this & that

15

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.



Menopause

& perimenopause and HRT

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Obstetrics & Gynaecology

Diagnosis & management

Verified against ACOG · Menopause Society · NICE/BMS · SOGC — October 2026

Menopause & HRT

At a glance: the numbers to remember

51 y	7.4 y	<60 or <10 y	12–14 d	≤4 / ≤7 mm
average age of natural menopause	median duration of hot flushes (SWAN)	start HRT before 60 or within 10 y of menopause: benefits > risks	progestogen per cycle in sequential HRT	reassuring endometrium on continuous / sequential HRT (BMS)

Covers diagnosis, counselling, HRT prescribing, follow-up and bleeding on HRT. Non-hormonal care, genitourinary syndrome, bone health and premature ovarian insufficiency are in No. 16. Where societies disagree, each position carries the society name. Brand names are those residents meet most; check your formulary. Abbreviations are listed in Section 10.

01 Definitions and stages

Term	Definition	Bedside point
Menopause	Permanent cessation of menses from loss of ovarian follicular activity. Diagnosed **retrospectively** after 12 months of amenorrhoea.	Average age ≈51 in textbooks; 49.9 y in the US (ACOG 2026); 46–52 worldwide.
Perimenopause (menopausal transition)	From the first cycle changes to 12 months after the final period. STRAW+10: early = persistent ≥7-day difference in consecutive cycle lengths; late = amenorrhoea ≥60 days. ESE 2025: cycles outside 21–35 days.	Median onset ≈47.5 y; lasts ≈4–5 y (2–8). Up to 25% of long cycles are still ovulatory, so she still needs contraception.
Postmenopause	From the final menstrual period onward.	GSM worsens with time if untreated; VMS usually wane.
Early menopause	Menopause at 40–45 y.	≈10% of women. HRT at least to ≈51 y unless contraindicated.
POI	Loss of ovarian function before 40 y.	Intermittent function in ≈25%; spontaneous pregnancy ≈5%. No. 16.
Surgical / iatrogenic	Bilateral oophorectomy, chemotherapy, pelvic radiotherapy, GnRH analogues.	Abrupt, more severe VMS (≈90% in year 1 after BSO).
GSM	Genitourinary syndrome of menopause: vulvovaginal dryness, dyspareunia, urgency, dysuria, recurrent UTI.	≥50% of postmenopausal women; does not settle without treatment. No. 16.

- Hot flushes last a median of 7.4 years (SWAN), and longer than 11 years when they begin in early perimenopause. Counsel on this before discussing "how long" to treat.
- Oestradiol does not fall steadily through the transition. It stays normal or high until about a year before the final period, so a single oestradiol or FSH value in a cycling woman means little.

02 Diagnosis and assessment

IF	THEN
Over 45 with typical symptoms	• Diagnose **clinically**: perimenopause if VMS + irregular periods; menopause if no period for 12 months (or symptoms alone after hysterectomy) • **No FSH**, AMH, inhibin, oestradiol, antral follicle count or ovarian volume (NICE, ESE 2025)

IF	THEN
40–45 with symptoms incl. cycle change	Consider FSH (NICE). A raised FSH (Williams: >40 IU/L) supports ovarian failure; a normal value does not exclude the transition.
Under 40	Suspected POI → No. 16, Section 4. Exclude pregnancy, hyperprolactinaemia, thyroid disease and hypothalamic amenorrhoea.
On combined hormonal contraception or high-dose progestogen	FSH is unreliable (NICE). Diagnose clinically. For contraception decisions → Section 7.
Flushing that is atypical, resistant to HRT or with other features	• Check TSH; review drugs (tamoxifen, aromatase inhibitors, GnRH analogues) • Consider phaeochromocytoma, carcinoid, lymphoma/leukaemia, infection, alcohol (Speroff, Berek)
Abnormal bleeding in perimenopause	Investigate as abnormal uterine bleeding (No. 08). Do not treat irregular cycles with HRT: it neither regulates anovulatory bleeding reliably nor contracepts (Speroff).

