this & that

16

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.

Menopause Beyond HRT

& non-hormonal care, GSM, bone and POI

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

Menopause beyond HRT

At a glance: the numbers to remember

8–12 wk	LFTs	No progestogen	T ≤ −2.5	≈51 y
time to judge a non-hormonal drug (ACP)	fezolinetant: baseline, monthly ×3, then months 6 and 9	needed with low-dose vaginal oestrogen	osteoporosis on DXA: treat	continue HRT or CHC in POI at least to this age

Companion to No. 15 (Menopause & HRT). Covers non-hormonal treatment of vasomotor symptoms, genitourinary syndrome and sexual function, bone health, premature ovarian insufficiency and women who cannot take HRT. Where societies disagree, each position carries the society name. Abbreviations are listed in Section 8.

01 Non-hormonal treatment of vasomotor symptoms

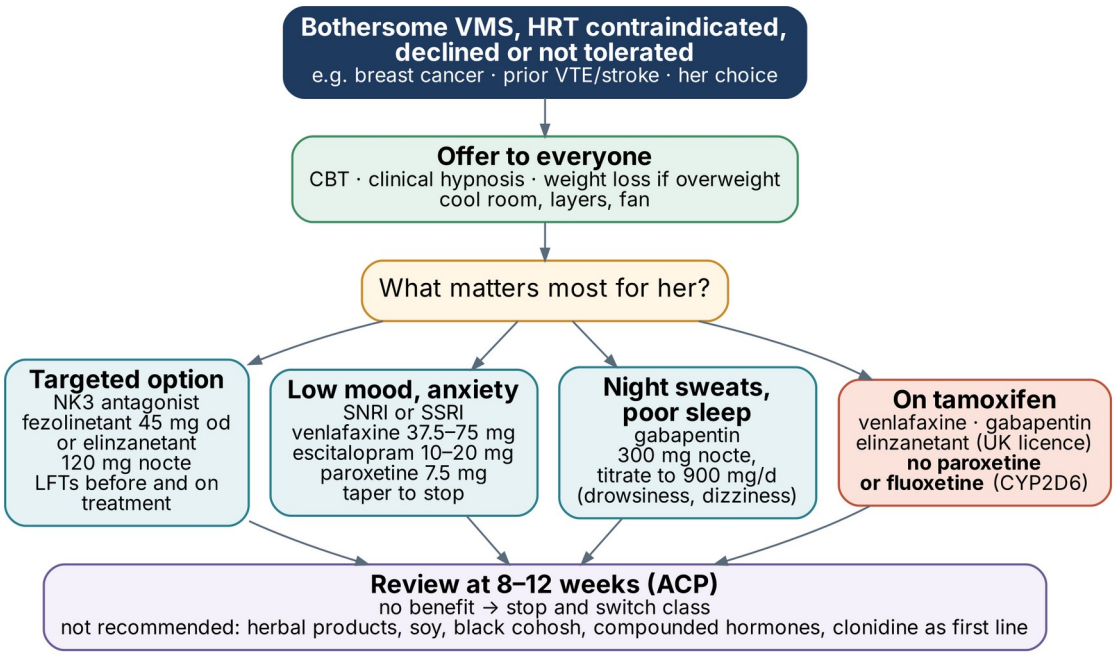


Figure 1. *Choosing a non-hormonal treatment when HRT is not used.*

Agent	Dose	Status	Watch for
Fezolinetant (Veoza, Veozah) NK3 antagonist	45 mg once daily	FDA, EMA, MHRA. NICE TA1143 (Mar 2026): when HRT unsuitable. ACOG: recommended	**LFTs** (ALT, AST, ALP, bilirubin) at baseline and monthly ×3, then periodically (US: months 6 and 9). Do not start if ALT/AST or bilirubin ≥2× ULN; stop if >5× ULN, or >3× with bilirubin >2× ULN or symptoms. Not in cirrhosis, eGFR <30 (US) or with CYP1A2 inhibitors (fluvoxamine, ciprofloxacin).
Elinzanetant (Lynkuet) NK1/NK3 antagonist	120 mg at bedtime (60 mg with moderate CYP3A4 inhibitors)	MHRA 2025 (+ VMS from adjuvant endocrine therapy, 2026); FDA Oct 2025; NICE pending	Avoid strong CYP3A4 inhibitors, inducers, grapefruit; not in severe hepatic impairment. LFTs at baseline (US: repeat at 3 months). Somnolence, fatigue.
Paroxetine SSRI	7.5 mg nocte (Brisdelle, FDA); 10 mg (BMS)	Only FDA-approved antidepressant for VMS	**Not with tamoxifen** (CYP2D6). Nausea, sexual dysfunction.

