Provincial Menopause and Perimenopause Primary Care Clinical Pathway

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This pathway is intended for use with patients who present with **Menopause/Perimenopause symptoms and/or menstrual changes**

Menopause/Perimenopause Symptoms (typically age 45-55)
- Vasomotor (VMS) (e.g., hot flashes, night sweats)
- Genitourinary syndrome of menopause (GSM) (e.g., vaginal dryness, urinary frequency, dyspareunia)
- Mood, sleep or cognition changes
- Musculoskeletal (e.g., joint pain)

*If perimenopause symptoms occur before age 40, other causes should be carefully considered.
*For those who do not have a uterus or are on hormonal contraception diagnosis relies on symptoms rather than bleeding patterns.
*Amenorrhea under age 45 needs medical evaluation.

1. History and Assessment

MQ6 Assessment:
If any "**Yes**" / concerns, continue with assessment
- Any changes in your periods?
- Are you having any hot flashes?
- Any vaginal dryness, pain or sexual concerns?
- Are you having any bladder issues or incontinence?
- How is your sleep?
- How is your mood?

- Medication review
- Family history, recent sexual, reproductive and gynecological history
- Risk factors including history of cancer, cardiometabolic risk and lifestyle factors
- Height, weight, BP
- Breast exam, if indicated
- Vaginal/pelvic exam, if indicated

Consider co-conditions or differential diagnosis: If the following are suspected, follow appropriate pathways or guidelines.
- Hypothyroidism
- Obstructive Sleep Apnea
- Chronic Insomnia
- Mood disorders
- Iron Deficiency Anemia
- PCOS

If any the following are present or suspected, consult/refer to specialist as indicated:
- Primary ovarian insufficiency (POI) (≤40years)
- Hyperprolactinemia
- Hypercalcemia
- High risk/history of VTE
- Malignancies
- CVD
- Early menopause before age 45 (naturally occurring or medically/surgically induced)

Referral to specialty care or consult **specialty advice**

2. Investigations: Hormonal testing is not routinely recommended

- Determine investigations based off current screening needs and differential diagnoses
- Consider β-HCG
- **FSH only if:**
  - Suspected primary ovarian insufficiency (4 months amenorrhea, ≤40 years)
  - Suspected early menopause (≤45years)

Presentation consistent with menopause and other etiologies have been considered

3. Management should be based off symptoms, treatment goals and include shared decision making. Due to the unique experience and complexity of the menopause and perimenopause journey, multiple patient visits may be required to assess whole person health and coordinate care (e.g., team-based care).

For all symptoms, consider overall lifestyle measures:
- Physical activity
- Healthy relationships
- Healthy eating
- Avoidance of substances
- Mental well-being
- Restorative sleep

Vasomotor Symptoms (VMS)
- Cognitive behavioural therapy
- Clinical hypnosis

Genitourinary Syndrome of Menopause (GSM)
- Vaginal lubricants/ moisturizers
- Pelvic floor physio
- If indicated, follow the Female Urinary Incontinence pathway

Mood, sleep, cognition supports
- Depressive and anxiety symptoms: Behavioral psychotherapies as appropriate
- Sleep: Offer sleep hygiene education, r/o primary sleep disorders, consider Cognitive Behavioural Therapy
- Cognition: Encourage lifestyle measures

Sexual health symptoms
- Consider pelvic physiotherapy, if indicated
- Self-management resources
- Sex therapy

Are medications (Menopause Hormonal Therapy and Non-Hormonal Therapy) **desired** by the patient for management?

Yes → **Follow the Algorithm on page 2** to determine appropriateness and management of medications.

No → **Follow Up and Monitoring**
- Encourage lifestyle measures
- Continue routine screening as indicated
- Consider bone health optimization
- If no improvement in 3 months, try an alternate therapy or consult specialty for advice.

Primary Care Alberta

Call to Action: We need your feedback during this **new** pathway's initial testing phase!

Alberta's Pathway Hub | Patient Resources | Background

Provincial Menopause and Perimenopause Primary Care Clinical Pathway

4. Medication Management: Medications available fall into two groups: Hormonal and non-hormonal medications. All medication options should be considered and discussed to support informed decision making and to create a care plan that accounts for patient's preference and risk/benefit profile.

Medication Options include:

Menopause Hormone Therapy (MHT)

- Systemic MHT is safest when started ≤60 years or within 10 years of Final Menstrual Period (FMP) in those without contraindications; it is the most effective treatment for vasomotor symptoms (affecting ~80% of women) and supports bone health.
- Vaginal estrogen treatment is preferred when treating GSM symptoms alone.

Non-Hormonal Therapy

- Those initiating treatment at ≥60 years of age or more than 10 years from their final menstrual period (FMP), or those with contraindications to MHT.

Notes:
- A combination of MHT and non-hormonal therapies can be used.
- For treatment of premature ovarian insufficiency (FMP< 40), early menopause (FMP<45), induced menopause or bilateral oophorectomy (FMP <45), higher doses are required [Hormone Replacement Therapy (HRT)]. Specialist consultation or advice may be required.

Trouble-shooting guide for medication management

MHT is indicated, patient is interested

Is **GSM the only** indication for MHT?

Yes

GSM treatments
- Vaginal estrogen therapy
- Vaginal DHEA
- Ospemifene SERM (oral)

No

Are there any contraindications to systemic MHT?
- Undiagnosed abnormal vaginal bleeding
- Known, suspected or personal history of breast cancer
- Coronary heart disease
- Active or history of venous thromboembolism
- Known or suspected estrogen-dependent cancers (e.g., endometrial, ovarian)
- Active or history of stroke
- Known thrombophilia
- Active liver disease
- Known or suspected pregnancy
- Uncontrolled hypertension

Those with contraindications to systemic MHT can still benefit from vaginal estrogen

Yes → **Non-Hormonal Therapy**

No

MHT contraindicated or non-hormonal therapy preferred by patient

Non-Hormonal Therapy

	VMS	SLEEP	MOOD
Neurokinin B Receptor Antagonists (i.e., fezolinetant, elinzanetant)	+++	+	
Gabapentin*	++ [1]	+++ [1]	+/- [2]
Antidepressants* (i.e., SSRI, SNRI)	++	+/-	++/+++
Oxybutynin*	++		

*Indicates off label use for vasomotor symptoms
**Options and dosing in expanded details
1. Gabapentin can be sedating at higher doses and has shown potential benefits for night sweats.
2. There is some evidence for benefits of gabapentinoid treatments for mood and anxiety disorders.

Assess for comorbidities
- Diabetes mellitus
- Metabolic syndrome
- Migraine with or without aura
- Hyperlipidemia
- Obesity
- Malabsorption
- Hypertension
- Elevated risk for VTE
- Elevated cardiovascular risk
- Gallstones
- Smoking

No comorbidities: Any estrogen (oral or transdermal)
Comorbidities identified: Transdermal estrogen preferred

Has the patient had a **hysterectomy**?

Yes → **Estrogen Only: Options and Equivalency Table**

No

MHT: Options and Equivalency Table
- Estrogen + Progestogen therapy
- Tissue Selective Estrogen Complex
- Selective Tissue Estrogenic Activity Regulator

Final Menstrual Period >1 yr?

YES: Continuous Regimen
NO: Cyclic Regimen - continuous estrogen with a progestogen added 12-14 days a month

Symptoms of GSM?
If **YES**, local vaginal estrogen can be used in addition to systemic therapy, if necessary

Follow Up and Monitoring
- Review symptoms, efficacy, side effects (q3 months until stable and then annually), and correct usage.
- Reassess risk profile and need for continued therapy.
- Refer to Troubleshooting guide.
- Monitor bone density if indicated.
- Refer to Provincial Post-Menopausal Bleeding Pathway as indicated.
- Refer to Female Urinary Incontinence pathway as indicated.

Discontinuation of MHT
- Tapering or abrupt cessation both acceptable options. Up to 50% may experience a recurrence of symptoms.
- No fixed time duration for MHT use.

Advice or referral to specialty may be considered if:
- Management unclear due to unique patient factors (i.e., younger age, surgical or medically induced menopause).
- Symptoms persist despite ≥3 months per therapy trial.
- Continue supportive care while awaiting specialist referral or advice.

Table of Contents

This pathway is intended for healthcare providers and focuses specifically on the care and management of patients experiencing menopause and perimenopause. This primary care pathway was co-designed provincially by Primary Care Providers, Specialist Physicians (Endocrinologist, Urogynecologist, Menopause Specialists), Patient and Family Advisors, and the Provincial Pathways Unit. The information presented is based on current evidence from reputable sources, including Alberta healthcare professionals, peer-reviewed journals, current clinical guidelines, and specialty care recommendations. It is designed to support clinical decision-making but should not replace the professional judgment of a qualified healthcare provider. This resource does not account for the unique circumstances of individual patients. Providers should always apply their clinical expertise and consider patient-specific factors when delivering care.

Note: Throughout this pathway, the term 'women and people experiencing menopause and perimenopause' includes all individuals who may go through these stages, such as women, Two-Spirit people, trans men, and nonbinary individuals assigned female at birth.

EXPANDED DETAILS

Pathway Primer

Menopause is a natural physiological transition marked by the cessation of menstrual periods and the end of reproductive capacity. Menopause typically occurs between the ages of 45 and 55 years, with the average age being 51 years [1].People experience an array of symptoms during this transition phrase of life and each person's experience of menopause is shaped by biological, psychological, and social factors. Individualized care and symptom management are essential.