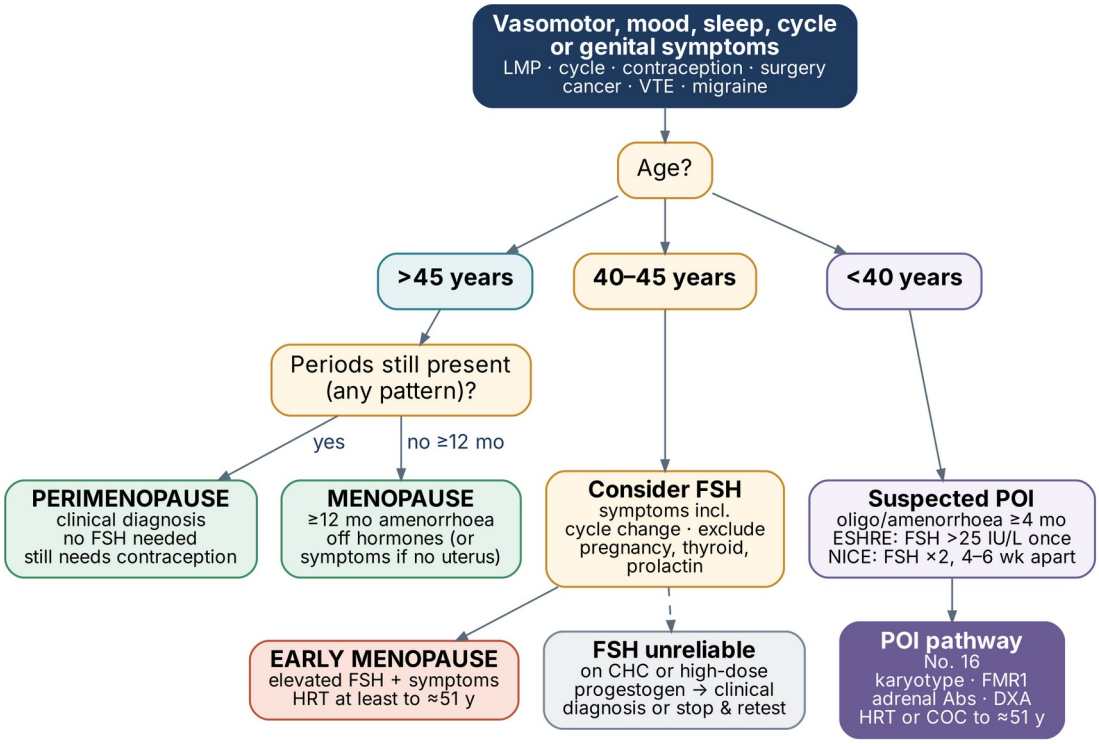


Figure 1. *Diagnosing perimenopause, menopause, early menopause and POI by age.*

Assessment before any treatment

IF	THEN
Every woman	• Symptom burden: VMS frequency, sleep, mood, GSM, sexual function, joint pain • LMP and bleeding pattern; contraception needs; surgery (hysterectomy, ablation, BSO) • BP, BMI, smoking, alcohol; breast screening up to date per national programme • Personal/family history: VTE, breast or endometrial cancer, CVD/stroke, migraine, liver or gallbladder disease

IF	THEN
Risk tools	• Fracture risk (FRAX) and CV risk before starting HRT (ESE 2025); ACOG names the ACC cardiovascular risk calculator • Breast cancer risk: Gail (NCI BCRAT) or Tyrer–Cuzick (ACOG CPG 13) • No routine thrombophilia screen, mammogram, pelvic scan or endometrial biopsy before HRT unless otherwise indicated
Strong family history of VTE or known thrombophilia	Consider haematology advice before HRT (NICE).

03 Counselling: benefits, risks and contraindications

HRT is the most effective treatment for VMS and also treats GSM and prevents bone loss. In healthy women under 60 or within 10 years of menopause, benefits outweigh risks (ACOG CPG 13, The Menopause Society 2022). ACP 2026 makes oestrogen ± progestogen the only strong first-line recommendation for VMS (high-certainty evidence). In Nov 2025 the FDA began removing the boxed warnings on CVD, breast cancer and dementia; the first relabelled products were approved in Feb 2026.