Agent	Dose	Status	Watch for
Venlafaxine SNRI	37.5 mg → 75 mg daily (max 150 mg)	Preferred with tamoxifen (BMS); ACP 2026 second-line	Nausea, dry mouth, BP; taper to stop.
Desvenlafaxine SNRI	50–150 mg daily	USA; ACP second-line	As venlafaxine.
Escitalopram / citalopram SSRI	10–20 mg / 10–30 mg	Off-label	QT with citalopram >20 mg in older women.
Gabapentin	100–300 mg nocte → max 900 mg/day (e.g. 300 mg day + 600 mg night)	Off-label; good for night sweats	Drowsiness, dizziness; UK Schedule 3; reduce in renal impairment.
Oxybutynin	2.5 mg bd → 5 mg bd	Off-label (TMS Level I–II); ACP: no recommendation	Anticholinergic: avoid ≥65 or with cognitive concern.
Clonidine	25 µg bd → max 50 µg tds	Weak; not first line (NICE, TMS, ACOG)	Hypotension, dry mouth; withdraw slowly (rebound hypertension).

IF	THEN
Non-drug options with evidence	• **CBT** (menopause-specific): NICE, TMS Level I, ACOG • **Clinical hypnosis** (TMS, ACOG); weight loss if overweight; stellate ganglion block (TMS Level II–III) • Sleep problems with VMS: menopause-specific CBT (NICE, ACOG); mindfulness and exercise for sleep and mood (ACOG; not for VMS)
Where the societies place drugs	• **ACOG CPG 13 (2026):** SSRIs/SNRIs and NK antagonists recommended (strong); gabapentin suggested if others fail • **ACP 2026:** venlafaxine/desvenlafaxine second line; escitalopram, paroxetine, gabapentin, fezolinetant, elinzanetant third line (NK antagonists placed third on cost: fezolinetant judged low value). Judge response at 8–12 weeks • **NICE NG23:** do not routinely offer SSRIs, SNRIs or clonidine first line for VMS alone
Not recommended	• Soy/isoflavones, black cohosh (liver injury; avoid with tamoxifen), red clover, other herbal products, compounded hormones. NICE: some evidence for isoflavones and black cohosh, but safety and preparations vary • St John's wort: uncertain dose and serious interactions (tamoxifen, anticoagulants, anticonvulsants) (NICE) • Paced respiration (TMS). Exercise, yoga, mindfulness for VMS (TMS; ACOG suggests them for sleep and mood only). Acupuncture: TMS not recommended; ACOG suggests it (low-quality evidence) • Pregabalin (TMS); progestogen alone, DHEA or testosterone for VMS (ACOG CPG 13)

02 Genitourinary syndrome and sexual function

Product	Regimen
Estradiol 10 µg vaginal tablet (Vagifem, Vagirux)	1 daily × 2 weeks, then twice weekly
Estriol 0.1% cream (Ovestin)	0.5 g daily for 2–4 weeks, then twice weekly
Estradiol 7.5 µg/day ring (Estring)	Replace every 90 days
Conjugated oestrogen cream (Premarin)	0.5 g twice weekly (USA)
Prasterone (Intrarosa) 6.5 mg pessary	Nightly; DHEA converted locally to oestrogens and androgens

Product	Regimen
Ospemifene (Senshio, Osphena) 60 mg	Oral daily with food; SERM. Can worsen VMS; VTE risk