Primary care providers are well positioned to support patients along their menopause journey. Evidence suggests that primary care providers may need additional information and resources to help provide this care. This pathway aims to:

- Support evidence-based management of menopause and perimenopause-related symptoms
- Promote proactive, person-centered care
- Guide appropriate use of hormonal and non-hormonal therapies
- Identify when referral to gynecology, endocrinology, or menopause clinics is warranted (e.g., complex cases, high-risk populations, refractory symptoms, premature ovarian insufficiency)

Definitions are informed by the STRAW+10 (Stages of Reproductive Aging Workshop) criteria, the internationally recognized standard for staging female reproductive aging based on menstrual cycle patterns [1].

Definitions

- **Menopause:** Retrospective diagnosis after ≥12 consecutive months of amenorrhea, not attributable to other causes. It marks the end of natural reproductive capacity. The average age of menopause in Canada is approximately 51 years, with 95% of women transitioning between ages 45–55 [2].
- **Early menopause**: Early menopause is defined as menopause occurring between the age of 40 and less than 45 years.
- **Perimenopause (menopausal transition):** The interval preceding menopause and extending to 12 months after the final menstrual period. This phase is marked by menstrual cycle variability and symptom onset. This term is often used interchangeably with menopause.
    - Early Perimenopause: Menstrual cycle persistent variability of ≥7 days between cycles, with or without symptoms. Persistence is defined as a recurrence within 10 cycles/months. Duration of this stage is variable.
    - Late Perimenopause: ≥60 days of amenorrhea, often accompanied by vasomotor symptoms.
    - Symptoms such as hot flashes, mood changes, and sleep disturbances may precede menstrual changes. Fertility declines but pregnancy remains possible during this stage. This stage may last 1-3 years [2].
- **Premature Ovarian Insufficiency:** Premature Ovarian Insufficiency (POI) is the onset of menopause under the age of 40 years with amenorrhea or irregular menstrual cycle for 4-6 months, in combination with low estrogen and elevated gonadotrophins.

Patients may present with:

- Menstrual irregularities suggestive of early or late perimenopause
- Menopause related symptoms
- ≥12 months of amenorrhea
- Patients may also present without a uterus or may be using hormonal contraception
    - Diagnosis should rely on symptom presentation and clinical judgment, not bleeding patterns.

Menopause-related symptoms including vasomotor instability (e.g., hot flashes, night sweats); genitourinary syndrome of menopause (e.g. vaginal dryness, itching, urinary urgency and painful intercourse); mood and cognitive changes; sleep disturbances; and musculoskeletal pain, and sexual dysfunction which may begin during perimenopause and persist for years. These symptoms may significantly impact quality of life, work productivity, and long-term health outcomes.

In Canada:

- Up to 80% of women experience menopause symptoms
- 25% seek treatment due to severity [3]
- Only 27% report having proactive discussions with their physician [3]
- 1 in 2 report feeling unprepared, and 4 in 10 feel alone during the transition [3]

Note: This pathway applies only to individuals experiencing physiological menopause and perimenopause.
The following presentations require further evaluation:

- Perimenopause symptoms before age 40
    - Requires further investigation; other causes should be considered in collaboration with specialty care.
- Amenorrhea under age 45
    - Considered abnormal; requires evaluation and investigation for other causes in conjunction with specialty care.

History

Effective menopause and perimenopause management begins with a focused history that identifies the patient's most bothersome symptoms, their severity, and impact on quality of life. The Menopause Quick 6 (MQ6) assessment tool is a validated, evidence-based screening instrument developed by a Canadian family physician to address gaps in mature women's care [3]. This tool can be self-administered by patients or used during clinical encounters to guide discussion and support shared decision-making.

MQ6 questions:

1. Any changes in your periods?
2. Are you having any hot flashes?
3. Any vaginal dryness, pain or sexual concerns?
4. Are you having any bladder issues or incontinence? (frequency, urgency, leakage)
5. How is your sleep? (new sleep difficulties)
6. How is your mood? (new or increased anxiety, irritability, depression or low mood)

Scoring MQ6 questions:

- A "yes" to question 1 requires further inquiry to determine if your patient may be perimenopausal or menopausal.
- A "yes" to questions 2, 3, or 4 indicate symptoms for which menopausal hormone therapies may be indicated.
- A "yes" to questions 5 or 6 suggest other symptoms that may be related to menopause which should be considered in treatment recommendations.

In addition to the MQ6 questions,

- A medication review helps identify potential drug interactions, adherence issues, or side effects that may mimic or exacerbate symptoms.
- Family history, especially cancer or cardiovascular disease, helps identify genetic risk factors and supports risk stratification. A thorough review of the patient's medical and surgical history is also essential for accurate assessment.
- Recent sexual and gynecological history is essential for identifying conditions that may present with overlapping symptoms or require specific screening (such as dyspareunia, urinary incontinence and pelvic organ prolapse).
- Determine reproductive history, including conditions such as gestational diabetes and preeclampsia, as these are well-established predictors of future cardiovascular disease.
- Lifestyle assessment of factors such as smoking, alcohol use, diet, and physical activity offer context for both diagnosis and management and supports person-centred care planning.

Assessment

A thorough physical assessment is essential to support accurate diagnosis and safe management during menopause and perimenopause.

Key components include:

- **Height, weight, and blood pressure**, which help assess cardiovascular risk and guide treatment decisions. Healthcare professionals should be aware of their weight biases and the impact this may have on their approach to requesting anthropometric measurements. Providers can refer to Resources for healthcare professionals | Obesity Canada.
- **A breast examination** should be performed if clinically indicated, such as when there is a history of breast disease, or new breast symptoms. Follow the Alberta Breast Cancer Screening Clinical Practice Guideline.
- **A vaginal/pelvic examination** is also recommended when there are gynecologic complaints (e.g., abnormal bleeding, pelvic pain, urinary incontinence, unexplained gastrointestinal symptoms, abnormal vaginal discharge, vulvar complaints, abnormal post-menopausal bleeding, pelvic organ prolapse, pelvic pain, and dyspareunia) [4]. Follow the Alberta Cancer Screening Clinical Practice Guideline.

Consider Co-Conditions or Differential Diagnoses:

If any of the following conditions are suspected, follow appropriate clinical pathways or guidelines:

- **Thyroid disorders:**
  - Hypothyroidism is common in midlife women and can mimic menopause symptoms (fatigue, weight gain, mood changes, cold intolerance). Hyperthyroidism may present with hot flashes and night sweats [5].
- **Obstructive Sleep Apnea (OSA):**
  - Night sweats, fatigue, and poor sleep quality may be attributed to menopause, but these could also indicate OSA, especially in women with increased BMI or snoring [6]. Refer to the Provincial Obstructive Sleep Apnea Primary Care Clinical Pathway.
- **Chronic Insomnia:**
  - Difficulty falling or staying asleep ≥3 times/week for ≥3 months. Treat with CBT-I or pharmacologic options.
- **Mood Disorders**:
  - Depression and anxiety are common during the menopausal transition but may also signal underlying psychiatric conditions. Differentiating perimenopausal mood variability from major depressive disorders is important.
- **Iron Deficiency Anemia:**
  - Symptoms (fatigue, low mood, cognitive changes, headaches) overlap with menopause. Screen for iron deficiency, especially with ongoing menstrual cycles [8].
  - Indicators: Hemoglobin <120 g/L; ferritin <30 µg/L (often <20).
  - If iron deficiency is suspected or confirmed (e.g., Hemoglobin <120 g/L in females), then follow the Iron Deficiency Anemia Pathway.

  Note: Iron deficiency can be present with or without anemia. There are many definitions of iron deficiency, although typically ferritin <30 µg/L, and certainly <20 µg/L, reflect iron deficiency.

- **Polycystic Ovary Syndrome (PCOS):**
  - Although typically diagnosed earlier in life, PCOS may persist in perimenopause and contribute to irregular cycles, metabolic issues, and androgen excess. If any of the following are present: clinical or biochemical hyperandrogenism (hirsutism, acne or hair loss), irregular or no menstrual cycles or suggestive pelvic ultrasound, suspect PCOS and follow the Provincial Polycystic Ovary Syndrome (PCOS) Primary Care Clinical Pathway.

Consider referral to specialist or consult for specialty advice if the following are suspected:

- **Primary Ovarian Insufficiency (POI):**
  - Defined as loss of ovarian function before age 40, POI presents with amenorrhea, oligomenorrhea, vasomotor symptoms, and elevated FSH.
  - People with POI may have other autoimmune diseases (2 to 3 times higher incidence).
  - Refer to gynecology or endocrinology or to fertility specialist for fertility counseling, if indicated.
- **Hyperprolactinemia:**
  - Common symptoms of hyperprolactinemia are amenorrhea and galactorrhea.
  - Physiological hyperprolactinemia occurs during pregnancy and breastfeeding. Assess obstetric history and complete a β-HCG if appropriate.
  - Other common causes are medications (antidepressants) and pituitary adenoma. If the cause is unknown, or the hyperprolactinemia is persistent or significant, consider imaging to rule out pituitary adenomas and refer for endocrine evaluation if needed.

- **Hypercalcemia:**
  - Primary hyperparathyroidism is common in perimenopausal women and symptoms of hypercalcemia may overlap with menopausal symptoms. Screening investigations to rule out hypercalcemia are important, especially if supplementation is considered [7].

- **High risk/history of VTE:**
  - Women with prior VTE or thrombophilia (e.g., Factor V Leiden) have a markedly higher recurrence risk, making individualized risk-benefit assessment essential.
  - Management often requires multidisciplinary input (hematology/thrombosis specialists) for decisions on hormone therapy, anticoagulation, and alternative treatments.
- **Malignancies:**
  - Postmenopausal bleeding (please see Provincial Post-Menopausal Bleeding Primary Care Clinical Pathway) , unexplained weight loss, or persistent fatigue should prompt evaluation for gynecologic or systemic cancers.
- **Cardiovascular Disease (CVD):**
  - Menopause increases CVD risk due to estrogen decline. The CVD risk is higher in younger menopausal women due to the early age of hypoestrogenism. Symptoms like chest pain, palpitations, or exertional fatigue warrant cardiac assessment.
- **Early menopause before age 45 (naturally occurring or medically/surgically induced):**
  - Premature loss of ovarian function whether naturally occurring or medically/surgically induced (surgical oophorectomy, chemotherapy or pelvic radiation leading to ovarian failure, or POI), results in prolonged hypoestrogenism and increased long-term health risks:
    - Osteoporosis and fracture due to accelerated bone mineral density loss.