Outcome	Effect of HRT	Numbers to quote	What changes the risk
Breast cancer	Combined: small ↑ with duration, higher in current users, persists ≥10 y after stopping; very small ↑ in breast cancer deaths. Sequential < continuous. Oestrogen-only: little or no change (NICE; WHI CEE-alone HR 0.78).	5 years of combined HRT from 50 → about 20 extra breast cancers per 1000 women by age 69 (1 in 50 users). Full figures in the table below.	Duration, combined vs oestrogen-only, current use. Micronised progesterone and dydrogesterone show lower risk in observational data (E3N, Vinogradova 2020); NICE judges the evidence insufficient. Vaginal oestrogen: no effect.
VTE	↑ with oral; no ↑ with transdermal at standard doses.	WHI oral E+P: +10 per 1000 over 5.6 y (RR 2.03); oestrogen-only +5 per 1000. Oral aOR 1.58, transdermal 0.93 (Vinogradova 2019).	Use transdermal if BMI >30 or any VTE risk factor.
Stroke	Oral: small ↑ with dose, duration and age at start. Transdermal: unlikely to ↑.	WHI: E+P +5 per 1000, oestrogen-only +8 per 1000 (all ages). Under 60: <0.5 extra per 1000 users/year. Tibolone HR 2.19 (LIFT).	Prefer transdermal; avoid tibolone if stroke risk.
CHD	No ↑ when started <60 (NICE); ↑ if started ≥60 or >10 y after menopause.	NICE: 9 vs 10 per 1000 over 5 y (not significant). Started <60 or <10 y: CHD RR 0.52 (Cochrane).	Timing of start (ELITE, KEEPS). Not for CVD prevention.
Endometrial cancer	Oestrogen alone with a uterus ↑ sharply. Continuous combined ↓; sequential slight ↑.	NICE per 1000 over 5 y: no HRT 4; continuous combined 1; sequential 8.	Adequate progestogen; avoid long-cycle regimens.
Ovarian cancer	Very slight ↑ (NICE).	≈1 extra per 1000.	—
Dementia	Combined: may ↑ if started ≥65. Oestrogen-only: unlikely to ↑ (NICE).	WHIMS: EPT doubled probable dementia in women ≥65.	Not an indication to start HRT.
Fracture	↓ while taking HRT; benefit fades after stopping.	WHI hip fracture HR 0.66.	First-line bone option ≤60 (NOGG 2024).
Type 2 diabetes · mortality	No ↑ in T2DM (NICE); WHI showed ↓. No change in all-cause mortality at 18 y (WHI).	—	—

Breast cancer: numbers for counselling

Number of women per 1000 who are diagnosed with breast cancer between age 50 and 69, if HRT is started at 50. The figure in brackets is the extra cases caused by HRT.

HRT taken from age 50	NICE 2024	MHRA 2019
None	59	63
Oestrogen-only for 5 years	69 (+10)	68 (+5)
Combined for 5 years	79 (+20)	Sequential 77 (+14) Continuous combined 83 (+20)
Combined for 10 years	92 (+33)	About twice the 5-year excess

How to say it

- "If 1000 women start combined HRT at 50 and take it for 5 years, about 80 will be diagnosed with breast cancer by 69, compared with about 60 who never take HRT. That is about 20 extra cases, or 1 in every 50 women who take it."
- Oestrogen-only HRT (after hysterectomy) adds far fewer cases, and in the WHI trial it lowered the risk.
- The two columns differ slightly because NICE used its own 2024 evidence review and the MHRA used the 2019 Collaborative Group meta-analysis. Quote one source consistently.

Contraindications

IF	THEN
Do not use systemic HRT	• Current, past or suspected breast cancer • High-grade or advanced endometrial cancer, uterine sarcoma, low-grade serous or endometrioid ovarian cancer, granulosa cell tumour (ACOG) • Stage I–II endometrial cancer or high-grade serous ovarian cancer: HRT can be considered with gynaecological oncology input (ACOG) • Undiagnosed genital bleeding (investigate first) • CHD, or active or past arterial disease: MI, angina, stroke, TIA (ACOG). NICE: not absolute; HRT may be offered by a menopause specialist (off-label) • Active liver disease; pregnancy • Untreated hypertension (treat, then reassess)
Previous VTE or known thrombophilia	ACOG: contraindication to MHT. UK: oral contraindicated; transdermal standard-dose oestradiol may be considered after haematology advice. Otherwise non-hormonal.
Caution (prefer transdermal, lowest effective dose)	• Gallbladder disease, hypertriglyceridaemia, BMI >30, smoker, diabetes, migraine (with or without aura) • Endometriosis, fibroids, SLE, high familial breast cancer risk: specialist discussion
Relative contraindication and other options have failed	HRT may still be appropriate after a documented risk–benefit discussion (Berek).