IF	THEN
Mild dryness or dyspareunia	Vaginal moisturiser 2–3 times a week plus lubricant for sex. Pelvic floor physiotherapy and dilators for severe dyspareunia.
Moderate–severe, or moisturisers not enough	• **Low-dose vaginal oestrogen** (table above); expect benefit within weeks • **No progestogen** and no routine endometrial monitoring (NICE, TMS, ACOG); continue as long as needed; symptoms recur on stopping • Any bleeding → investigate as postmenopausal bleeding • Vaginal oestrogen not tolerated or ineffective: prasterone (NICE); local treatment impractical (e.g. disability): oral ospemifene (NICE)
Already on systemic HRT with persistent GSM	Add vaginal oestrogen (NICE).
Recurrent UTIs or urgency	Vaginal oestrogen reduces recurrent UTI and urgency. It does not cure incontinence, and systemic HRT can worsen it (Berek).
History of breast cancer	• Offer non-hormonal moisturisers and lubricants first • Persisting symptoms: consider vaginal oestrogen (NICE; off-label), considering recurrence risk. ER-negative: likely safe. ER-positive: effect on recurrence unknown; tamoxifen offsets any effect • On an aromatase inhibitor: decide with the breast team (NICE); generally avoided (BMS 2025); shared decision (ACOG CC 2021) • Alternatives: vaginal DHEA or testosterone (ACOG)
Laser or energy-based devices	Not recommended outside trials (TMS 2020; FDA warning).
Low sexual desire with distress (HSDD)	• Biopsychosocial assessment; treat GSM, mood, relationship factors and drug causes (SSRIs) • Optimise oestrogen first; transdermal route keeps free testosterone higher • Then consider **transdermal testosterone** (off-label in women): Testogel 1/8 of a 40.5 mg sachet (≈5 mg) daily or Tostran 2% 10 mg on alternate days (BMS 2026) • Total testosterone at baseline, at 2–3 months, then every 6–12 months within the female range; stop if no benefit by 6 months
Fatigue, cognition, bone or CV benefit	**Not** indications for testosterone (Global Consensus 2019). No oral DHEA.

03 Bone health and osteoporosis

Bone loss accelerates around the final period and continues at about 1–1.5% a year after menopause (Comprehensive Gynecology). Each standard deviation fall in BMD roughly doubles fracture risk, and a prior fragility fracture raises the risk of another 1.5- to 9.5-fold; 20% of women with a new vertebral fracture have another within a year (Williams). Prevention starts at the menopause visit.