        - Cardiovascular disease from adverse lipid changes and endothelial dysfunction.
        - Neurocognitive decline and mood disorders, including depression and anxiety.
    - Management requires multidisciplinary care (gynecology, endocrinology, cardiology) for long-term health optimization and referrals should be considered.

Special Considerations/Populations [9]

Menopause affects individuals differently based on biological, social, and cultural factors. Inclusive, evidence-based care that considers diverse backgrounds including gender identity, ethnicity, and access to care, supports equitable outcomes and patient-centered decision-making.

Populations Disproportionately Affected

Certain populations are at increased risk for adverse health outcomes during menopause due to systemic barriers and biological factors:

- Individuals with limited access to care may experience delayed diagnosis and inadequate symptom management.
- Those with complex medical histories require tailored approaches to hormone therapy and chronic disease management.

Transgender and Gender Diverse Populations [10]

Understanding of the experience of menopause and hormone changes is based on research involving cisgender people and may not reflect the experience and health needs of transgender and gender diverse populations.

- Gender affirming hormone therapy (GAHT) should not be withheld solely based on age and stage of life. Follow the Provincial Adult Gender-Affirming Care Primary Care Clinical Pathway for guidance in providing care to gender diverse patients.
- No formal recommendations exist for GAHT for transgender and gender diverse patients in menopause and perimenopause.
- Some individuals may experience a shift in their gender identity and level of dysphoria during the perimenopausal/menopausal period [10].
- Providers can also refer to Menopause: Care for Women and Gender-Diverse People.

Ethnic and Racial Considerations

The relationship between race, ethnicity, and menopause is complex and shaped by a mix of biological, social, cultural, and economic factors. While biological changes during menopause are universal, the experience and severity of symptoms can vary significantly across racial and ethnic groups [11].

Symptom severity and reporting:

- Research has shown that women from different racial and ethnic backgrounds may report varying levels of symptoms such as hot flashes, sleep disturbances, and mood changes.
- Menopause experiences vary significantly by race and ethnicity, independent of socioeconomic status.
- Compared with white women, black women often have the longest and most severe vasomotor symptoms and are less likely to report them.
- Hispanic women frequently experience vaginal dryness and mood changes but may underreport due to cultural norms.
- Middle Eastern and Indigenous participants had the highest severity for brain fog.
- Asian women generally have fewer vasomotor symptoms and shorter duration but may avoid discussing symptoms altogether. However, South Asian women had the highest severity for weight changes of all races and ethnicities.
- Cultural beliefs about aging and menopause influence symptom disclosure and care-seeking, while systemic barriers and stressors can worsen symptoms for marginalized groups [11].

What to do in practice:

- Screen proactively for menopause symptoms in all patients.
- Use culturally sensitive communication to normalize discussion and address stigma.
- Assess access barriers and provide equitable resources for symptom management.
- Engage in shared decision-making to align treatment with patient values and cultural context.

Hormonal IUDs

- Menstrual changes may be unreliable indicators in people with IUDs, therefore, other symptoms should be considered as indicators of menopause and perimenopause.
- Hormonal IUDs do not replace systemic estrogen and are not a substitute for menopausal hormone therapy (MHT); however, they can be used in combination with MHT estrogen. The levonogestrel 20 mcg/ day IUCD (Mirena) has been approved for endometrial protection for patients receiving estrogen therapy and should be replaced every five years when used for this purpose. The 17.5 mg/ day IUCD (Kyleena) prevents pregnancy but has not been approved for endometrial protection for individuals on MHT at this time, so an additional progestogen source would be required.
- Continue contraception until menopause is confirmed or age 55.

Combined hormonal contraception

- Combined hormonal contraception may provide good control of vasomotor symptoms for many patients, especially if taken on an extended or continuous basis.
- Some patients can still have menopause symptoms on combined hormonal contraceptives. It may be appropriate to switch them to menopausal hormone therapy (MHT) for better symptom control if contraception is not required.
- Continue contraception until menopause is confirmed or age 55.

Surgical Menopause:

- Bilateral oophorectomy causes immediate estrogen and androgen loss, leading to more severe symptoms and increased risk of osteoporosis, cardiovascular disease, and cognitive decline.
- Hormone therapy is recommended for individuals <45 who experience surgical menopause, provided there are no contraindications, and should ideally continue until the average age of natural menopause (around 51). After 51, menopausal hormone therapy can be used for ongoing symptom management if needed, but doses should be the lowest effective amount and reassessed regularly.
- Estrogen-only therapy is appropriate if uterus is removed.
- Monitor bone health, cardiovascular risk, and mental health closely.

Investigations

Hormonal testing is not routinely recommended. The diagnosis of menopause is primarily clinical and should be based on a thorough history and symptom assessment rather than routine hormonal testing [12] [13].

- Hormonal fluctuations during perimenopause are highly variable and unpredictable. Follicle-stimulating hormone (FSH) and estrogen levels can change daily, making single measurements unreliable for confirming menopausal status.
- Instead, investigations should be tailored to the patient's age, symptom profile, and risk factors identified through life-cycle-based screening.

Over-reliance on hormonal testing can:

- Delay appropriate symptom management.
- Increase healthcare costs without improving diagnostic accuracy.
- Cause confusion or anxiety for patients due to fluctuating or inconclusive results.

Although, routine hormonal testing is not recommended for diagnosing menopause, FSH and estrogen may be considered in women under 45 with atypical symptoms or suspected premature ovarian insufficiency (POI) or early menopause.

Current guidelines advise reserving FSH testing for:

- POI: Age <40
- Early menopause: Age <45

  Note: Interpret results cautiously, as hormone levels fluctuate during perimenopause and throughout the menstrual cycle. Hormonal contraception with estrogen may suppress FSH. According to European Society of Human Reproduction and Embryology (ESHRE) guidelines, an FSH >25 IU/L after 4 months of amenorrhea supports a POI diagnosis, but clinical context remains essential [14].

Use Table 1 to determine investigations based off current screening needs and differential diagnoses.

Table 1: Summary of medical investigations that may be considered during menopause assessment.

Investigation	Purpose / Clinical Rationale
CBC	Evaluate for anemia, infection, or hematologic abnormalities contributing to fatigue or abnormal bleeding.
Creatinine	Estrogen therapy may affect renal clearance; baseline renal function is recommended for safe prescribing.
TSH (Thyroid-Stimulating Hormone)	Hypothyroidism and hyperthyroidism are common in midlife and may be misdiagnosed as menopausal symptoms.
Serum Calcium and albumin	Menopausal hormonal changes can unmask underlying conditions such as primary hyperparathyroidism, which often presents with elevated serum calcium; measuring albumin alongside calcium ensures accurate interpretation by allowing clinicians to adjust values and correctly diagnose hypo- or hypercalcemia.
Beta-HCG	Pregnancy should be ruled out before attributing symptoms to menopause or initiating hormone therapy in those at risk.
Liver Function Tests (LFTs)	Active liver dysfunction or abnormal liver function tests are contraindications to hormone therapy. Estrogen and other hormones used in menopausal treatment are metabolized by the liver. Impaired liver function can alter hormone processing, increasing the risk of side effects or toxicity. Fatty liver disease, which becomes more common in midlife, may indicate compromised liver health. Screening with liver function tests ensures safe prescribing and helps identify women who need alternative therapies or further evaluation.
Lipid Panel (Total Cholesterol, LDL, HDL, Triglycerides)	Menopause is associated with adverse lipid profile changes; lipid screening guides preventive strategies. Assess cardiovascular risk, which increases post-menopause due to estrogen decline. Lipids can also be relevant to the risk assessment for hormone therapy and decisions about transdermal vs. oral estrogen.
HbA1c (Glycated Hemoglobin)	Screen for type 2 diabetes as per AsAP guidelines and Screening for Diabetes in Adults - Diabetes Canada, especially in individuals with weight gain, fatigue, or metabolic syndrome. Relevant to the risk assessment for hormone therapy and

Investigation	Purpose / Clinical Rationale
	decisions about transdermal vs. oral estrogen. Pertinent to the risk assessment for hormone therapy and the choice between transdermal and oral estrogen administration.
Mammography	Breast density influences both breast cancer risk and hormone therapy selection. A mammogram helps identify women with dense breasts and those at elevated cancer risk, guiding clinicians to choose the most appropriate and breast-safe hormone therapy. Women with very dense breasts have a higher risk of breast cancer and may require tailored therapy (Note: Tissue selective estrogen complex agents (conjugated estrogens and baxedoxifene) such as TSEC/Duavive, which antagonize breast tissue proliferation and tibolone (breast-neutral) are considered safer options for these patients).

Management

Effective menopause care benefits from a team-based approach, involving physicians, nurses, pharmacists, dietitians, mental health professionals, and other allied health providers.

Despite the high prevalence of symptoms, many patients report dissatisfaction with care. In a recent survey, 40% of women sought medical advice, yet 72% found it unhelpful or only somewhat helpful, and 38% felt undertreated [15] [16]. This underscores the need for better provider education and more responsive, individualized care.