04 Prescribing HRT

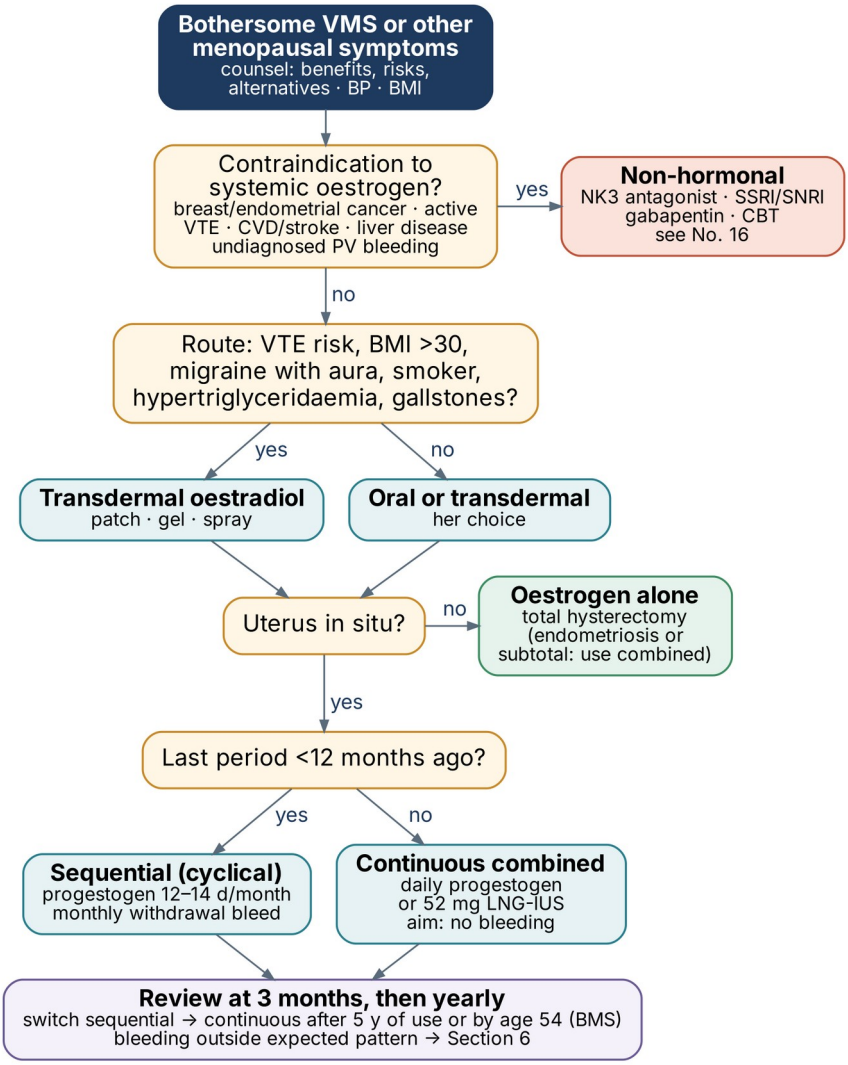


Figure 2. *Choosing an HRT regimen: route, oestrogen alone or combined, sequential or continuous.*