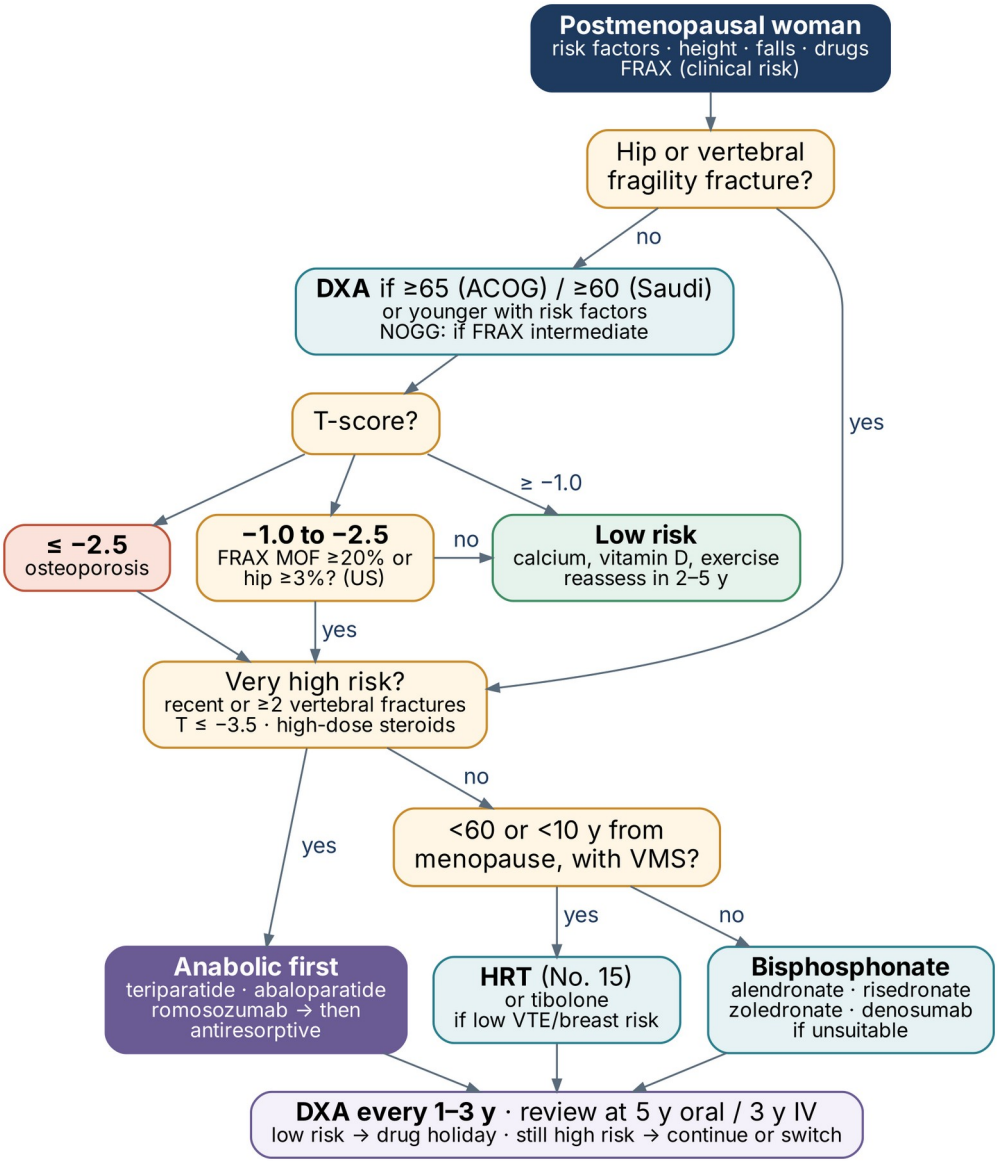


Figure 2. *Assessing fracture risk and choosing treatment in a postmenopausal woman.*

Who to assess with DXA

Source	Who to scan	Notes
ACOG CPG 1 (2021)	All women ≥65. Under 65 if a formal risk tool (e.g. FRAX) shows raised risk	Do not rescan within 2 years unless near a threshold or risk changes
Saudi Osteoporosis Society (2023)	All women ≥60. Younger with a risk factor: fragility fracture after 40, menopause before 45, prolonged amenorrhoea, glucocorticoids, primary hyperparathyroidism, height loss or kyphosis	Uses Saudi FRAX with age-specific thresholds (e.g. age 70: MOF <3.96% no DXA; 3.96–9.1% DXA; >9.1% treat without DXA)
NOGG (UK, 2022; updated 2024)	Postmenopausal women with clinical risk factors: FRAX first	DXA only when FRAX places her at intermediate risk
Williams Gynecology (NOF)	Vertebral imaging if ≥70 with T ≤ −1.0, or 65–69 with T ≤ −1.5	Many vertebral fractures are silent; measure height every year
POI or early menopause	DXA at diagnosis (BMS, ESHRE)	Repeat every 1–3 years if abnormal or risk factors (ESHRE)

Risk factors, DXA reading and work-up

IF	THEN
Major risk factors (Williams)	• Age >65; low BMD; vertebral or other fragility fracture after 40; parental hip fracture • Glucocorticoids >3 months (prednisolone ≥5 mg/day); malabsorption; primary hyperparathyroidism; hypogonadism or menopause before 45; falls
Minor risk factors and bone-losing drugs	• Rheumatoid arthritis, hyperthyroidism, smoking, alcohol excess, low calcium intake, weight <57 kg • Aromatase inhibitors, DMPA, GnRH agonists, anticonvulsants (phenytoin), heparin, excess thyroxine, SSRIs, thiazolidinediones
Reading a postmenopausal DXA (T-score)	• ≥ −1.0: normal • −1.0 to −2.5: low bone mass (osteopenia) • ≤ −2.5: osteoporosis; with a fragility fracture: established osteoporosis
Premenopausal or POI (Z-score)	Use the Z-score. Z ≤ −2.0 is below the expected range for age: look for a secondary cause (Williams).
Osteoporosis or Z ≤ −2.0: secondary causes	• Calcium, phosphate, ALP, renal function, PTH, 25(OH)D, TSH, full blood count (Berek, Williams) • 24-h urinary calcium and creatinine; targeted tests if history suggests (cortisol, alcohol, malignancy, osteomalacia)

When to treat

IF	THEN
Hip or vertebral fragility fracture	**Treat regardless of BMD** (all societies). Consider referral to a fracture liaison service or bone specialist.
T-score ≤ −2.5 at hip, femoral neck or spine (Saudi: also distal radius)	Treat.
Osteopenia (T −1.0 to −2.5)	• US (ACOG, Williams): treat if FRAX 10-y major osteoporotic fracture ≥20% or hip ≥3% • Osteoporosis Canada 2023: treat if 10-y major fracture risk ≥20% • NOGG: age-dependent FRAX thresholds; Saudi: Saudi FRAX age-specific thresholds
Very high risk (NOGG): vertebral fracture in last 2 years, ≥2 vertebral fractures, T ≤ −3.5, high-dose glucocorticoids	Anabolic agent first or specialist referral, then an antiresorptive.
Low risk	Lifestyle measures, calcium and vitamin D; reassess risk in 2–5 years or if risk changes.

