The Endocrine Society recommends that women with a uterus who decide to undergo menopausal hormone therapy with estrogen and progestogen be informed about risks and benefits, including the possible increased risk of breast cancer during and after discontinuing treatment. Health care providers should advise all women, including those taking menopausal hormone therapy, to follow guidelines for breast cancer screening.

Transdermal estrogen therapy by patch, gel or spray is recommended for women who request menopausal hormone therapy and have an increased risk of venous thromboembolism7mdash;a disease that includes deep vein thrombosis.

Progestogen treatment prevents uterine cancer in women taking estrogen for hot flash relief. For women who have undergone a hysterectomy, it is not necessary.

If a woman on menopausal hormone therapy experiences persistent unscheduled vaginal bleeding, she should be evaluated to rule out endometrial cancer or hyperplasia.

Medications called selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), gabapentin or pregabalin are recommended for women who want medication to manage moderate to severe hot flashes, but either prefer not to take hormone therapy or have significant risk factors that make hormone therapy inadvisable.

Low-dose vaginal estrogen therapy is recommended to treat women for genitourinary symptoms of menopause, such as burning and irritation of the genitalia, dryness, discomfort or pain with intercourse; and urinary urgency or recurrent infections. This treatment should only be used in women without a history of estrogen-dependent cancers.

Summary of Recommendations

- 1.0 Diagnosis and symptoms of menopause

  1.1 We suggest diagnosing menopause based on the clinical criteria of the menstrual cycle. (2|⊕⊕⚪⚪)

  1.2 If establishing a diagnosis of menopause is necessary for patient management in women having undergone a hysterectomy without bilateral oophorectomy or presenting with a menstrual history that is inadequate to ascertain menopausal status, we suggest making a presumptive diagnosis of menopause based on the presence of vasomotor symptoms (VMS) and, when indicated, laboratory testing that includes replicate measures of FSH and serum estradiol. (2|⊕⊕⚪⚪)

- 2.0 Health considerations for all menopausal women

  2.1 When women present during the menopausal transition, we suggest using this opportunity to address bone health, smoking cessation, alcohol use, cardiovascular risk assessment and management, and cancer screening and prevention. (Ungraded best practice statement)

- 3.0 Hormone therapy for menopausal symptom relief

  3.1 Estrogen and progestogen therapy3.1a For menopausal women < 60 years of age or < 10 years past menopause with bothersome VMS (with or without additional climacteric

symptoms) who do not have contraindications or excess cardiovascular or breast cancer risks and are willing to take menopausal hormone therapy (MHT), we suggest initiating estrogen therapy (ET) for those without a uterus and estrogen plus progestogen therapy (EPT) for those with a uterus. (2|⊕⊕⚪⚪)

Cardiovascular risk

3.1b For women < age 60 or < 10 years past menopause onset considering MHT for menopausal symptom relief, we suggest evaluating the baseline risk of cardiovascular disease (CVD) and taking this risk into consideration when advising for or against MHT and when selecting type, dose, and route of administration. (2|⊕⊕⚪⚪)

3.1c For women at high risk of CVD, we suggest initiating nonhormonal therapies to alleviate bothersome VMS (with or without climacteric symptoms) over MHT. (2|⊕⊕⚪⚪)

3.1d For women with moderate risk of CVD, we suggest transdermal estradiol as first-line treatment, alone for women without a uterus or combined with micronized progesterone (or another progestogen that does not adversely modify metabolic parameters) for women with a uterus, because these preparations have less untoward effect on blood pressure, triglycerides, and carbohydrate metabolism. (2|⊕⊕⚪⚪)

Venous thromboembolic events3.1e For women at increased risk of venous thromboembolism (VTE) who request MHT, we recommend a nonoral route of ET at the lowest effective dose, if not contraindicated (1|⊕⊕○○); for women with a uterus, we recommend a progestogen (for example, progesterone and dydrogestone) that is neutral on coagulation parameters. (1|⊕⊕⊕⚪)

Breast cancer3.1f For women considering MHT for menopausal symptom relief, we suggest evaluating the baseline risk of breast cancer and taking this risk into consideration when advising for or against MHT and when selecting type, dose, and route of administration. (2|⊕⊕⚪⚪)

3.1g For women at high or intermediate risk of breast cancer considering MHT for menopausal symptom relief, we suggest nonhormonal therapies over MHT to alleviate bothersome VMS. (2|⊕⊕⚪⚪)

Tailoring MHT3.1h We suggest a shared decision-making approach to decide about the choice of formulation, starting dose, the route of administration of MHT, and how to tailor MHT to each woman's individual situation, risks, and treatment goals. (Ungraded best practice statement)

Custom-compounded hormones3.1i We recommend using MHT preparations approved by the US Food and Drug Administration (FDA) and comparable regulating bodies outside the United States and recommend against the use of custom-compounded hormones. (Ungraded best practice statement)

3.2 Conjugated equine estrogens with bazedoxifene3.2 For symptomatic postmenopausal women with a uterus and without contraindications, we suggest the combination of

conjugated equine estrogens (CEE)/bazedoxifene (BZA) (where available) as an option for relief of VMS and prevention of bone loss. (2|⊕⊕⊕⚪)