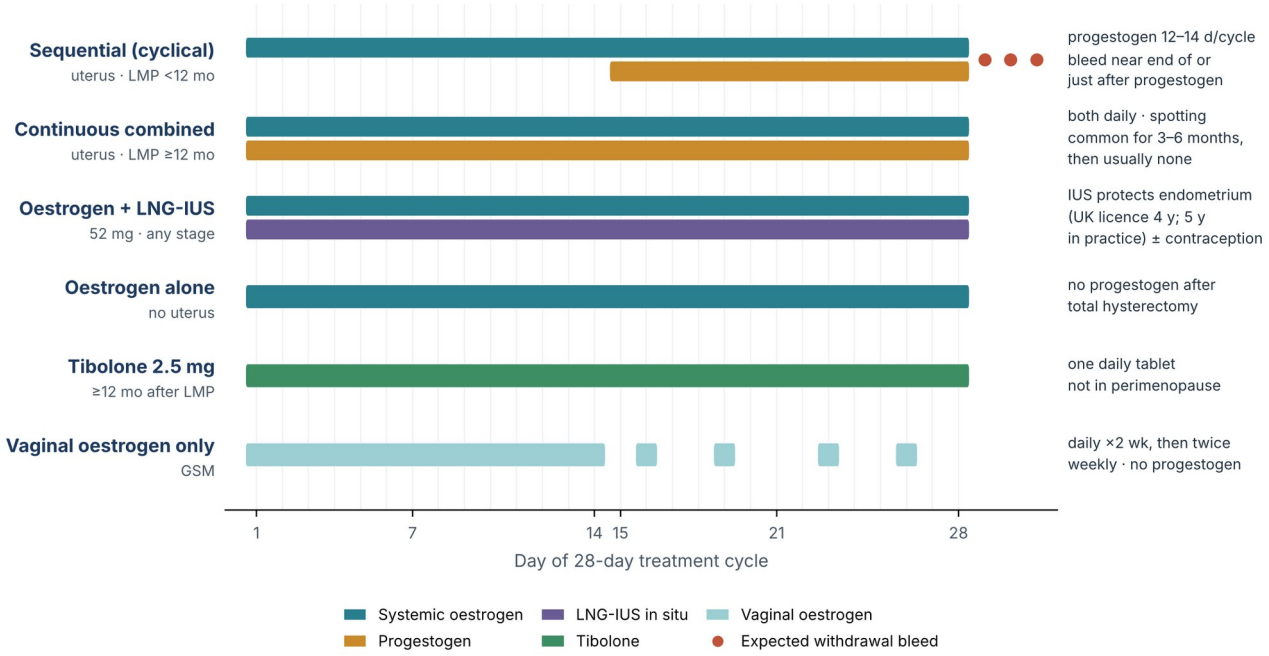


Figure 3. *Where each regimen sits across a 28-day cycle.*

Oestrogen: doses by strength (start low or medium; reassess after 2–3 months)

Preparation	Low	Medium (standard)	High
Oral estradiol (Progynova, Estrofem, Elleste Solo)	0.5 mg	1–2 mg	3–4 mg (off-licence)
Estradiol patch (Evorel, Estradot, Climara)	25–37.5 µg	50–75 µg	100 µg
Estradiol gel: Oestrogel pump	1 pump	2–3 pumps	4 pumps
Estradiol gel: Sandrena sachet	0.5 mg	1 mg	>1 mg (off-licence)
Estradiol spray (Lenzetto, Evamist)	1–2 sprays	3 sprays	>3 (off-licence)
Conjugated oestrogens (Premarin)	0.3–0.45 mg	0.625 mg	1.25 mg

Sources: BMS Practical prescribing (Aug 2026); Williams Gynecology. Rough equivalence: estradiol 1 mg oral ≈ 50 µg patch ≈ 2 pumps gel ≈ CEE 0.625 mg. Younger women, surgical menopause and POI often need medium to high doses.

Progestogen: doses that protect the endometrium

Progestogen	Sequential (per 28 days)	Continuous (daily)	Notes
Micronised progesterone (Utrogestan, Prometrium)	200 mg nocte, days 1–12 (300 mg with high-dose oestrogen)	100 mg nocte (200 mg with high-dose oestrogen)	Take at bedtime (sedating). Vaginal use off-licence, same dose. No breast cancer excess in E3N (observational).
Dydrogesterone (Duphaston; in Femoston)	10 mg × 12–14 days	5 mg (2.5 mg with low-dose oestrogen)	Femoston 1/10, 2/10 (sequential); Femoston-conti 1/5, 0.5/2.5. Lowest VTE and breast signals in UK data (Vinogradova).
Medroxyprogesterone (Provera)	10 mg × 12–14 days (Speroff: 5 mg × 14 days)	2.5 mg	CEE + MPA (WHI regimen): highest VTE signal (aOR 2.10).
Norethisterone / NETA (Primolut-N; in Kliofem, Activelle)	5 mg × 12 days (≥1 mg × 10 days with low-dose oestrogen)	0.5–1 mg	Highest breast cancer signal in UK data (aOR 1.88). Off-label: 3 × 350 µg POP daily.
LNG-IUS 52 mg (Mirena)	—	Continuous	UK licence for HRT: 4 years; 5 years is common practice (BMS). No evidence for 13.5 or 19.5 mg devices. Also contraceptive.
Drospirenone (Angeliq)	—	2 mg with estradiol 1 mg	Antimineralocorticoid; useful if bloating or raised BP.

Sources: BMS Progestogens and endometrial protection (2026); Speroff Table 17.9. Fewer than 10–12 days of progestogen per month, or progestogen every 3 months (long-cycle), raises hyperplasia risk: the Scandinavian Long Cycle Study stopped early with 12.5% endometrial pathology. Use such regimens only with surveillance.

Choosing route and regimen

IF	THEN
BMI >30, VTE risk, smoker, diabetes, hypertension, migraine, gallbladder disease, high triglycerides, malabsorption, low libido	**Transdermal oestradiol** (patch, gel or spray). No hepatic first pass, no rise in SHBG or clotting factors.
No risk factors	Oral or transdermal by her preference. Oral raises SHBG and triglycerides but improves LDL/HDL.
ACP 2026 on route	Route does not change efficacy. The RCTs were too short to show that transdermal is safer; the lower VTE and stroke risk rests on observational data (Vinogradova 2019), which NICE and the BMS accept.