Choosing a drug

Agent	Dose	Best for	Avoid / watch	Duration
HRT (see No. 15)	Standard or low dose; even CEE 0.3 mg, E2 0.5 mg or a 14 µg patch prevents bone loss	<60 or <10 y from menopause, with VMS or high risk and low VTE/breast risk (NOGG 2024: first line ≤60)	HRT contraindications	While indicated; benefit fades after stopping: reassess fracture risk first

Agent	Dose	Best for	Avoid / watch	Duration
Tibolone	2.5 mg daily	Women <60 (Endocrine Society)	Stroke risk, breast cancer	As HRT
CE/bazedoxifene (USA)	0.45/20 mg daily	Uterus, VMS and bone prevention	VTE	As HRT
Raloxifene	60 mg daily	Vertebral fractures; high breast cancer risk	Prior VTE, stroke risk; worsens VMS; no hip benefit	Long term
Alendronate	70 mg weekly (35 mg prevention)	First line for most	eGFR <35, oesophageal disease; fasting, full glass of water, upright 30 min	Review at 5 y
Risedronate	35 mg weekly or 150 mg monthly	First line; vertebral and hip	As alendronate	Review at 5 y
Ibandronate	150 mg monthly oral or 3 mg IV 3-monthly	Vertebral only	No hip or non-vertebral evidence	Review at 5 y
Zoledronic acid	5 mg IV once a year	Oral intolerance or poor adherence	Correct vitamin D and calcium first; eGFR <35; flu-like reaction after first dose	Review after 3 doses
Denosumab	60 mg SC every 6 months	High risk; bisphosphonate unsuitable	Hypocalcaemia: correct vitamin D first; do not delay doses	No holiday; on stopping, give a bisphosphonate
Teriparatide / abaloparatide	20 µg / 80 µg SC daily	Very high risk	Osteosarcoma risk factors; hypercalcaemia	Max 2 years, then antiresorptive
Romosozumab	210 mg SC monthly × 12	Very high risk (Saudi: first line)	Previous MI or stroke	12 months, then antiresorptive

Sources: Berek Table 18-5; Williams Ch. 22; Endocrine Society 2019/2020; ACOG CPG 2; NOGG 2024; Saudi Osteoporosis Society 2023. Rare adverse effects of long-term antiresorptives: osteonecrosis of the jaw (mostly after invasive dental work) and atypical femoral fracture (RR ≈1.7, more after >5 years); warn about new thigh or groin pain.

Monitoring and drug holidays

IF	THEN
On treatment	• DXA every 1–3 years (Endocrine Society); Williams: 2 years after starting, then every 2 years • Check adherence and technique at each visit; measure height yearly
Bisphosphonate after 5 years oral or 3 years IV, risk now low–moderate	• **Drug holiday**: up to 5 years (Endocrine Society); NOGG: pause 18–36 months • Reassess sooner for drugs with low skeletal retention: risedronate at 1 year, alendronate at 1–2 years, zoledronate at 2–3 years (Williams)
Still high risk (T ≤ −2.5, previous hip or vertebral fracture, new fracture)	Continue: up to 10 years oral or 6 years IV (ACOG, Endocrine Society); consider switching to an anabolic agent.
Fracture on treatment	Check adherence, technique, vitamin D and secondary causes; refer for specialist review or anabolic treatment.
Stopping denosumab	Never stop without follow-on bisphosphonate: rebound bone loss and multiple vertebral fractures.

IF	THEN
Stopping HRT in a woman at fracture risk	Assess fracture risk and plan an alternative before stopping (Williams).

