapeutic first move.

STAGING THE TRANSITION

Staging is clinical — read the menstrual history, not the lab

Stage -3 LATE REPRODUCTIVE Cycles regular or slightly irregular Ovarian reserve falling	Stage -2 EARLY TRANSITION ≥7-day change in cycle length Variable FSH	Stage -1 LATE TRANSITION Cycles ≥60 days apart FSH high	Stage +1 EARLY POSTMENOPAUSE 12 months since last menses Reserve very low
--	---	--	--

FINAL MENSTRUAL PERIOD anchors the timeline

time →

Adapted from STRAW+10 staging · Lancet Menopause Series, 2024

WHAT'S NORMAL — AND WHAT TO NAME

The symptom clusters are real, connected, and mostly treatable

THE HEADLINE SYNDROMES

Vasomotor

~80%

Hot flashes & night sweats — often persist 7–10 years.

Genitourinary

45–77%

Dryness, painful sex, recurrent UTIs. Progressive — won't self-resolve.

ALSO COMMON — AND CONNECTED

Sleep

Fragmented sleep & fatigue, driven by night sweats.

Mood & cognition

Irritability, low mood, “brain fog.”

Musculoskeletal

Joint & muscle aches — the MSK syndrome of menopause.

Sexual health

Lower libido & arousal — multifactorial, often unaddressed.

CASE ONE

01

Diane, 47

Cycles now 3–6 weeks apart with skipped months. 3 a.m. night sweats, irritability, disrupted sleep. “Am I too young for this?”

WHAT SHE NEEDS FIRST

- **Staging:** name the late transition—no FSH needed
- **Validation:** this is real and expected
- **Contraception** still matters until 12 months out
- **The menu** of options—so she feels in control

SECTION THREE

Hormone Therapy: The Evidence Reset

What the WHI actually showed, how it was misread, and where we've landed.

WHI, THEN · 2002

The headline that reshaped a generation of care

WHAT THE TRIAL DID

161,808 women enrolled; **68,132** in the hormone trials, ages 50–79.

Estrogen + progestin arm **stopped early** for signals of breast cancer, CHD, stroke, and VTE.

Prescriptions fell **~80%** within a year.

THE FATAL MISREAD

Age 63

was the **average participant** — a decade past menopause. Findings from older women were applied to symptomatic 50-year-olds.

Manson et al., JAMA 2024 · “Then and Now,” J Clin Endocrinol Metab 2026

Same data, read by age — a different conclusion

WHAT STILL HOLDS

Not for prevention

HT is still **not** indicated to prevent cardiovascular disease, dementia, or other chronic conditions.

READ BY AGE, THE BALANCE SHIFTS

- + Started **<60 or <10 years** out — absolute risks small, adverse-event rates lower.
- + Breast-cancer signal came from **estrogen + progestin** ; estrogen-alone (post-hysterectomy) trended **lower**.

THE HONEST SUMMARY

Not a prevention drug — but for the right woman at the right time, effective for moderate-to-severe symptoms.

THE TIMING HYPOTHESIS

Same therapy, opposite balance — it depends on when you start

THE WINDOW IS OPEN

Age <60 or <10 yrs from menopause

Healthy endothelium · symptom relief · bone protection · **favorable benefit-risk.**

THE WINDOW IS CLOSING

Age >60 or >10 yrs out

Established atherosclerosis · rising CV & stroke risk · **new initiation generally discouraged.**

Final menstrual period

+10 years

Age 60+

THE 2022 BOTTOM LINE · THE MENOPAUSE SOCIETY

For women **younger than 60** or **within 10 years** of menopause onset and without contraindications, the benefit-risk ratio is **favorable** for treating bothersome VMS and preventing bone loss.”

HT remains the most effective treatment for vasomotor symptoms and the genitourinary syndrome of menopause.

NAMS / The Menopause Society Position Statement, Menopause 2022

A CRITICAL DISTINCTION

Treat symptoms — do not prescribe for prevention

✓ Treat

The **symptomatic** woman in the window—
disabling VMS, GSM, early bone loss. HT is
appropriate and effective.

✗ Don't prescribe

HT to **prevent chronic disease** in an
asymptomatic woman. USPSTF recommends
against it.