IF	THEN
Uterus, LMP <12 months ago (perimenopause)	**Sequential** combined: oestrogen daily + progestogen 12–14 days. Expect a withdrawal bleed in 80–90%.
Uterus, LMP ≥12 months ago	**Continuous combined**. Irregular bleeding in 40–60% in the first 6 months, 10–20% at 1 year (Speroff).
On sequential HRT for a while	Switch to continuous combined after 5 years of use or by age 54, whichever first (BMS/RCOG 2024).
Total hysterectomy	Oestrogen alone.
Hysterectomy for endometriosis, subtotal hysterectomy or endometrial ablation	**Combined** HRT (continuous combined or tibolone): residual endometrium or endometriosis can be stimulated (EMAS 2025, Speroff).
Needs contraception too	LNG-IUS 52 mg + oestrogen covers both. Otherwise HRT plus a separate method (Section 7).
Tibolone 2.5 mg daily (UK/EU; not FDA-approved)	• Only ≥12 months after the last period; no withdrawal bleed intended • Treats VMS and bone; may help libido • Avoid with stroke risk or over 60 (LIFT, women 60–85: stroke HR 2.19) and after breast cancer (LIBERATE: recurrence HR 1.40)
Conjugated oestrogens/bazedoxifene (Duavee; USA)	Progestogen-free option for women with a uterus; treats VMS and prevents bone loss. ACOG CPG 13: conditional alternative to oestrogen–progestogen.
Requests "bioidentical" hormones	Prescribe regulated estradiol + micronised progesterone (body-identical). **No compounded products**, pellets or salivary level testing (ACOG CC 6, BMS).

05 Follow-up, side effects and stopping

IF	THEN
Review	• At 3 months, then yearly (NICE, ACOG CPG 13): symptoms, bleeding, side effects, BP, weight, adherence • Breast screening as per national programme; no extra imaging because of HRT • No routine oestradiol or FSH levels; FSH cannot be used to titrate dose
VMS persist at 3 months	• Check adherence and technique (gel on clean dry skin, patch adhesion, sites) • Increase the oestrogen dose one step; wait 2–3 months before judging • Transdermal only: oestradiol level can help; aim ≈40–100 pg/mL (≈150–370 pmol/L) (Williams, Speroff) • High level with persisting symptoms → look for another cause
Low mood or depressive symptoms	• Perimenopause: HRT may improve depressive symptoms and augment antidepressants; postmenopause: no better than placebo (ACOG CPG 13) • Major depression, or depression as the main symptom → SSRI/SNRI and CBT per depression guidelines • NICE: consider HRT, or CBT, for depressive symptoms that start with other menopausal symptoms but do not meet criteria for depression; manage depression with NICE depression guidance
Breast tenderness	Usually settles by 3 months. Lower the oestrogen dose or change progestogen.

IF	THEN
Mood change, bloating, PMS-like symptoms (progestogen intolerance)	Switch to micronised progesterone or dydrogesterone, to LNG-IUS, or from sequential to continuous; drospirenone if bloating.
Headache or migraine worse	Transdermal, steady dose, continuous regimen.
BP rises after starting oral oestrogen (≈5%, CEE)	Switch to transdermal; recheck BP (Comprehensive Gynecology).
Low sexual desire despite adequate oestrogen	→ No. 16, Section 2 (testosterone).
How long?	• **No arbitrary stop age or duration** (ACOG, The Menopause Society, NICE). Review yearly with shared decision-making • Continuing beyond 60–65 is acceptable for persistent VMS or bone protection, after counselling • NICE: discuss likely duration at the start, rediscuss at every review, and use the lowest effective dose • Breast cancer risk rises with duration of combined HRT; transdermal and lower doses limit VTE and stroke risk • **ACP 2026** (internal medicine) differs: common practice is not to start after 60 or >10 years from the last period and to limit use to 3–5 years, with regular reassessment
Stopping	• Abrupt or tapered are both acceptable (ACOG). VMS recur in ≈50% either way (RCTs; Speroff). NICE: gradual reduction may limit short-term recurrence • Offer non-hormonal options if symptoms return
First start ≥60 or >10 years after menopause	Individualise. Start low-dose transdermal; consider non-hormonal first. Never start for CVD or dementia prevention.

06 Bleeding on HRT

Based on the BMS joint guideline on unscheduled bleeding on HRT (2024, with RCOG, CoSRH and UK gynaecological cancer and endoscopy societies). Risk factors for endometrial cancer: **major** = BMI ≥40, Lynch or Cowden syndrome; **minor** = BMI 30–39, diabetes, PCOS.

