

FEMALE FORCE READINESS NAVY MEDICINE
OPERATIONAL CLINICAL COMMUNITY



Caring for Service Women During Menopause and Perimenopause

*Information for providers on menopause
and perimenopause, including common
symptoms, clinical management, and
implications for service women across the
Navy and Marine Corps*

OCTOBER 2024



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PURPOSE OF THE RESOURCE

This guide aims to help primary care clinicians deliver comprehensive and empathetic care to service women ensuring they feel supported and informed during perimenopause and menopause.

Service women are staying in the Armed Forces later in their lives due to increased career longevity and additional support opportunities, signaling the need for primary care clinicians to provide menopause-and-perimenopause-focused care to maintain optimal readiness of the female force.

DISCLAIMER | The views presented in this resource do not reflect those of the Department of Defense and any medical information is not intended to replace advice from a professional health care provider. Any mention of specific apps or products does not indicate endorsement but is meant for an example that has worked for others.



Understanding Menopause & Perimenopause

This section defines and explains the biological processes of perimenopause and menopause, including hormonal changes and associated symptoms.

WHAT IS MENOPAUSE?

Menopause is a **biologic process for people born with ovaries**. It is defined by the cessation of menstrual cycles for 12 consecutive months, also known as amenorrhea. Menopause occurs after periods stop permanently, and patients can no longer become pregnant. Patients have reached menopause only after a full year since their last period, meaning they have not had bleeding or spotting, for 12 months in a row.

WHAT IS PERIMENOPAUSE?

Perimenopause is a **transition period to complete menstrual cessation**, preceding menopause, where hormone levels fluctuate, and women may experience menopause symptoms and irregular bleeding. Perimenopause is also marked by fluctuations in hormone levels that often result in clinical symptoms.

TRANSITION PERIOD TO MENOPAUSE

Women may experience the symptoms of menopause for **as long as 10 years** before menstrual bleeding stops. During the transition to menopause, estrogen and progesterone levels fluctuate, decreasing over time. The ovaries attempt to increase the amount of estrogen in the body, and periods become irregular. Irregular periods (e.g., changes in duration, frequency, and volume) happen during this time because patients may not ovulate every month. Many women also have hot flashes and other symptoms (e.g., breast changes, vaginal dryness, skin thinning, irritability) during this transition.

AFTER MENOPAUSE

After menopause, the amount of estrogen and progesterone in the body is significantly decreased. Common side-effects of menopause are due to the decrease of these hormones. This can also increase risk for certain health problems.

CULTURAL DIFFERENCES IMPACTING MENOPAUSE

Black and Hispanic women tend to experience menopause at an earlier age, with studies showing that psychosocial stress was predictive of an earlier menopause among those women. Additionally, Black and Hispanic women experience symptoms for longer, up to or more than 10 years, and may have more intense symptoms. Clinicians should consider cultural sensitivities and demographic variations in diagnosis and symptom manifestation when assessing patients. Please see the [Cultural Competency Training Guide](#) for guidance on addressing cultural sensitivities and providing care to different demographics.



Common Symptoms

When caring for patients experiencing menopause or perimenopause, providers should review common physical and psychological symptoms, as well as other potential health concerns that have been linked to menopause or perimenopause.

TYPICAL AGE RANGE FOR MENOPAUSE

Most women experience menopause between the ages of 40 and 58, with the average age at menopause being 51. Women in this age range who have not had menstrual cycles due to Long-Acting Reversible Contraception (LARC) or other medications that cause menstrual suppression may not meet the 12-month menstruation cessation criteria but can experience other symptoms and will have similar health risks. Please note that knowing the exact date in which menopause officially begins does not impact a patient's symptoms or treatment.

SYMPTOMS AND CONCERNS

Physical Symptoms

- Breast atrophy
- Skin thinning or decreased elasticity
- Hair thinning
- Exercise intolerance
- Difficulty maintaining healthy weight
- Musculoskeletal changes
- Increased susceptibility to injury
- Vasomotor symptoms
 - Hot flashes
 - Night sweats
 - Insomnia
- Urogenital atrophy
 - Itching
 - Vaginal dryness
 - Urinary frequency or urgency
 - Urinary incontinence

Psychological Symptoms

- Mood disturbances
- Irritability
- Fatigue
- Memory loss
- Depression
- Difficulty concentrating
- Poor memory
- Decreased confidence
- Anxiety

Potential Health Concerns

- Decreased libido
- Vaginal dryness
- Difficulty reaching orgasm
- Pain during intercourse
- Changes in metabolism
- Changes in sleep patterns
- Other medical conditions (i.e., headaches)



Lifestyle Modifications

When treating patients experiencing menopause or perimenopause, providers should discuss the following lifestyle and behavioral modifications to improve menopausal symptoms.

RECOMMENDED LIFESTYLE MODIFICATIONS

DIETARY MODIFICATIONS: Recommended dietary adjustments to support hormonal balance and overall health include:

- Balanced diet rich in fruits, vegetables, and whole grains
- Limited saturated fats, oils, and sugars
- Daily Goal: 1,200 to 1,500 milligrams of calcium
- Daily Goal: 800 international units of vitamin D per day

ACTIVITY MODIFICATIONS: Providers should suggest at least 30 minutes of moderate-intensity physical activity on most days and muscle-strengthening and posture exercises a few days per week to improve mood, sleep, and physical health. Additionally, providers can review pelvic floor exercises to improve certain forms of urinary incontinence.