The USPSTF statement addresses **primary prevention only** —it does not speak to symptom management, which is a separate clinical decision.

US Preventive Services Task Force, JAMA 2022

WHAT HORMONE THERAPY TREATS WELL

Three indications where it is the most effective option

~75%

Vasomotor symptoms

Reduction in hot-flash frequency vs placebo—unmatched by non-hormonal agents.

GSM

Genitourinary syndrome

Low-dose vaginal estrogen reverses dryness, dyspareunia & recurrent UTIs—minimal systemic exposure.

Bone

Skeletal protection

Prevents bone loss and reduces fracture risk in early postmenopause.

Huang, Faubion & Grady, JAMA Intern Med 2025 · NAMS 2022

SECTION FOUR

Individualizing Hormone Therapy

Route, formulation, dose, and duration — where good prescribing lives.

ROUTE MATTERS

Equally effective for symptoms — not equal on risk

Transdermal

PATCH · GEL · SPRAY

Bypasses first-pass metabolism · little-to-no excess VTE or stroke signal · **preferred** with clot or CV risk, migraine, obesity, high triglycerides.

Oral

TABLET

First-pass raises clotting factors · higher VTE & stroke risk · reasonable for the **low-risk** woman who prefers a pill.

When in doubt, go through the skin. Meta-analysis shows no meaningful difference in VMS relief between routes.

BUILDING THE REGIMEN

Two questions decide the prescription

1 • Is there a uterus?

Yes → estrogen *plus* a progestogen for endometrial protection. Micronized progesterone preferred; LNG-IUD an option that also covers contraception.

No (hysterectomy) → estrogen alone — the more favorable breast-cancer arm.

2 • What dose?

Start low, titrate to symptoms. The target is the lowest effective dose that restores function—not a lab value.

Reassess at 4–12 weeks; adjust route or dose as life and risk change.

One evidence-based indication — and it isn't hot flashes

+1 satisfying sexual event per month vs placebo

The one indication: HSDD

Distressing low desire in postmenopausal women —
endorsed by 11 international societies (Global Consensus,
2019).

Not indicated for

Vasomotor symptoms

Mood or cognition

Bone density or lean mass

General wellbeing

Prescribe carefully: no FDA-approved female product · transdermal at physiologic doses · avoid oral (lipids) · avoid pellets (ACOG) ·
don't diagnose by hormone levels.

LOCAL ESTROGEN FOR GSM

3 in 4

women experience genitourinary
symptoms—and they **progress**
without treatment.

Low-dose vaginal estrogen is safe, local, and underused

- Cream, tablet, or ring — restores tissue, resolves dyspareunia
- Substantially reduces **recurrent UTIs**
- Minimal systemic absorption — **no progestogen needed**
- Appropriate for most women, including many cancer survivors after counseling

CONTRAINDICATIONS & CAUTIONS

Know the hard stops — and the off-ramps

ABSOLUTE — AVOID SYSTEMIC ESTROGEN

Breast or estrogen-sensitive cancer

Prior VTE or stroke / TIA

Coronary heart disease

Active liver disease

Unexplained vaginal bleeding

CAUTION — SLOW DOWN, PREFER TRANSDERMAL

Migraine with aura

High cardiovascular risk

Strong family history of breast cancer

High triglycerides / obesity

Gallbladder disease

Two reminders: most stops apply to *systemic*, not local vaginal estrogen · “not a hormone candidate” means **pivot to non-hormonal** , not “nothing to offer.”

DURATION OF THERAPY

There is no cliff at 5 years or age 65

No mandatory stop date. The right cadence is an **annual conversation** — continue while benefits outweigh risks, and deprescribe when she is ready, not when the calendar says so.



NAMS 2022 · Cochrane Database Syst Rev, CD004143, 2025

CASE TWO

02

Marie, 53

One year postmenopausal.

Soaking night sweats and sleep loss affecting work. Mother had breast cancer at 75. “I've heard hormones are dangerous.”