IF	THEN
Sequential HRT: bleed near the end of or just after the progestogen days	Expected. No investigation.
Continuous combined: irregular bleeding in the first 6 months	Expected. Reassure and review.
First 6 months of HRT, or within 3 months of a change; low risk	• Check adherence, missed doses, drug interactions (enzyme inducers), vomiting or diarrhoea, cervical screening and STI risk • **Adjust for up to 6 months:** raise the progestogen dose, change progestogen, or use LNG-IUS; sequential with heavy or early bleeds → longer or stronger progestogen
Bleeding starts >6 months after starting or >3 months after a change; or persists after adjustment; or is heavy/prolonged; or 2 minor risk factors	**TVS within 6 weeks.**

IF	THEN
1 major or 3 minor risk factors (any pattern)	**Urgent suspected cancer referral** for hysteroscopy and biopsy.
TVS endometrium ≤4 mm (continuous) or ≤7 mm (sequential)	Low risk: adjust the regimen and review. Scan sequential users at the end of the progestogen phase or just after the bleed (Speroff).
Endometrium above these thresholds, focal lesion, or bleeding persists despite a normal scan	Endometrial biopsy and/or outpatient hysteroscopy. A thin endometrium with persistent bleeding can hide a polyp or submucous fibroid (Speroff).
USA (ACOG CPG 13)	Unscheduled bleeding is common in the first 3 months. Evaluate for EIN/atypical hyperplasia and cancer if bleeding starts or continues after 6 months; follow ACOG postmenopausal bleeding guidance.
Bleeding after ≥12 months of amenorrhoea off HRT	Postmenopausal bleeding pathway (NICE NG12: suspected cancer referral if ≥55).

07 Special situations

Contraception in the perimenopause (details: No. 09)

IF	THEN
Any woman on HRT who is still cycling	**HRT is not a contraceptive.** Use LNG-IUS 52 mg (also the progestogen), or HRT plus another method. The etonogestrel implant contracepts but does not protect the endometrium (ACOG).
When can she stop contraception?	• Non-hormonal method: after 2 years of amenorrhoea if <50, 1 year if ≥50; all women can stop at 55 (CoSRH); ACOG: assess need until 55 • Over 50, amenorrhoeic on POP, implant or LNG-IUS: single FSH ≥30 IU/L → continue 1 more year, then stop (CoSRH)
Switching CHC to HRT	• CoSRH: switch at 50; FSH is unreliable on CHC • Speroff: FSH on day 6–7 of the pill-free week >20 IU/L suggests it is time to switch (variable accuracy)

Other situations

IF	THEN
Breast cancer survivor	Systemic HRT contraindicated (ER-positive; BMS 2025); stop HRT at diagnosis (NICE). HABITS stopped early for excess recurrence. Non-hormonal and vaginal options: No. 16.
High familial breast cancer risk, no cancer	• HRT is not contraindicated (NICE, BMS); counsel on individual risk; prefer oestrogen-only where possible, or micronised progesterone/dydrogesterone • **ACP 2026 lists family history of breast cancer and BRCA mutation as contraindications**; expect US internists to follow this
Previous VTE or thrombophilia	No oral HRT. Transdermal after haematology advice (NICE), or non-hormonal. ACOG: contraindication.
Previous CHD or stroke	ACOG: contraindication. NICE: a menopause specialist may discuss and offer HRT (off-label).

IF	THEN
Migraine (including with aura)	Not a contraindication to HRT (unlike CHC). Transdermal, steady dose, continuous regimen.
Endometriosis	Combined HRT even after hysterectomy; continuous combined or tibolone (EMAS 2025). Avoid oestrogen-only.
Fibroids	HRT may enlarge fibroids; lowest effective transdermal dose; scan if bleeding or growth.
Epilepsy on lamotrigine	Oestrogen can lower lamotrigine levels: monitor levels and seizure control; transdermal preferred (EMAS 2026).
Diabetes, obesity, hypertension	Transdermal; HRT does not increase T2DM risk (NICE). Treat BP before starting.
Liver disease	Avoid HRT in active disease; transdermal if stable.
Ramadan fasting	Patches and gel are unaffected. Oral HRT and night-time progesterone fit at iftar or suhoor.

08 Do not

- Use FSH, AMH, inhibin or oestradiol to diagnose menopause in women over 45, or FSH in women on CHC.
- Give oestrogen alone to a woman with a uterus, after endometrial ablation or subtotal hysterectomy, or after hysterectomy for endometriosis.
- Use HRT as contraception or to regulate perimenopausal cycles.
- Give progestogen for fewer than 10–12 days a month, or every 3 months, without endometrial surveillance.
- Prescribe compounded "bioidentical" hormones, oestradiol pellets, or titrate to salivary levels.
- Start HRT to prevent CVD or dementia, or set an arbitrary stop age.
- Use oral HRT after VTE, or tibolone with stroke risk, after breast cancer or before 12 months of amenorrhoea.
- Ignore bleeding that starts after 6 months of HRT or more than 3 months after a change.