Management should focus on:

- Most bothersome symptoms and severity
- Menopause stage, comorbidities, uterine status, and contraceptive needs
- Personal preferences and practical factors (e.g., affordability)
    - Some helpful resources related to medication costs:
        - Alberta College of Family Physicians (Hormone Replacement Therapy)
        - NIHB Drug Benefit List

Care must be tailored, not “one-size-fits-all,” and often requires multiple visits to address evolving needs.

Overall Lifestyle Management

Lifestyle medicine provides a foundational, evidence-based approach to menopause management, emphasizing nutrition, physical activity, sleep, stress reduction, and social connection. These interventions have demonstrated benefits in reducing vasomotor symptoms, improving sleep and mental well-being, supporting healthy weight, and lowering cardiometabolic and osteoporosis risk.

Incorporating multidisciplinary, person-centered strategies enhances adherence and patient outcomes, while remaining cost-effective and adaptable across diverse populations [17].

Physical Activity

During menopause, declining estrogen levels contribute to increased inflammation, reduced metabolism, and a shift toward central (visceral) fat storage.

Regular physical activity may help counter these effects by [18]:

- Reducing inflammation in fat and muscle tissue [19]
- Maintaining lean muscle and reducing fat storage
- Supporting cardiovascular health and maintaining bone density

Physical activity is a cornerstone of menopause care.

- The Canadian Society for Exercise Physiology recommends adults engage in at least 150 minutes of moderate- to vigorous-intensity aerobic activity per week, plus muscle and bone strengthening exercises at least twice weekly [20] .
- Similarly, the American Heart Association and International Menopause Society advise 150–300 minutes of moderate aerobic activity or 75–150 minutes of vigorous activity, along with 2 or more days of resistance training [17].
- Aerobic exercise during and after menopause can play a role in managing symptoms and supporting overall health. [17].
- Resistance training during menopause helps improve muscle strength, body composition, and physical function.
- Multi-component exercise, which combines resistance, aerobic, and balance training has shown broader benefits. It can improve VMS, enhance cardiorespiratory fitness, flexibility, agility, and support overall quality of life. This approach is especially effective for maintaining strength and mobility during and after menopause [17].

Healthy Eating

There is no single prescribed diet for menopause, but healthy eating patterns can support cardiovascular, bone, and metabolic health during this life stage. Evidence suggests:

- The Mediterranean style of eating can have beneficial impacts on women’s health during menopause. This eating pattern emphasizes plenty of vegetables, fruits, beans, lentils, fish, nuts, and olive oil. At the same time, it limits saturated fats, red and processed meats, refined grains, and added sugars. Following this approach can help lower heart disease risk, support weight management, and improve diabetes and high blood pressure [21].

- Protein intake is important for preserving muscle mass and metabolic health in midlife and beyond. Recommend dietary protein intake of 1.0-1.2 g/kg body weight/day for postmenopausal women, with 20-25 g of protein at each meal [22].
- Adequate fiber supports digestive health and helps manage cholesterol and blood sugar. Women are recommended to achieve 21-25 g/day. Refer to www.ahs.ca/NutritionResources and search 'fibre' for more information.
- Nutrition is essential for bone health during menopause.
    - Calcium
        - Women aged 51 and older should aim for 1,200 mg/day of calcium from food sources and take supplements only if dietary intake is insufficient.
        - Avoid excessive supplementation; do not take more than 500 mg at one time for proper absorption.
        - Canada's Food Guide encourages calcium-rich foods such as:
            - Lower-fat milk, yogurt, and cheese
            - Fortified plant-based beverages (soy, almond)
            - Calcium-fortified foods (e.g., orange juice)
    - Vitamin D
        - Health Canada recommends that all adults over 50 take a daily vitamin D supplement of 400 IU because it is difficult to meet needs through food and sunlight alone.
        - Food sources include fortified milk and plant beverages, eggs, and fatty fish, but these alone are usually insufficient [23]
- When patients need nutrition support, consider including a registered dietitian. Together with the patient, they develop a nutrition care plan that respects individual food preferences and promotes a flexible, personalized, and sustainable strategy to meet nutrient goals. This helps to avoid overly restrictive or nutritionally unbalanced diets that may conflict with evidence-based guidelines. To refer your patient to a registered dietitian, see referral section.

Mental well-being

Midlife and menopause can be challenging due to physical changes, life transitions, and caregiving responsibilities. While irritability or mood changes may occur during menopause, not all symptoms should be attributed to hormonal shifts. Some mood disturbances are hormone-sensitive and improve with treatment, while others indicate underlying depression or anxiety that require separate management.

- Screen proactively for mental health during menopause visits, especially if patients report sleep issues, mood changes, or cognitive concerns.

- Current guidelines recommend routine screening for mental health concerns in midlife women using validated tools:
    - **For Depression: Use the Patient Health Questionnaire - PHQ-9:**
        - PHQ-9 is a patient-reported tool that asks a patient to answer 9 questions on depression. See Patient Health Questionnaire (PHQ-2 & PHQ-9).
    - **For Generalized Anxiety Disorder: Use the GAD-7:**
        - GAD-7 is a patient-reported tool that asks the patient to answer 7 questions on anxiety. See Self-Test for Anxiety (GAD-7).
- Interpret scores according to standard thresholds and manage as per general population guidelines, including referral to mental health services when indicated (example: Help in Tough Times | Alberta Health Services).
- Incorporate shared decision-making and consider non-pharmacologic strategies (e.g., CBT, lifestyle interventions) alongside medical treatment when appropriate.

Studies show that stress is closely linked to the severity of menopausal symptoms, especially hot flashes and sleep disturbances [24].

Healthy Relationships

Social connection is a key determinant of healthy aging and well-being during menopause.
Strong social support may be associated with [25]:

- Improved management of chronic conditions (e.g., heart disease, diabetes, osteoporosis)
- Better mood, cognitive function, and overall quality of life
- Lower risk of mortality and disability

Conversely, loneliness and social isolation can be linked to:

- Increased risk of stroke, cardiovascular disease, metabolic syndrome, and depression
- Poor nutrition, reduced physical activity, and lower bone mineral density

Recommendations to support healthy relationships

- Ask about social support, relationships, and feelings of isolation during menopause-related visits.
- Encourage connection:
    - Promote engagement in community, family, or peer support groups
    - Recommend activities that foster social interaction and physical movement
- Support mental health:
    - Recognize the role of healthy relationships in reducing anxiety and depression
    - Refer to appropriate mental health supports when relationship stress impacts well-being. Please see: Help in Tough Times | Alberta Health Services
- Highlight relationship quality:

    - Discuss the importance of nurturing positive relationships
    - Encourage open communication and emotional support within partnerships
- Strategies to improve overall quality of life. These include mindfulness, cognitive-based therapy and relaxation techniques [17].

Avoidance of substances

Substance use has traditionally been studied through a male-centric lens, often overlooking how biological factors like ovarian hormones influence women's vulnerability and response to substances [26]. Some trends show that substance use among women is rising, even surpassing men in some areas [27].

Alcohol and Menopause:

- Increased vulnerability: Physiological changes during menopause make women more susceptible to alcohol's harmful effects, including earlier onset of alcohol-related diseases [28].
- Hormonal disruption: Alcohol can interfere with the neuro-hormonal axis, increase estrogen levels, and affect hormone metabolism, impacting reproductive health and potentially altering the timing of menopause [17].
- Alcohol consumption is a well-established, yet often overlooked, modifiable risk factor for breast cancer. Even low levels of intake such as 3 to 6 drinks per week, have been associated with a statistically significant increase in breast cancer risk [29]. A 2024 systematic review and meta-analysis further confirmed that alcohol is an established cause of female breast cancer, with risk increasing in a dose-dependent manner across all levels of consumption [30]
- Changing patterns: The gender gap in alcohol consumption narrows with age, with women increasingly matching or exceeding men's intake.
- Encourage adherence to national guidelines. Canada's 2023 Guidance on Alcohol and Health recommends a low-risk threshold of 2 or fewer standard drinks per week, with no more than 1 drink on any given occasion, to minimize alcohol-related harms [31].
- Refer to the Primary Care Pathway: Alcohol Use Disorder for guidance and connect patients with behavioral health, counseling, or substance use support services.

Smoking and Menopause:

- Smoking is linked to an earlier onset of menopause and worsened physical and vasomotor symptoms.
- Longer smoking history (20–30 years) is associated with more severe menopausal symptoms compared to shorter durations (<10 years) [32].
- Menopause increases cardiovascular risk, and smoking compounds this, making cessation especially critical during this life stage.

- Routinely assess smoking status during midlife and menopause visits. Educate on impact and explain how smoking affects menopause timing, symptom severity, and cardiovascular health.
- Refer to smoking cessation programs tailored for midlife women.

Restorative Sleep

Restorative sleep refers to sleep that improves daytime functioning, enhancing mood, energy, cognition, and overall well-being. During menopause, hormonal changes disrupt sleep architecture, leading to non-restorative sleep, insomnia, and frequent awakenings.

- Sleep disturbances are common in midlife, affecting 40–60% of menopausal women [33], and are linked to:
    - Increased severity of vasomotor symptoms
    - Mood disorders
    - Cognitive decline and reduced quality of life
    - Higher risk of cardiovascular disease

Recommendations for supporting restorative sleep:

- Ask about sleep quality, duration, and daytime functioning during menopause-related visits.
- Consider sleep diaries or questionnaires to assess non-restorative sleep and insomnia symptoms.
- Evaluate for vasomotor symptoms, mood changes, pain, and other sleep disorders (e.g., sleep apnea, restless legs syndrome).
- Promote sleep hygiene [17]:
    - Encourage consistent sleep schedules
    - Recommend a cool, dark, quiet sleep environment
    - Limit caffeine, alcohol, and screen time before bed
    - Suggest regular daytime physical activity
- Cognitive Behavioral Therapy for Insomnia (CBT-I) is recognized as one of the most effective nonpharmacological treatments for chronic insomnia. It offers outcomes comparable to sleep medications but without the associated side effects. It is associated with lower relapse rates and sustained improvements in sleep, often continuing well beyond the conclusion of treatment. These long-term benefits are attributed to patients learning strategies that support and enhance the body's natural sleep processes [34].