HOW WE REASON

- **In the window** — under 60, recently menopausal
- One late-onset relative is a **caution, not a contraindication**
- **Transdermal estrogen** + micronized progesterone, start low
- **Share the decision** — modest absolute risk vs. real suffering

SECTION FIVE

Non-Hormonal & Lifestyle Options

For the woman who can't — or won't — take hormones.

THE NON-HORMONAL MENU

Match the agent to her other symptoms

AGENT	CLASS	NOTES
Fezolinetant(disc.)	NK-3 antagonist	First targeted non-hormonal; FDA 2023. Monitor LFTs.
Elinzanetant	Dual NK-1 + NK-3	Newer dual antagonist; adds sleep & mood benefit.
Paroxetine 7.5 mg	SSRI	Only FDA-approved non-hormonal for VMS · 10–25% reduction.
Venlafaxine / SNRIs	SNRI (off-label)	Modest VMS relief; helpful when mood is also a target.
Gabapentin	Anticonvulsant	Bedtime dosing targets night sweats & sleep.
Oxybutynin	Anticholinergic	Modest relief; watch anticholinergic burden in older women.

Huang, Faubion & Grady, JAMA Intern Med 2025 · “disc.” = speaker disclosure applies

Resetting the hypothalamic thermostat — without hormones



Fezolinetant
(disc.)

First targeted agent (FDA 2023). Blocks NK-3 to quiet the flashes. **Monitor LFTs.**

NK-3

Elinzanetant

Adds NK-1 blockade for **sleep & mood** . >70% had ≥50% VMS reduction; effective even on endocrine therapy (OASIS).

DUAL NK-1 + NK-3

Both hormone-free — well suited to women who cannot take estrogen · Cardoso et al., NEJM 2025 (OASIS)

BEHAVIORAL THERAPIES

Real effect sizes, zero pharmacologic risk

CBT for menopause

Targets the distress and sleep loss around flashes; durable skills.

~45%

Clinical hypnosis

Reduces flash frequency vs. attention control; limited availability.

~45–55%

Layer the basics: sleep hygiene, cooling, paced breathing, limit alcohol & caffeine triggers.

Be honest: black cohosh and most OTC botanicals lack convincing evidence.

Huang, Faubion & Grady, JAMA Intern Med 2025

LIFESTYLE FOUNDATIONS

Nutrition, movement & alcohol — the daily foundation

As estrogen falls, muscle leaves and visceral fat arrives. The strategy is protective habits, not a crash diet.



NUTRITION

- **Protein first** — every meal, ~1.0–1.2 g/kg
- **Mediterranean pattern** for CV & metabolic health
- **Calcium & vitamin D** to protect bone



MOVEMENT

- **150 min / week** moderate aerobic activity
- **2× / week** resistance training
- **Strength** — the under-prescribed longevity tool



ALCOHOL

- **Less is better** — no safe lower threshold
- Worsens **VMS & sleep**
- Raises **breast-cancer risk**

SECTION SIX

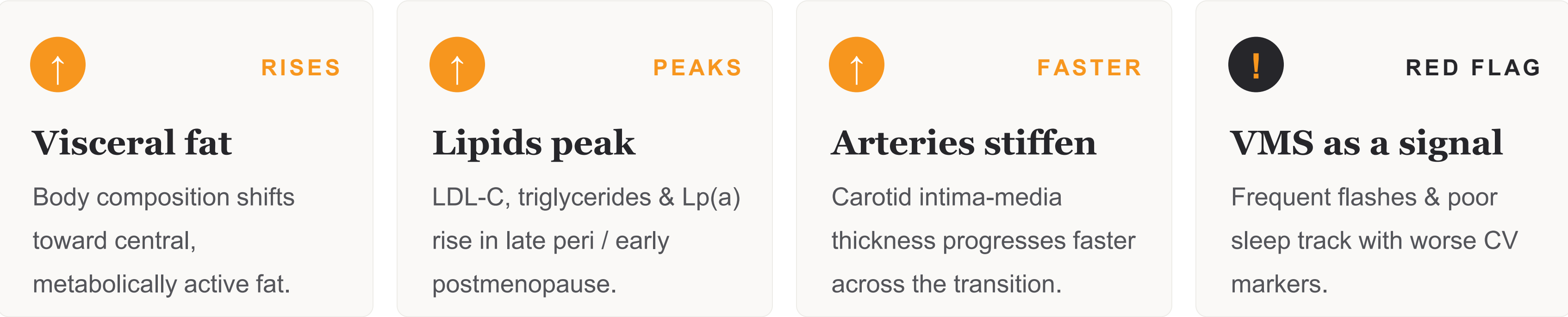
Cardiometabolic & Long-Term Health

The transition is an inflection point for the heart, the bones, and the brain.