09 Where the guidelines differ

Topic	USA (ACOG / TMS / ACP / FDA)	UK (NICE / BMS / RCOG / MHRA)	Other (SOGC / ESE / IMS)
Boxed warning	Removed for CVD, breast cancer, dementia (FDA 2025–26)	No boxed warnings; MHRA 2019 breast cancer figures	SOGC welcomed FDA change (2025)
Duration and age at start	ACOG/TMS: no fixed limit. ACP: avoid starting >60 or >10 y; 3–5 y common	No arbitrary limit (NICE)	—
Previous CHD, stroke or VTE	ACOG: contraindications	CHD/stroke: menopause specialist may offer HRT (off-label). VTE: transdermal after haematology advice	—
Family history or BRCA	ACP: contraindication	Not a contraindication; HRT to 51 after RRSO (NICE, BMS)	—
LNG-IUS as HRT progestogen	Off-label; replace at 5 y (ACOG)	Licensed 4 y; BMS 5 y	Speroff: up to 10 y (textbook)
Unscheduled bleeding	Evaluate if bleeding starts or continues after 6 months (ACOG)	BMS triage: risk factors + TVS ≤4 mm continuous / ≤7 mm sequential	—

10 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACC	American College of Cardiology	ER	oestrogen receptor	PB	Practice Bulletin (ACOG)
ACOG	American College of Obstetricians & Gynecologists	ESE	European Society of Endocrinology	PCOS	polycystic ovary syndrome
ACP	American College of Physicians	ESHRE	European Society of Human Reproduction	PMS	premenstrual syndrome
AMH	anti-Müllerian hormone	FDA	US Food and Drug Administration	POI	premature ovarian insufficiency
aOR	adjusted odds ratio	FMR1	fragile X gene	POP	progestogen-only pill
BCRAT	Breast Cancer Risk Assessment Tool	FRAX	fracture risk assessment tool	RCOG	Royal College of Obstetricians & Gynaecologists
BMI	body mass index	FSH	follicle-stimulating hormone	RRSO	risk-reducing salpingo-oophorectomy
BMS	British Menopause Society	GnRH	gonadotrophin-releasing hormone	SHBG	sex hormone-binding globulin
BP	blood pressure	GSM	genitourinary syndrome of menopause	SLE	systemic lupus erythematosus
BSO	bilateral salpingo-oophorectomy	HDL	high-density lipoprotein	SNRI	serotonin–noradrenaline reuptake inhibitor
CBT	cognitive behavioural therapy	HR	hazard ratio	SOGC	Society of Obstetricians & Gynaecologists of Canada
CC	Clinical Consensus (ACOG)	HRT	hormone replacement therapy	SSRI	selective serotonin reuptake inhibitor
CDC	US Centers for Disease Control	IMS	International Menopause Society	STI	sexually transmitted infection
CEE	conjugated equine oestrogens	IU	international units	STRAW	Stages of Reproductive Aging Workshop
CHC	combined hormonal contraception	LDL	low-density lipoprotein	SWAN	Study of Women's Health Across the Nation
CHD	coronary heart disease	LMP	last menstrual period	T2DM	type 2 diabetes
COC	combined oral contraceptive	LNG-IUS	levonorgestrel intrauterine system	TIA	transient ischaemic attack
CoSRH	College of Sexual & Reproductive Healthcare	MHRA	UK medicines regulator (MHRA)	TMS	The Menopause Society (ex-NAMS)
CPG	Clinical Practice Guideline (ACOG)	MHT	menopausal hormone therapy	TSH	thyroid-stimulating hormone
CV	cardiovascular	MI	myocardial infarction	TVS	transvaginal ultrasound
CVD	cardiovascular disease	MPA	medroxyprogesterone acetate	UTI	urinary tract infection
DXA	dual-energy X-ray absorptiometry	NCI	US National Cancer Institute	VMS	vasomotor symptoms
E+P	oestrogen plus progestogen	NETA	norethisterone acetate	VTE	venous thromboembolism
EIN	endometrial intraepithelial neoplasia	NICE	National Institute for Health & Care Excellence	WHI	Women's Health Initiative
EMAS	European Menopause & Andropause Society	nocte	at night	WHIMS	WHI Memory Study
EPT	oestrogen–progestogen therapy	NOGG	National Osteoporosis Guideline Group		

11 Sources

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Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.