Everyone

IF	THEN
Calcium and vitamin D	• Calcium 800–1200 mg/day (Saudi 2023); 1200 mg/day from age 51 (Williams), preferably from diet • Vitamin D3 1000–2000 IU/day after correcting 25(OH)D <50 nmol/L; up to 4000 IU if obese, malabsorption or dark skin; target ≥75 nmol/L if osteoporotic (Saudi 2023)
Lifestyle and falls	• Weight-bearing and resistance exercise at least 30 min three times a week (Williams) • Stop smoking; limit alcohol; review sedating drugs; home hazards, footwear, night lights; hip protectors only in supervised care

04 Premature ovarian insufficiency and early menopause

IF	THEN
Under 40 with oligo/amenorrhoea ≥4 months	• **ESHRE/ASRM 2024:** one FSH >25 IU/L confirms POI; repeat FSH or AMH only if uncertain • **NICE:** FSH on 2 samples 4–6 weeks apart; never on a single test. **BMS 2024:** FSH >40 IU/L twice • AMH is not a first-line test
Confirmed POI: find the cause	• Karyotype (Turner, X mosaicism) and FMR1 premutation • 21-hydroxylase (adrenal) antibodies; thyroid antibodies and TSH • History of chemotherapy, radiotherapy or ovarian surgery • DXA at diagnosis; CV risk factors
Counselling	• Ovarian function returns intermittently in ≈25%; spontaneous pregnancy ≈5% (Bidet 2011) • Needs contraception if pregnancy is unwanted: HRT does not contracept • Best fertility option: oocyte donation • WHI risks do not apply: HRT here replaces what the ovaries should make
Hormone replacement	• **HRT or a combined hormonal contraceptive until at least ≈51 y** (NICE, ESHRE) • Higher doses: estradiol 100 µg patch or 2 mg oral (or equivalent), with progestogen scaled to the dose (e.g. micronised progesterone 200 mg daily or 300 mg × 12 days) • COC: continuous or extended regimens preferred (ESHRE). NICE: both HRT and COC protect bone; HRT may give lower BP than COC. ESHRE: bone protection with COC less certain. Avoid COC if trying to conceive (Comprehensive Gynecology) • Repeat DXA every 1–3 years if abnormal or risk factors; at 5 years if normal and adherent (ESHRE)
Early menopause (40–45)	Offer HRT at least until ≈51 unless contraindicated. NICE: benefits and risks lie between those of POI and of women ≥45; offer psychological support.
Surgical menopause before 51	Start HRT soon after surgery (oestrogen alone after total hysterectomy; combined if endometriosis).

IF	THEN
BRCA carrier without breast cancer, after risk-reducing BSO	HRT until ≈51 is generally offered (NICE CG164; BMS). Oestrogen-only if hysterectomy.

05 Women who cannot or will not take HRT

IF	THEN
Breast cancer survivor with VMS	• Non-hormonal options (Section 1); CBT • On tamoxifen: venlafaxine or gabapentin; **no paroxetine or fluoxetine** • Elinzanetant is licensed in the UK for VMS caused by adjuvant endocrine therapy; NICE made no recommendation on fezolinetant during breast cancer treatment
Breast cancer survivor with GSM	Section 2: non-hormonal first, then vaginal oestrogen with the breast team.
On an aromatase inhibitor	Bone loss accelerates: assess fracture risk and DXA, treat as in Section 3 (Williams).
Previous VTE, stroke or CHD	Non-hormonal options (Section 1). If HRT is still wanted, specialist review (No. 15).
Liver disease	Fezolinetant contraindicated in cirrhosis; elinzanetant not in severe hepatic impairment. SSRIs/SNRIs, gabapentin or CBT instead.
Fezolinetant or elinzanetant in Saudi Arabia	SFDA registration not confirmed (Oct 2026): check the hospital formulary before prescribing.

06 Do not

- Prescribe paroxetine or fluoxetine with tamoxifen.
- Start fezolinetant without baseline LFTs, or in cirrhosis.
- Offer clonidine, herbal products or compounded hormones as first-line treatment for VMS.
- Add a progestogen or scan the endometrium routinely for low-dose vaginal oestrogen.
- Use vaginal laser for GSM outside a trial.
- Offer testosterone for fatigue, cognition or before oestrogen is optimised.
- Stop denosumab without follow-on bisphosphonate.
- Give oral bisphosphonates or zoledronate if eGFR <35, or zoledronate/denosumab before correcting vitamin D.
- Use AMH to diagnose POI, or tell a woman with POI that the WHI risks apply to her.