THE MIDLIFE INFLECTION

The transition is a cardiovascular window — not just aging

Around the final menstrual period, risk markers move in the wrong direction—independent of how old she is.



LATE PERIMENOPAUSE ————— EARLY POSTMENOPAUSE

Risk markers climb across the final menstrual period — **independent of chronological age.**

El Khoudary et al., AHA Scientific Statement, Circulation 2020 · JACC Adv 2025

THE CARDIOMETABOLIC CHECK

The menopause visit is a prevention visit in disguise



Lipids

Recheck a full panel across the transition



10-year CV risk

Plus female-specific risk enhancers



Glucose / A1c

Screen for diabetes



BP, weight & waist

Track the trend over time



History flags

Preeclampsia, GDM or early menopause



Treat to target

Statin, BP control, smoking cessation

Dastmalchi et al., JACC Adv 2025 (cardiometabolic competencies for the MT)

PROTECTING BONE

2%/yr

Peak bone loss happens around the final period — **silent until a fracture.**

Screen early, build the foundation, use HT's double duty

- **DXA** at 65 — earlier with risk factors; **FRAX** to guide
- Calcium, vitamin D, weight-bearing & resistance exercise
- **HT** prevents loss & fracture in the window — double duty
- Bisphosphonates & other agents when HT isn't appropriate

PERIMENOPAUSE · GORDON RCT

17%

estradiol + progesterone

32%

placebo

developed clinically significant
depressive symptoms — **independent**
of hot-flash relief.

Prevention in perimenopause — not a depression treatment

- HT is **not FDA-approved** to treat depression at any stage
- Treat a depressive disorder as **at any life stage** — therapy, antidepressants, or both
- With bothersome VMS, an **SSRI / SNRI** can treat both at once

Validate the symptom — correct the myth

What's true

Perimenopause is a **window of vulnerability** for depression — screen and treat.

“Brain fog” is real but usually **transient**, driven by sleep loss & VMS.

Treating sleep and flashes often **restores cognition**.

What to correct

HT is **not** indicated to prevent dementia.

Late initiation may **harm** cognition — timing matters here too.

Don't prescribe hormones as a **memory drug**.

SECTION SEVEN

The Empowerment Approach

Handing the decision back — with information, not fear.

SHARED DECISION-MAKING

A five-minute sequence that builds trust and adherence

Elicit

Symptom burden & her values
— relief vs. risk tolerance.

Inform

Options & **absolute** risks —
per 1,000, not scary
percentages.

Decide

Choose together — and
document the conversation.

Revisit

A living decision — reassess
as her life and risks change.

THE “INFORM” NUMBERS

Combined HT — extra or fewer cases **per 1,000 women over 5 years** (starting age 50–59)

Breast cancer

+5

▲
more

~22 → ~27 per 1,000

Blood clots (VTE)

+7

▲
more

Oral only — transdermal: no increase

Stroke

+1

▲
more

Rare before age 60

Fragility fractures

–6

▼
fewer

A clear benefit of HT

NICE NG23 · WHI · NAMS 2022 — quote **absolute** numbers, not relative percentages, and note that transdermal estrogen avoids the clot & stroke excess.