Symptom Specific Management

Symptom management during the perimenopausal and postmenopausal years requires a comprehensive and individualized approach. While lifestyle modifications are foundational and beneficial for all patients, targeted interventions should be guided by the specific symptoms each

individual presents with. This following section outlines evidence-based recommendations for symptom-specific management in addition to lifestyle management.

Vasomotor Symptoms (VMS)

- VMS associated with menopause are experienced by approximately 80% of women, with up to 40% reporting symptoms that are moderate to severe [35]. These symptoms typically persist for an average duration of 7.4 years.
- Vasomotor symptoms are attributed to fluctuating and declining estrogen levels during the menopausal transition, which disrupt the hypothalamic thermoregulatory center, leading to transient episodes of peripheral vasodilation and heat sensation.
- VMS can significantly affect various aspects of daily life, with sleep being the most commonly and severely impacted domain.
- Frequent or persistent VMS are associated with higher risk of cardiovascular events and adverse metabolic markers (e.g., hypertension, dyslipidemia, insulin resistance). Study of Women's Health Across the Nation (SWAN) cohort data show women with frequent VMS had a 51% higher risk of CVD events, and persistent symptoms increased risk by 77% [36].
- These symptoms are linked to increased use of healthcare resources and notable impairments in both work productivity and routine activities. Among postmenopausal women, hot flashes are the most frequently cited reason for seeking treatment.
- Lifestyle modifications are recommended as part of a holistic approach to managing VMS and are outlined above (link). Table 2 (below) outlines what current evidence shows for lifestyle techniques for VMS

Table 2: Current Evidence for Mind-Body Techniques for VMS.

Current Evidence for Mind-Body Techniques for VMS [37]			
Technique	**Canadian Menopause Society (2021)**	**The Menopause Society (2023)**	**International Menopause Society (2023)**
Cognitive Behavioral Therapy	**Efficacious**	**Recommend**	**Significantly reduces VMS**
Clinical Hypnosis	**Efficacious**	**Recommended**	**Can be considered**
Mindfulness Based Interventions	May be efficacious	Not enough data to recommend	-
Paced Respiration	Not recommended	Not recommended	-
Relaxation	Not recommended	Not recommended	-

Cognitive Behavioral Therapy is an evidence-based, non-hormonal approach that shows significant benefit in managing VMS.

- Clinical trials indicate that CBT can:
    - Reduce hot flash frequency and severity.
    - Improve coping strategies, sleep quality, and emotional well-being.
    - Enhance overall quality of life, particularly for women who prefer non-hormonal options or have contraindications to MHT.
- Studies report up to 65–78% improvement in symptom burden. While CBT may not always reduce frequency, it consistently lessens how disruptive symptoms feel. It is effective across multiple delivery formats including group sessions, self-guided programs, nurse-led interventions, and online platforms, making it an ideal mind-body therapy for women seeking non-pharmacologic solutions [38].

Clinical Hypnosis for VMS management:

- The Menopause Society acknowledges hypnosis as a promising nonhormonal therapy for VMS. Specifically, the statement cites randomized controlled trials (RCTs) demonstrating that clinical hypnosis significantly reduces the frequency and severity of hot flashes in menopausal women. These effects are comparable to or exceed those of some pharmacologic treatments, with the added benefit of minimal side effects.
- Hypnosis interventions typically involve multiple sessions with a trained provider and include guided imagery, relaxation techniques, and suggestions for cooling and comfort. The mechanism is thought to involve modulation of the autonomic nervous system and stress response, which are implicated in the pathophysiology of VMS [38].

Menopausal Hormone Therapy (MHT) for VMS:

- Hormone therapy remains the most effective treatment for vasomotor symptoms [35, 39]. It can be safely initiated in women under 60 years of age or within 10 years of menopause onset, provided there are no contraindications [1] [13]. It is essential to engage patients in a thorough discussion of all available pharmacological options-both hormonal and non-hormonal. This ensures informed decision-making and supports the development of a personalized care plan that reflects each patient's preferences, treatment goals, and individual risk–benefit profile.
- To provide benefit and minimize risks, aim for the lowest effective dose of systemic estrogen therapy consistent with treatment goals [39].
- Prolonged exposure of the endometrium to unopposed estrogen increases the risk of endometrial hyperplasia and cancer. The primary menopause-related reason for prescribing progestogen is to prevent endometrial overgrowth and reduce this cancer risk during estrogen therapy (ET).

Women with an intact uterus who use systemic ET should receive adequate progestogen, except when taking conjugated estrogens combined with bazedoxifene (BZA) [39].

- If patient has desire for MHT, review the following contraindications as per the SOGC, to determine if MHT is appropriate or not.

Table 3: Contraindications to Systemic Estrogen.

Contraindications to Systemic Estrogen [39, 37]	
• Unexplained vaginal bleeding • Known, suspected, or history of breast cancer • Known or suspected estrogen-dependent cancer (i.e., endometrial, ovarian) • Coronary heart disease	• Active or history of venous thromboembolism • Active or history of stroke • Known thrombophilia • Active liver disease • Known or suspected pregnancy • Uncontrolled hypertension

Note: Those with contraindications to MHT can still benefit from vaginal estrogen for GSM.

Table 4: Contraindications to Progestogen.

Contraindications to Progestogen [37]	
• Undiagnosed abnormal vaginal bleeding	• Active breast cancer or **personal history** of breast cancer

Table 5: Comorbidities and Risk Factors.

Assess Comorbidities and risk factors (these are not contraindications)		
• Diabetes mellitus • Metabolic syndrome • Migraine with or without aura* • Fatty liver without impaired liver function	• Hyperlipidemia • High triglycerides • Malabsorption • Gallstones • Elevated CVS risk	• Obesity • Elevated risk for VTE • Smoking • Hypertension

***Headaches/migraines** [18]

- Migraine frequency may increase during perimenopause and decrease after menopause.
- Although migraine headaches are often managed with triptans, beta-blockers, anti-depressants or anticonvulsants, MHT may be helpful as frequency and intensity of migraines may be impacted by fluctuations in hormone levels.
- The use of transdermal estrogen may improve menstrual migraines (use week before menses and continue until end of menses).
- Migraine without aura: May experience improvement with MHT. Transdermal estrogen and micronized progesterone may be preferred as oral estrogen provides less stable serum estrogen levels and synthetic progestins may aggravate headaches.

    - Migraine with aura: May experience adverse effects with MHT. If aura worsens, decrease dose or discontinue MHT. Migraine headaches with aura are associated with double the risk of stroke.
    - Consult a headache expert as needed.

- **Determine Uterine Status.** Assess whether the patient has an intact uterus, as this determines the need for endometrial protection
    - No uterus: Estrogen-only therapy is appropriate.
    - Intact uterus: Combined therapy (estrogen plus a progestogen, either systemic or intrauterine) is required to prevent endometrial hyperplasia and carcinoma, as recommended by SOGC and CMS guidelines.
    - Patients with endometriosis: Even after hysterectomy, add-back progestogen therapy is recommended to reduce the risk of stimulating residual endometriotic tissue.
- **Choose Therapy Type Based on Menstrual History**
    - Determine the timing of the final menstrual period. If more than one year has passed, continuous combined therapy is recommended.
    - If last menstrual period was less than one year ago, a cyclic regimen is preferred, involving daily estrogen with progestogen added for 12–14 days per month. This approach aligns with CMS recommendations to mimic natural hormonal fluctuations and minimize side effects.
- **Address Genitourinary Syndrome of Menopause (GSM)**
    - If GSM symptoms are present, such as vaginal dryness or discomfort, consider adding local vaginal estrogen therapy. This can be used alone or in conjunction with systemic MHT. Local therapy is effective for GSM and has minimal systemic absorption, making it suitable for women with contraindications to systemic estrogen.
- **Select Appropriate Dosing and Formulation**
    - Use the Canadian Menopause Society's MHT Dosing Table and Equivalency Table to guide selection of appropriate products and dosages. These resources provide detailed information on oral, transdermal, and combination therapies, including starting doses and equivalencies

Menopause Hormone Therapy (MHT)

Canadian Menopause Society MHT Dosing Table

Canadian Menopause Society MHT Equivalency Table

Timing of Estrogen Therapy Initiation:

- Primary care providers should consider the timing of therapy as part of individualized risk-benefit discussions, while continuing to follow established guidelines for safety and monitoring. MHT can be initiated during perimenopause, it is not necessary to wait to initiate therapy until after the last menstrual period.
- Current evidence suggests that initiating estrogen-based therapy during perimenopause may be associated with lower risk and potentially greater benefit compared to starting later in the postmenopausal period. While these findings are based on observational data and may be influenced by biases such as healthy-user effect, they highlight an important area for future research on optimizing hormone therapy timing [40].

Note: Compounded Bioidentical Hormones [38]

- The terms *"bioidentical"* or *"body identical"* are frequently used in marketing by businesses promoting compounded hormone products. **These compounded formulations are not approved by Health Canada and pose significant safety concerns because they are unregulated, lack standardized manufacturing processes, and do not meet established quality or sterility requirements.**
- Current evidence does not support the safety or efficacy of compounded bioidentical hormone therapy for most individuals.
- According to the Canadian Menopause Guidelines, Health Canada, and the North American Menopause Society (NAMS), compounded bioidentical hormones should not be used due to the following concerns:
    - **Not approved or regulated:** These products do not meet Health Canada standards for safety, potency, or consistency.
    - **Insufficient evidence:** No large-scale clinical trials demonstrate superior safety or effectiveness compared to approved therapies.
    - **Quality risks:** Potential for inaccurate dosing, contamination, and lack of sterility.
    - **Unreliable monitoring:** Salivary hormone testing, often marketed with these products, is inaccurate and not recommended.