07 Where the guidelines differ

Topic	USA (ACOG / TMS / ACP)	UK (NICE / BMS / NOGG)	Other (ESHRE / Saudi / Canada)
First-line non-hormonal VMS	ACOG: SSRI/SNRI or NK antagonist (strong). ACP: SNRI 2nd, NK3 3rd line	CBT; no routine SSRI/SNRI first line; fezolinetant if HRT unsuitable	—
Acupuncture	ACOG: suggested for VMS (low quality). TMS: not recommended	—	—
Elinzanetant	FDA Oct 2025; endocrine-therapy VMS under review	MHRA 2025, incl. endocrine-therapy VMS (2026); NICE pending	EU Nov 2025; Canada endocrine-therapy indication 2026

Topic	USA (ACOG / TMS / ACP)	UK (NICE / BMS / NOGG)	Other (ESHRE / Saudi / Canada)
Vaginal oestrogen after breast cancer	ACOG: shared decision with oncologist	NICE: consider if non-hormonal fails (ER– likely safe); BMS: avoid with AI	—
Testosterone	No female product; HSDD only (Global Consensus)	Consider for low desire if HRT insufficient (NICE)	IMS: HSDD only
DXA screening	≥65; younger if FRAX raised (ACOG)	FRAX first, DXA if intermediate (NOGG)	Saudi: ≥60 or risk factors
Treating osteopenia	FRAX MOF ≥20% or hip ≥3%	Age-dependent FRAX thresholds (NOGG)	Canada: ≥20%; Saudi FRAX age-specific
HRT as bone treatment	TMS/Endocrine Society: <60 or <10 y	First-line option ≤60 if low VTE/cancer risk (NOGG 2024)	Canada: alternative <60 if symptoms
Bisphosphonate holiday	After 5 y oral / 3 y IV, up to 5 y (Endocrine Society, ACOG)	Pause 18–36 months (NOGG)	—
POI biochemistry	ASRM co-authored ESHRE 2024: one FSH >25 IU/L	NICE: 2 FSH 4–6 wk apart; BMS: >40 IU/L twice	ESHRE 2024: one FSH >25 IU/L

08 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACOG	American College of Obstetricians & Gynecologists	DHEA	dehydroepiandrosterone	MI	myocardial infarction
ACP	American College of Physicians	DMPA	depot medroxyprogesterone acetate	NICE	National Institute for Health & Care Excellence
ALP	alkaline phosphatase	DXA	dual-energy X-ray absorptiometry	NK	neurokinin (receptor)
ALT	alanine aminotransferase	eGFR	estimated GFR	nocte	at night
AMH	anti-Müllerian hormone	EMA	European Medicines Agency	NOGG	National Osteoporosis Guideline Group
ASRM	American Society for Reproductive Medicine	ER	oestrogen receptor	od	once daily
AST	aspartate aminotransferase	ESE	European Society of Endocrinology	POI	premature ovarian insufficiency
bd	twice daily	ESHRE	European Society of Human Reproduction	SERM	selective oestrogen receptor modulator
BMD	bone mineral density	FDA	US Food and Drug Administration	SFDA	Saudi Food & Drug Authority
BMS	British Menopause Society	FMR1	fragile X gene	SmPC	product licence summary (SmPC)
BP	blood pressure	FRAX	fracture risk assessment tool	SNRI	serotonin–noradrenaline reuptake inhibitor
BSO	bilateral salpingo-oophorectomy	FSH	follicle-stimulating hormone	SSRI	selective serotonin reuptake inhibitor
CBT	cognitive behavioural therapy	GnRH	gonadotrophin-releasing hormone	tds	three times daily
CC	Clinical Consensus (ACOG)	GSM	genitourinary syndrome of menopause	TMS	The Menopause Society (ex-NAMS)
CEE	conjugated equine oestrogens	HRT	hormone replacement therapy	TSH	thyroid-stimulating hormone
CHC	combined hormonal contraception	HSDD	hypoactive sexual desire disorder	ULN	upper limit of normal
CHD	coronary heart disease	IMS	International Menopause Society	UTI	urinary tract infection
CO	Committee Opinion (ACOG)	IU	international units	VMS	vasomotor symptoms
COC	combined oral contraceptive	IV	intravenous	VTE	venous thromboembolism
CPG	Clinical Practice Guideline (ACOG)	LFTs	liver function tests	WHI	Women's Health Initiative
CV	cardiovascular	MHRA	UK medicines regulator (MHRA)		

09 Sources

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