COMPOUNDED “BIOIDENTICAL” HORMONES

Don't dismiss her — address what drove her there

WHY SHE'S THERE

- “Natural & safer” marketing
- Post-WHI fear & a training gap
- Longer visits — she feels heard

WHAT THE EVIDENCE SHOWS

- No FDA oversight of potency or safety
- Blood / saliva level testing **not recommended**
- No long-term safety trials

THE REGULATED ANSWER

Same molecules — with oversight

Transdermal estradiol

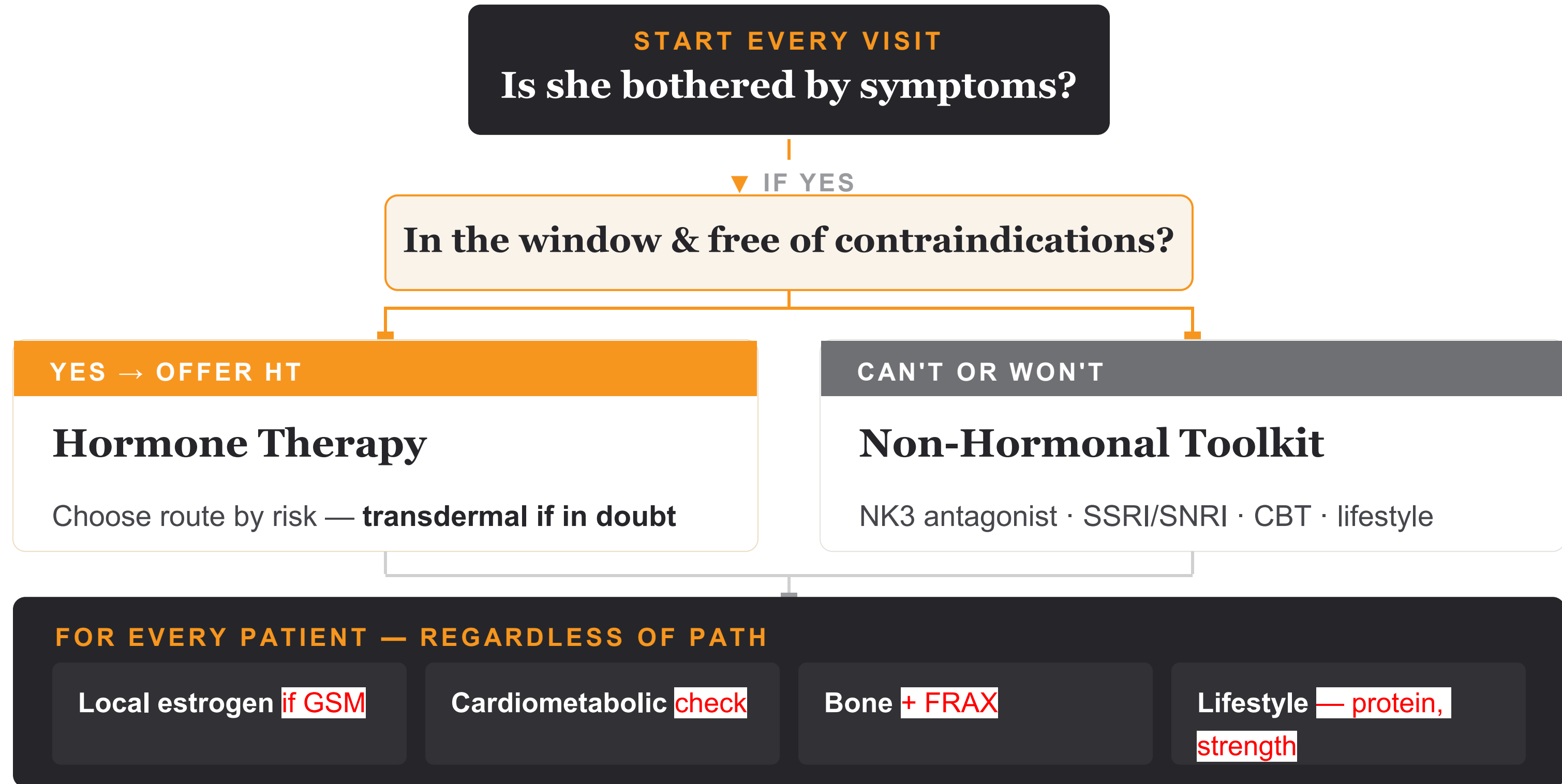
Micronized progesterone

Vaginal DHEA

ACOG Clinical Consensus No. 6, 2023 · Crandall, Mehta & Manson, JAMA 2023

AN INDIVIDUALIZED FRAMEWORK

One question in — a tailored plan out



CASE THREE

03

Sandra, 62

On transdermal HT since 51,
feeling well. “My friend says I have
to stop now that I’m past 60. Do I?”