- **No standardized risk labeling:** Patients may be unaware of potential harms, including increased risk of endometrial hyperplasia, breast cancer, and cardiovascular events due to inconsistent dosing.
- Clinicians should educate patients about these risks and caution against misleading marketing claims that portray compounded hormones as “natural” or “safer.”

- In contrast, commercially manufactured bioidentical hormones that are regulated and approved by Health Canada are considered safe when used appropriately. These include estrogen, local vaginal estrogen (for GSM symptoms) and progesterone. These formulations have undergone rigorous scientific testing for safety, efficacy, and quality control, unlike compounded products, which should not be recommended [41].

Non-Hormonal Pharmacological Therapy for VMS:

Non-hormonal pharmacologic options are recommended for patients who cannot or choose not to use hormone therapy for VMS. When prescribing non-hormonal therapies, clinicians should engage in shared decision-making to ensure patients understand both the rationale for treatment and the mechanism by which the selected medication may alleviate vasomotor symptoms. This is particularly important as some patients may not recognize the connection between certain medications, such as antidepressants, and the improvement of their symptoms. Clear, collaborative discussions can help address misconceptions and support informed choices.

Table 6: Non-hormonal pharmaceutical options for VMS.

Non-hormonal pharmaceutical options for VMS [18, 35]			
Drug	Trade Names/Strengths Available	Doses	Comments
Serotonin-Norepinephrine Reuptake Inhibitors (SNRI)			
venlafaxine*	Effexor XR®, generics 37.5, 75, 150mg caps	37.5mg-150mg	Start 37.5mg daily x1 week, then increase to 75 mg daily. Taper to discontinue
desvenlafaxine*	Pristiq®, generics 50, 100 mg tabs	100-150mg daily	Start with 50 mg, then increase to 100mg over a few days. Taper to discontinue
Selective Serotonin Reuptake Inhibitors (SSRI)			
paroxetine*	Paxil CR®, generics 12.5, 25 mg tabs	12.5-25mg daily	Taper to discontinue
citalopram*	Celexa®, generics 20, 40mg tabs	20 mg daily	Taper to discontinue
escitalopram*	Cipralex®, generics 10, 20mg tabs	10-20mg daily	Taper to discontinue

Non-hormonal pharmaceutical options for VMS [18, 35]			
Drug	Trade Names/Strengths Available	Doses	Comments
Alpha-adrenergic agonists			
clonidine	generics 0.025mg tabs	0.05mg bid	**No longer routinely recommended as medication alternatives are available that are more effective and have fewer side effects. Some women may require higher doses (i.e.: 0.05mg tid), but side effects may limit use. Taper slowly to discontinue. Not recommended by the Menopause Society Non-Hormonal Position Statement (NAMS) 2023.
Gabapentinoids			
gabapentin*	Neurontin®, generics 100, 300, 400 mg caps 600, 800mg tabs	Start 300mg daily, then increase to 300mg tid at 3-4 day intervals**	May take 1-2 weeks to see effective dose for VMS.
pregabalin*	Lyrica, generics 25, 50, 75, 150, 200, 225, 300 mg caps	150-300 mg daily	Less well studied in menopause, not recommended by the Menopause Society Non-Hormonal Position Statement (NAMS) 2023.
Anticholinergic Agent			
oxybutynin*	Generics 2.5, 5 mg tabs	2.5-5mg twice daily	Reductions in VMS also demonstrated with 15 mg extended -release daily dose; this dose is not currently available in Canada.
Neurokinin B (NKB) Receptor Antagonists			
fezolinetant	Veozah® 45mg tab	45mg po OD	First Health Canada approved non-hormonal treatment for moderate to severe hot flashes Approx. 60–65% reduction in hot flash frequency after 12 weeks (vs ~40% with placebo) Common side effects: mild headache, stomach upset, or sleep changes Complete baseline ALT, AST, ALP and a total and conjugated bilirubin

Non-hormonal pharmaceutical options for VMS [18, 35]			
Drug	Trade Names/Strengths Available	Doses	Comments
			before initiation. Repeat at month 1, 2, 3, 6 and 9. Do not start if: • ALT or AST ≥ 2x ULN • Total bilirubin ≥ 2x ULN • Proceed with caution if ALT/AST > 1.5x ULN and < 2x ULN
elinzanetant	Lynkuet® 50mg cap	120 mg po OD HS (2 x 60mg tablets)	Expected to offer hot-flash relief with added benefit on sleep and mood. Hot flashes cut by ~70% from baseline by week 12. Approved in Canada July 2025 Safe in those with a history of breast cancer.
*Off-label use: Not approved by Health Canada for this indication. **Gabapentin can also be used as a nightly dose to help with sleep. It is recommended to start with 300mg nightly and increase in increments of 100mg to doses of 600-900mg nightly.			

Gabapentinoids

Gabapentin is effective for managing vasomotor symptoms and is especially useful in patients with concurrent neuropathic pain. Common side effects include dizziness and drowsiness, which typically resolve within 4 weeks. Start with a low dose and increase gradually as tolerated. The target dose for treating hot flashes is 300 mg po TID.

Antidepressants (SSRIs/SNRIs)

These medications are commonly used to manage vasomotor symptoms in patients who cannot or choose not to use hormone therapy. Low doses are often sufficient for symptom relief. In high doses, all SSRIs and SNRIs can cause hot flashes.

Anticholinergic

Oxybutynin can help reduce sweating associated with vasomotor symptoms. However, it carries a risk of significant side effects, including dry mouth, urinary retention, and constipation. In older adults, it may also cause cognitive difficulties, and in some cases, these impairments can become permanent.

NK3 Antagonists- Neurokinin B Receptor Antagonists

Emerging research highlights the role of Neurokinin B (NKB) signaling via the neurokinin-3 receptor (NK3R) in the pathophysiology of menopausal hot flashes. This pathway, active within the preoptic area of the hypothalamus, has become a promising target for nonhormonal treatment strategies. Recent clinical trials have demonstrated that NK3R antagonists can lead to rapid and sustained reductions in hot flash frequency and severity, while also improving quality of life. Importantly, these benefits are achieved without the use of estrogen, making NK3R antagonists a valuable option for individuals seeking nonhormonal therapies [42].

Natural Health Products and Supplements in Menopause Care [34]

- Many natural health products and dietary supplements that are marketed for menopause management and menopause relief are not approved by Health Canada. Given the lack of evidence on efficacy and safety, they are not recommended.
- Products not approved by Health Canada lack robust evidence of effectiveness in managing moderate to severe symptoms and are not subject to the same regulatory standards as prescription medications.
- Purity, potency, and safety can vary widely, and claims of benefit are often based on limited or low-quality studies.

  Key Risks:
  - **Unregulated quality**: No assurance of consistent dosing or absence of contaminants.
  - **Drug interactions:** Supplements can interact with prescription medications, increasing the risk of adverse effects.
  - **False sense of safety**: “Natural” does not mean safe or effective.

  Clinical Guidance:
  - Advise patients that these products are not approved by Health Canada for menopause treatment.
  - Emphasize the lack of strong evidence and potential risks.
  - Encourage evidence-based therapies and refer to a registered dietitian or pharmacist for safe, individualized care. [43]. See Provider Resources section for referral information.

Cannabinoids and Menopausal Symptoms:

- Cannabis use among midlife women is increasingly common, with surveys indicating that approximately 25–35% of women report using cannabis to manage menopausal symptoms.

- The most frequently cited reasons include improving sleep, reducing anxiety and depression, and alleviating muscle and joint discomfort. However, current evidence is limited to patient-reported surveys, and no randomized controlled trials have been completed to date.
- According to the 2023 NAMS Position Statement and Canadian guidelines, there is insufficient evidence at present to recommend cannabinoids for the treatment of vasomotor symptoms [35].

Genitourinary Syndrome of Menopause (GSM)

Estrogen and androgen receptors are widely distributed throughout the female genitourinary tract. Menopausal estrogen decline leads to structural and functional changes in the vagina, vulva, urethra, and bladder, including epithelial thinning, collagen loss, and reduced vascularization. These changes result in vaginal narrowing, decreased elasticity, and dryness. The reduction in glycogen-rich epithelial cells diminishes lactobacilli support, raising vaginal pH and increasing susceptibility to infections, including urinary tract infections.

Genitourinary syndrome of menopause (GSM) refers to a range of vulvovaginal, urinary, and sexual symptoms resulting from decreased estrogen and androgen levels in the genitourinary tract during menopause.

- Urinary symptoms, such as urgency or frequency, can overlap with other common urologic conditions in aging populations such as overactive bladder, making evaluation and management more complex.
- Estimates suggesting that 40% to 50% of postmenopausal women experience GSM are primarily based on self-reported symptoms [44]. Under-reporting is common, as many individuals attribute their symptoms to normal aging or feel uncomfortable discussing them with healthcare providers. In a 2018 study by Palacios et al., involving 2,160 postmenopausal women attending gynecology clinics, over 90% reported at least one genitourinary symptom of menopause. On average, participants experienced five symptoms, and clinical examinations confirmed atrophy in 81% of cases [45].

Common symptoms of GSM include:

- Vaginal symptoms: Dryness, itching, bleeding, dyspareunia (pain during intercourse).
- Urinary symptoms: Urgency, frequency, stress incontinence, recurrent urinary tract infections. For guidance on Female Urinary Incontinence please follow: Provincial Female Urinary Incontinence Primary Care Clinical Pathway.
- Sexual symptoms: Decreased lubrication, arousal, and libido due to vaginal discomfort and dryness.