3.3 Tibolone3.3a For women with bothersome VMS and climacteric symptoms and without contraindications, we suggest tibolone (in countries where available) as an alternative to MHT. (2|⊕⊕⚪⚪)

3.3b We recommend against adding tibolone to other forms of MHT. (1|⊕⊕⚪⚪)

3.3c We recommend against using tibolone in women with a history of breast cancer. (1|⊕⊕⚪⚪)

3.4 Clinical management of patients taking hormone therapies

Monitoring during therapy3.4a For women with persistent unscheduled bleeding while taking MHT, we recommend evaluation to rule out pelvic pathology, most importantly, endometrial hyperplasia and cancer. (1|⊕⊕⊕⚪)

3.4b We recommend informing women about the possible increased risk of breast cancer during and after discontinuing EPT and emphasizing the importance of adhering to age-appropriate breast cancer screening. (1|⊕⊕⊕⚪)

3.4c We suggest that the decision to continue MHT be revisited at least annually, targeting the shortest total duration of MHT consistent with the treatment goals and evolving risk assessment of the individual woman. (Ungraded best practice statement)

3.4d For young women with primary ovarian insufficiency (POI), premature or early menopause, without contraindications, we suggest taking MHT until the time of anticipated natural menopause, when the advisability of continuing MHT can be reassessed. (2|⊕⊕⚪⚪)

Stopping considerations3.4e For women preparing to discontinue MHT, we suggest a shared decision-making approach to elicit individual preference about adopting a gradual taper vs abrupt discontinuation. (2|⊕⊕⚪⚪)

- 4.0 Nonhormonal therapies for VMS

4.0 For postmenopausal women with mild or less bothersome hot flashes, we suggest a series of steps that do not involve medication, such as turning down the thermostat, dressing in layers, avoiding alcohol and spicy foods, and reducing obesity and stress. (2|⊕⊕⚪⚪)

4.1 Nonhormonal prescription therapies for VMS4.1a For women seeking pharmacological management for moderate to severe VMS for whom MHT is contraindicated, or who choose not to take MHT, we recommend selective serotonin reuptake inhibitors (SSRIs)/serotonin-norepinephrine reuptake inhibitors (SNRIs) or gabapentin or pregabalin (if there are no contraindications). (1|⊕⊕⊕⚪)

4.1b For those women seeking relief of moderate to severe VMS who are not responding to or tolerating the nonhormonal prescription therapies, SSRIs/SNRIs or gabapentin or pregabalin, we suggest a trial of clonidine (if there are no contraindications). (2|⊕⊕⚪⚪)

4.2 Over-the-counter and alternative nonhormonal therapies for VMS4.2 For women seeking relief of VMS with over-the-counter (OTC) or complementary medicine

therapies, we suggest counseling regarding the lack of consistent evidence for benefit for botanicals, black cohosh, omega-3-fatty acids, red clover, vitamin E, and mind/body alternatives including anxiety control, acupuncture, paced breathing, and hypnosis. (2|⊕⊕⚪⚪)

- 5.0 Treatment of genitourinary syndrome of menopause

5.1 Vaginal moisturizers and lubricants5.1a For postmenopausal women with symptoms of vulvovaginal atrophy (VVA), we suggest a trial of vaginal moisturizers to be used at least twice weekly. (2|⊕⊕○○)

5.1b For women who do not produce sufficient vaginal secretions for comfortable sexual activity, we suggest vaginal lubricants. (2|⊕⊕○○)

5.2 Vaginal estrogen therapies5.2a For women without a history of hormone- (estrogen) dependent cancers who are seeking relief from symptoms of genitourinary syndrome of menopause (GSM) (including VVA) that persist despite using vaginal lubricants and moisturizers, we recommend low-dose vaginal ET. (1|⊕⊕⊕⚪)

Practice statement5.2b In women with a history of breast or endometrial cancer, who present with symptomatic GSM (including VVA), that does not respond to nonhormonal therapies, we suggest a shared decision-making approach that includes the treating oncologist to discuss using low-dose vaginal ET. (Ungraded best practice statement)

5.2c For women taking raloxifene, without a history of hormone- (estrogen) dependent cancers, who develop symptoms of GSM (including VVA) that do not respond to nonhormonal therapies, we suggest adding low-dose vaginal ET. (2|⊕⊕⚪⚪)

5.2d For women using low-dose vaginal ET, we suggest against adding a progestogen (ie, no need for adding progestogen to prevent endometrial hyperplasia). (2|⊕⚪⚪⚪)

5.2e For women using vaginal ET who report postmenopausal bleeding or spotting, we recommend prompt evaluation for endometrial pathology. (1|⊕⊕⚪⚪)

5.3 Ospemifene5.3a For treatment of moderate to severe dyspareunia associated with vaginal atrophy in postmenopausal women without contraindications, we suggest a trial of ospemifene. (2|⊕⊕⊕⚪)

5.3b For women with a history of breast cancer presenting with dyspareunia, we recommend against ospemifene. (1|⊕⚪⚪⚪)