THE MODERN ANSWER: NOT NECESSARILY

- **Reassess:** BP controlled, mammogram current, no new CVD
- Started in the window, **continued safely** — no forced stop
- Shared decision to **continue at lowest effective dose**
- Confirm bone & CV care; **revisit annually**

SECTION EIGHT

Menopause as a Teaching Laboratory

Every encounter trains the skills we most want our learners to carry.

MENOPAUSE AS A TEACHING LABORATORY

The training gap is real — and it closes fast

THE GAP

6.8%

feel **prepared** to manage menopause

34%

would **not offer HT** to an ideal candidate

31%

of OB/GYN programs **teach it**

ONE CLINIC, FOUR TEACHERS

The angry patient

→ DE-ESCALATION

The depressed patient

→ VALIDATION

The dismissed patient

→ PRESENCE

The informed patient

→ AUTONOMY

61% → 79%

Knowledge after a case-based curriculum — a large effect ($d = 1.2$). Ready-made pathways exist:

ACOG Menopause
eModule

Menopause Society
MSCP

Kling, Mayo Clin Proc 2019 · Allen, Menopause 2023 · Hickey, Lancet 2024 · Vesco, Menopause 2024

NEW TO MENOPAUSE CARE

You can manage most of it — and know when to refer



Start here

MANAGE IN PRIMARY CARE

- ✓ Diagnose **clinically** at age 45+ — no FSH needed
- ✓ Deliver lifestyle counseling — the high-yield basics
- ✓ Start **first-line HRT** in straightforward, low-risk women
- ✓ Treat GSM with topical vaginal estrogen
- ✓ Reassess, titrate & offer patient-initiated follow-up



Know your edge

REFER / SPECIALIST ADVICE

- ↗ Symptoms uncontrolled despite HRT adjustments
- ↗ Unscheduled bleeding >4–6 months despite progestogen change
- ↗ POI / early menopause where diagnosis is unclear
- ↗ Complex background — breast cancer, prior VTE or stroke
- ↗ GSM not relieved despite topical estrogen

Hamoda et al., Menopause Practice Standards, Clin Endocrinol 2022 (Standard 11)

FIVE THINGS TO CARRY HOME

The whole talk, in five lines

- 01** Ask the question — most suffering is silent.

- 02** Timing is everything — the window is <60 or <10 years out.

- 03** Treat symptoms, don't prescribe for prevention.

- 04** The non-hormonal toolkit is real — nobody is out of options.

- 05** The menopause visit is a long-term health visit — heart, bone, brain.

SELECTED REFERENCES

Evidence base

The Menopause Society (NAMS). 2022 Hormone Therapy Position Statement. *Menopause*. 2022.

Manson JE, et al. The Women's Health Initiative Randomized Trials and Clinical Practice: A Review. *JAMA*. 2024.

Bartz D, Tadikonda A, Manson JE. Opportunity for Improved Menopausal Hormone Therapy Prescribing. *JAMA*. 2026.

US Preventive Services Task Force. Hormone Therapy for Primary Prevention of Chronic Conditions. *JAMA*. 2022.

NEJM Clinical Practice. Treatment of Menopause-Associated Vasomotor Symptoms. *N Engl J Med*. 2020.

El Khoudary SR, et al. Menopause Transition and Cardiovascular Disease Risk. *Circulation* (AHA Scientific Statement). 2020.

Dastmalchi LN, et al. Improving Cardiovascular Competencies for the Menopausal Transition. *JACC Adv*. 2025.

Huang AJ, Faubion S, Grady D. Nonhormonal Treatment of Menopausal Vasomotor Symptoms. *JAMA Intern Med*. 2025.

Lambrinoudaki I, et al. Then and Now: What We Have Learned From the WHI. *J Clin Endocrinol Metab*. 2026.

Bofill Rodriguez M, et al. Long-Term Hormone Therapy. *Cochrane Database Syst Rev*. CD004143, 2025.



Thank you

Questions & discussion — the modern menopause is a conversation, not a verdict.