Non-Pharmacological Therapies for GSM [46]:

Non-pharmacological options may help women with mild GSM symptoms or those avoiding hormones, but they do not reverse atrophy.

- **Lubricants & Moisturizers:** Restores moisture and health to vaginal tissues. No prescription needed. Do not contain estrogen. Can be expensive and may not work as well as vaginal estrogen therapy for GSM symptoms.
    - Lubricants are used as needed before intercourse. Examples include: Uberlube, Astroglide, Probe, Slippery Stuff, and K-Y Liquid.
    - Moisturizers are meant to be used on a regular basis for individuals experiencing vaginal dryness. Examples include: Good Clean Love, RepaGyn, Replens, Cleo, Zestica, Mae,and Gynatrof.
- **Pelvic Floor Physiotherapy:** Does not treat atrophy but may help with related issues such as pain, incontinence, and prolapse.
- **Sexual Activity:** Sexual activity (either with or without a partner) enhances blood flow to vagina and can help ease symptoms and keep vaginal tissues healthy. If intercourse is painful, encourage patient to give themselves plenty of time to feel aroused.

Pharmacological Options for GSM

The most effective treatment for vaginal atrophy is vaginal estrogen, which has few contraindications.

Local vaginal estrogen key points:

- Low-dose vaginal estrogen is safe and effective, even for long-term use.
- Does not require progestogen for endometrial protection.

Can be used in breast cancer survivors after shared decision-making [47].

Table 7: Pharmacological Options for GSM

Pharmacological Options for GSM			
Type	**Trade Names**	**Strengths Available**	**Starting Doses**
Vaginal Hormone Therapy			
Conjugated estrogen (CE)	Premarin® Vaginal Cream	0.625 mg/gram vaginal cream Refillable applicator	0.5 g vaginally daily for 14 days, then 0.5 g 2–3 times weekly
17 β estradiol	Vagifem® vaginal inserts	10 µg vaginal tablet with applicator	One tablet vaginally daily for 14 days, then one tablet twice weekly
17 β estradiol	Imvexxy® vaginal ovules	4 µg, 10 µg vaginal ovules	One ovule vaginally daily × 14 days, then twice weekly

17 β estradiol	Estring® vaginal ring	2 mg/vaginal ring	Inserted every 3 months
estrone	Estragyn® 0.1% vaginal cream	1 mg/gm vaginal cream Refillable applicator	0.5 g vaginally daily for 14 days, then 0.5 g 2–3 times weekly
Prasterone (DHEA)	Intrarosa® vaginal ovules	6.5 mg ovule	One ovule inserted vaginally daily
Oral selective estrogen receptor modulator (SERM)			
Ospemifene	Osphena® oral tablets	60 mg tablet	One tablet daily by mouth. • This is a newer medication for postmenopausal women experiencing moderate to severe dyspareunia and/or vaginal dryness. • A few side effects to consider include: hot flashes, hyperhidrosis, muscle spasms and vaginal discharge. • Contraindications: undiagnosed abnormal genital bleeding; history of, or active DVT, PE or arterial thromboembolic disease; known or suspected estrogen-dependent neoplasia; severe hepatic impairment; women who are or may become pregnant; and hypersensitivity to the medication. • Not recommended to combine with systemic MHT (different from other GSM products).

For Suggested Doses in MHT Regimens for GSM see:

Canadian Menopause Society MHT Dosing Table

Mood, sleep and cognition

Menopause is associated with a range of neuropsychological symptoms that can significantly impact quality of life, daily functioning, and long-term health.

Mood Disturbances [48]

- The menopausal transition is a period of increased vulnerability to mood disturbances, including anxiety, irritability, mood swings, and depressive symptoms. These are particularly prevalent during perimenopause and may exacerbate pre-existing mental health conditions.
- Although Major Depressive Disorder (MDD) is less common than general depressive symptoms, the perimenopausal period represents a distinct window of vulnerability for the onset or recurrence of MDD. Clinical evidence indicates that women are at a 2–4 times higher risk of developing MDD during the menopausal transition compared to premenopausal or postmenopausal stages [48].
- First-line treatments for depressive symptoms at any life stage including antidepressants, cognitive behavioural therapy (CBT), and other evidence-based psychotherapies should remain the standard during the menopausal transition and post menopause.
- Pharmacologic treatment may be considered for moderate to severe symptoms, particularly when functional impairment is significant or when psychotherapy is insufficient. Options include both hormonal and non-hormonal therapy.
- Hormone therapy may provide antidepressant benefits comparable to traditional agents in perimenopausal women, particularly when vasomotor symptoms are present.

Sleep Disturbances [48]

- Sleep disturbances affect 40–60% of peri- and postmenopausal women, with common complaints including sleep fragmentation, difficulty maintaining sleep, early morning awakenings, and insomnia [49].
- Sleep issues are often multifactorial, associated with reduced quality of life, impaired work productivity, and increase the risk of cardiovascular disease, diabetes, obesity, and cognitive decline.
- Initial management should include sleep hygiene education, emphasizing regular sleep schedules, minimizing stimulants, and creating a conducive sleep environment.
- Important to rule out primary sleep disorders, including sleep apnea, especially in women with risk factors such as obesity or loud snoring. See the Provincial Obstructive Sleep Apnea Primary Care Clinical Pathway.

- Address vasomotor symptoms, as they significantly contribute to sleep disruption; hormone therapy may improve sleep when these symptoms are present.
- CBT for insomnia is considered the gold standard non-pharmacologic treatment for chronic sleep disturbances.

Cognition and Brain Fog [48]

- Cognitive complaints, including memory lapses, difficulty concentrating, and forgetfulness, are reported by 40–60% of women during perimenopause [50].
- These symptoms, often described as “brain fog”, can be distressing and interfere with daily functioning, though they typically stabilize and improve post-menopause. Women should be reassured about the transient nature of these changes and supported with lifestyle interventions that promote cognitive health.
- Rule out reversible causes of cognitive symptoms, including:
    - Mood disorders (e.g., depression, anxiety)
    - Sleep disturbances
    - Thyroid dysfunction
    - Medication side effects
    - Chronic pain or fatigue
- Consider screening for early dementia in individuals with:
    - Persistent or progressive cognitive decline
    - Functional impairment
    - Family history of neurodegenerative disease
    - Age >65 with additional risk factors
- Hormone therapy may be considered for cognitive symptoms in perimenopausal individuals, especially if accompanied by vasomotor symptoms, and in the absence of contraindications.

For menopause hormonal therapy options to support sleep, mood and cognition see:

Canadian Menopause Society MHT Dosing Table

Canadian Menopause Society MHT Equivalency Table

Sexual health symptoms

Sexual health concerns are common during the menopausal transition, often involving overlapping domains of desire, arousal, pain, and orgasm. These symptoms can significantly affect quality of life and intimate relationships.

Common menopause-related symptoms that contribute to sexual dysfunction include:

- Hot flashes and night sweats
- Sleep disturbances
- Fatigue and low energy
- Weight gain
- Mood swings and irritability
- Overall decreased sexual function

A comprehensive, biopsychosocial approach is essential, incorporating clinical assessment, education, and non-pharmacologic interventions tailored to individual needs. Treat co-existing VMS and GSM symptoms is key.

- Sexual dysfunction in menopause frequently coexists with vasomotor symptoms and genitourinary syndrome of menopause (GSM).
- Vaginal atrophy is a leading cause of sexual pain in postmenopausal women and should be addressed as part of a broader symptom management strategy. A vulvovaginal exam is needed to rule out other causes such as lichen sclerosis.
- A brief sexual history should be routinely included in the assessment of menopausal women to identify sexual health concerns and guide appropriate interventions.
- Management should reflect the interconnected nature of menopausal symptoms. Addressing genitourinary syndrome of menopause (GSM) and vasomotor symptoms (VMS) may alleviate sexual discomfort and enhance overall sexual function. However, persistent dyspareunia may not resolve with GSM treatment alone. In such cases, referral to pelvic floor physiotherapy and/or sex therapy may be considered.

Self-Management Resources

- Self-management strategies empower women to take an active role in addressing sexual health concerns. These may include:
    - Use of lubricants and vaginal moisturizers to alleviate dryness and discomfort.
    - Access to educational resources on sexual health during menopause [51].To support your patient, see the menopause and perimenopause patient pathway.
    - Participation in support groups or online communities to share experiences and reduce stigma [52].

- Encouraging open communication with partners and healthcare providers is essential to normalize sexual health discussions and promote shared decision-making.

Sex Therapy

- Sex therapy is a valuable component of care for women experiencing sexual dysfunction, particularly when psychological or relational factors are involved.
- Therapeutic modalities may include:
  - Cognitive behavioural therapy (CBT) to address maladaptive beliefs and anxiety.
  - Mindfulness-based therapy to enhance body awareness and reduce performance-related stress.
  - Couples therapy to improve intimacy and communication.
- These approaches are especially effective for managing low sexual desire with associated distress, which is the most prevalent sexual concern among midlife women.
  - A multidimensional framework that integrates psychological, relational, and contextual factors is essential for effective treatment planning.

Management of Hypoactive Sexual Desire Disorder (HSDD)

Therapies are available for the treatment of hypoactive sexual desire disorder (HSDD) in appropriately screened postmenopausal women. These treatments should only be considered for confirmed HSDD causing personal distress, not for general age-related concerns or other conditions. [53]. Refer to the SOGC Clinical Practice Guideline: Menopause and Sexuality for more information on assessing for, and treating, HSDD.

Referral Considerations

- Refer to a clinical psychologist, sexual health specialist, or menopause specialist as needed.

Follow-Up and Monitoring in Menopause and Perimenopause Care

- **Symptom review**: Assess symptom control, side effects, and correct use of therapy every 3 months until stable, then annually.
- **Lifestyle support**: Reinforce sleep hygiene, physical activity, nutrition, and stress management.
- **Screening**: Continue age-appropriate routine screening as per For Health Providers - Screening For Life | Screening For Life
- **Optimize Bone health**
  - Monitor bone density if indicated based on risk factors or therapy type.
  - Bone health is a vital consideration during menopause due to the accelerated loss of bone mineral density associated with declining estrogen levels. Estrogen plays a key role in maintaining bone homeostasis by inhibiting bone resorption. Its deficiency

during menopause leads to increased osteoclast activity, resulting in net bone loss and heightened fracture risk [40].
    - Estrogen regulates bone turnover by suppressing osteoclast-mediated bone resorption and promoting osteoblast survival. This results in a rapid decline in BMD, particularly in the first 5–10 years post-menopause, and contributes to the development of osteoporosis and fragility fractures
    - Menopausal bone loss affects both the quantity and quality of bone. Trabecular thinning and perforation reduce bone strength, while cortical porosity increases fracture susceptibility. These changes are often asymptomatic until a fracture occurs, underscoring the importance of early intervention.
    - Hormone therapy prevents bone loss and reduces fracture risk in healthy postmenopausal women, with dose-related effects on bone density [39].
- **Therapy evaluation**: Reassess risk profile and ongoing need for therapy. If no improvement after 3 months, consider alternate treatment or refer to a specialist.
- **Clinical tools**: Use the Troubleshooting Guide below and refer to relevant pathways as needed:
    - Provincial Post-Menopausal Bleeding Primary Care Clinical Pathway
    - Provincial Female Urinary Incontinence Primary Care Clinical Pathway

Discontinuation of MHT

- Approach: Tapering or abrupt cessation are both acceptable.
- Recurrence: Up to 50% may experience symptom recurrence.
- Duration: No fixed time limit for MHT use; decisions should be individualized based on benefits, risks, and patient preference [39].

The table below consolidates strategies for managing common adverse events and practical issues with MHT, aligned with clinical guidance and expert opinion and experience [1] [13] [35].

Table 8: Troubleshooting Menopause Hormone Therapy (MHT) Issues.

Troubleshooting Menopause Hormone Therapy (MHT) Issues [13] [54]	
Problem	**Recommended Action**
Application Problems	• Gel (Estrogel): Apply to same area daily (thighs or abdomen); spread thinly; allow 2 min to dry; replace bottle after 64 doses. • Gel (Divigel): Apply full packet to thigh; alternate sides daily; wait 1 hr before washing. • Patch: ○ Apply to clean, dry skin (buttocks, abdomen, hips); rotate sites; press firmly for 10 sec; avoid breasts and broken skin.

	○ If patch adhesion is poor, consider switching brands (e.g., Estradot often sticks better). ○ If patch falls off, apply a new one and resume original schedule. ○ For poor adhesion: Swab site with alcohol, let dry before application.
Missed Gel Dose	• If next scheduled dose is <12 hrs away, skip missed dose and continue usual schedule. • If next dose is >12 hrs away, apply missed dose and resume usual schedule.
Skin Irritation	• Rotate patch sites. • Avoid broken skin for gels. • Mild topical steroids as needed.
Vaginal Bleeding	• Common in first 3–6 months of continuous combined therapy (up to 40%). • Assess adherence. • Lower estrogen dose; increase progesterone dose. • If bleeding persists >6 months or new onset after 6 months, investigate for abnormal uterine bleeding.
Breast Symptoms	• Lower estrogen dose. • Switch progestogen product. • Switch to another estrogen
Fluid Retention	• Restrict salt. • Maintain adequate water intake. • Encourage exercise. • Consider mild prescription diuretic.
Bloating	• Lower progestogen dose. • Switch to another progestin or micronized progesterone.
Progestogen Intolerance	• Switch to micronized progesterone. • Switch to conjugated estrogens/bazedoxifene (Duavive) or Tibolone (Tibella) • Consider non-hormonal management of VMS with NKB antagonist. • Consider estrogen alone in people with hysterectomy.
Mood Changes	• Investigate preexisting depression or anxiety. • Lower or switch progestogen dose. • Switch route of administration. • Ensure adequate water intake; restrict salt, caffeine, and alcohol.
Headaches	• Switch to non-oral continuous estrogen. • Lower dose of estrogen or progestogen or both. • Ensure adequate water intake; restrict salt, caffeine, and alcohol.
Sleeping Issues	• Consider micronized progesterone (↑ sedation). • Rule out sleep disorders. • Consider CBT for insomnia and sleep hygiene.
Nausea	• Advise taking oral estrogen tablets with meals or before bed. • Switch to another oral estrogen. • Lower estrogen or progestogen dose.
Symptoms Persist	• Assess adherence. • Switch route of administration.

	• Optimize dosing and use lowest effective dose • Look for other problems that might interfere with response.

Advice Options

If this patient needs to be directed to hospital through RAAPID or the ER, call RAAPID for on-call surgeon or 911. *This box can be kept high level or specific Red Flags can be listed.*

Zone	Program	Online Request	Phone Number
Urgent Telephone			
All Zones	RAAPID	N/A	**North:** 1-800-282-9911 or 780-735-0811 **South:** 1-800-661-1700 or 403-944-4486
Non-Urgent Electronic			
All Zones	Netcare eReferral		N/A
Non-Urgent Telephone			
Calgary	Specialist Link	Online Request	403-910-[51
Edmonton, North	ConnectMD	Online Request	1-844-633-2263

In addition to where specified in the clinical pathway algorithm, you can request non-urgent advice at any point when uncertain about medications, next steps in treatment, or resources available.

*There are some exceptions to non-urgent telephone program hours of operation and exclusion.

Referral Process

Referral pathways help referring providers know how and where to send referrals to specialists. Referral pathways also outline what information, labs and diagnostic imaging are required with their referral to help the specialist clinically triage the patient. These pathways are co-designed with Primary and Specialty Care, Operations, and patients.

To ensure referring providers have referral information at their fingertips, referral pathways may link to clinical pathways when available. If you have questions or want to know more about the referral pathway development process, please email albertapathways@primarycarealberta.ca.

- **Urgent Referral –** Call surgeon on call via RAAPID or call 911 ***(if applicable).***
- **For all referrals to Gynecology** please ensure to follow the Provincial Gynecology, Adult Referral Pathway.
- **For referrals to Endocrinology**:
    - Search Endocrinology on the Alberta Referral Directory.
    - For Calgary Zone follow:
        - Endocrinology_AccessPathway (specialistlink.ca)
    - For Edmonton Zone:
        - Division of Endocrinology and Metabolism: 3B Kaye Edmonton Clinic: e-referral in Connect Care. Fax: 780-492-6444
        - Garneau Endocrinology Physician referral form www.garneauendocrinology.ca/GE_Referral_Form.pdf
        - C-endo (a division of C-health): https://c-health.ca/wp-content/uploads/2023/07/ACTIVE-C-endo-Edmonton-ABPM-Referral-Form-2023.pdf

      Zia Medical: ziamedical.ca/endocrinology

- **For all referrals to Menopause specialty clinics:**
    - Visit Alberta Referral Directory and search for menopause.
    - Note: When making referrals, ensure that the receiving clinics adhere to current, evidence-based menopause guidelines. Providers should also be aware of potential patient costs, including services or treatments that may not be covered by Alberta Health Care, and communicate this transparently to support informed decision-making.
- **For referrals to Nutrition Services:** To refer your patient to a Registered Dietitian:
    - Visit Alberta Referral Directory and search for nutrition counselling.
    - To learn more about programs and services offered in your zone, visit Nutrition Services | Alberta Health Services.
    - Health Link has Registered Dietitians available to answer nutrition questions. If a patient has a nutrition question, they can complete a self-referral at Health Link | Alberta Health Services or call 811 and ask to talk to a dietitian.

BACKGROUND

About this pathway

- This pathway was developed in collaboration with endocrinologists, urogynecologists, menopause specialists, primary care physicians, patient and family advisors, and the Provincial Pathways Unit.
- Condition-specific clinical pathways are intended to offer evidence-based guidance to support primary care providers in caring for patients with a range of clinical conditions.

Authors and conflict of interest declaration

The authors represent a multi-disciplinary team. Names of the content creators and their conflict-of-interest declarations are available on request by emailing albertapathways@primarycarealberta.ca.

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Pathway review process, timelines

Primary care pathways undergo scheduled review every three years or earlier if there is a clinically significant change in knowledge or practice. The next scheduled review is ***December 2028***. However, we welcome feedback at any time. Please send us your feedback here.

DISCLAIMER

This pathway represents evidence-based best practice but does not override the individual responsibility of healthcare professionals to make decisions appropriate to their patients using their own clinical judgment given their patients' specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified healthcare professional. It is expected that all users will seek advice of other appropriately qualified and regulated healthcare providers with any issues transcending their specific knowledge, scope of regulated practice or professional competence.

PROVIDER RESOURCES

Resource	Link
Canadian Menopause Society: Menopause HUB	Menopause HUB - Canadian Menopause Society
Menopause Management Tools: MQ6	MQ6 Menopause Management Tools
The 2022 Hormone Therapy Position Statement of the North American Menopause Society	nams-2022-hormone-therapy-position-statement.pdf

PATIENT RESOURCES

Resource	Link
Patient Pathway on MyHealth Alberta: A webpage and two PDF formats are available to allow for easy printing, download, or scanning a QR code with the patient's smart phone for more information at their convenience.	Will be available February 2026

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