SLEEP MODIFICATIONS: Providers should discuss the importance of adequate sleep and tips for improving sleep quality such as limiting caffeine intake in the afternoon or avoiding exercise before bedtime.

SMOKING MODIFICATIONS: Providers should discuss options for smoking cessation to reduce risk of heart disease, stroke, osteoporosis, and cancer. Stopping smoking can lessen hot flashes and reduce the risk of early menopause.

STRESS MODIFICATIONS: Providers should discuss stress management techniques such as mindfulness, yoga, meditation, and relaxation exercises.

BEHAVIORAL MODIFICATIONS: Providers should recommend behavioral modifications to treat mild hot flashes such as lowering room temperature, using a fan, dressing in layers, and avoiding triggers such as alcohol.



Clinical Management

Providers should evaluate each patient with perimenopause or menopausal symptoms individually and use the following guidelines for discussion with each patient.

PROVIDER EVALUATION FOR PERIMENOPAUSE AND MENOPAUSE

Evaluating patients during and after the menopausal transition should follow an individualized approach. It is recommended that providers assess menstrual cycle history and gather a detailed history of menopausal symptoms, obstetric care, and hormone use (for contraceptive and non-contraceptive purposes).

COMPONENTS OF PROVIDER EVALUATION FOR PERIMENOPAUSE AND MENOPAUSE

Providers should review a patient's symptoms and medical history with focus on individualized concerns when discussing perimenopause and menopausal symptoms. The following are key considerations for this clinical evaluation:

MILITARY SERVICE: Providers should discuss and review the unique risks associated with military service that may impact health such as deployments, permanent change of station (PCS), physically demanding duties, operational pressures, hazardous exposures, and physical readiness tests (PRT).

CONTRACEPTION: If contraception is used as the primary form of pregnancy prevention, patients should continue to use contraception until they have experienced 12 months of amenorrhea.

- Contraception may also lessen the hormonal symptoms of menopause.
- Intrauterine Devices (IUDs) can also be effective in managing abnormal or irregular bleeding that can occur during menopause.
- Specific questions about contraception can always be discussed with a women's health provider.

VAGINAL SYMPTOMS: If menopausal symptoms include vaginal dryness, dyspareunia, or sexual dysfunction, a pelvic exam is recommended.

HISTORY OF OBSTETRIC CARE LATER IN LIFE: If service women have a history of obstetric care later in life, it is recommended to discuss how changes in postpartum menstrual cycles are different from perimenopausal symptoms.

CHRONIC MEDICAL CONDITIONS: Discuss any changes to chronic medical conditions and review current medications and supplements to ensure no change is indicated.

BREAST HEALTH: Discuss breast health and the recommended screenings as well as cervical cancer screening guidelines.



Clinical Management

Providers should evaluate each patient with perimenopause or menopausal symptoms individually and use the following guidelines for discussion with each patient.

ADDITIONAL COMPONENTS OF PROVIDER EVALUATION

The following are additional key considerations for this clinical evaluation:

GENITOURINARY SYNDROME OF MENOPAUSE: Review indications for Vaginal Estrogen (VE) to treat Genitourinary Syndrome of Menopause (GSM).

- **VE relieves vaginal dryness, itching, painful intercourse, and urinary symptoms. GSM can be treated with systemic or vaginal estrogen.**
- For vaginal symptoms only, topical treatment is preferred. Providers can consider a low dose (vaginal tablet, ring, or cream) that releases small amounts of estrogen to be absorbed by the vaginal tissue.

EARLY DETECTION: Highlight the importance of regular check-ups for early detection of menopause related health issues like osteoporosis, cardiovascular disease, breast and endometrial cancer.

- **OSTEOPOROSIS:** Menopause can increase the risk of osteoporosis because of lowered estrogen levels. Estrogen production keeps bones strong and prevents bone mass loss.
- As estrogen levels decline during the menopausal transition, bone resorption increases due to the activity of osteoclasts, which weakens bones and raises the risk of fractures.
- **CARDIOVASCULAR DISEASE:** Menopause can increase the risk for cardiovascular disease because decreases in estrogen can cause arteries to narrow and become less flexible, increasing the risk of hypertension and cardiovascular conditions.
- Patients can help prevent these risks by increasing low-impact weight training, maintaining cardio-based workouts, and increasing calcium intake.

SHOULD CLINICIANS USE LABS TO DETERMINE MENOPAUSE

During the menopausal transition, patients will experience significant fluctuations in hormone levels. Because of the inconsistency in lab values, providers should not reflexively draw hormone levels. No lab or blood work will help providers with the care of menopausal symptoms more than the awareness and treatment of symptoms.

WHEN TO CONSULT A WOMEN'S HEALTH EXPERT

If providers have specific menopause questions, they are encouraged to reach out to a women's health provider. Specific instances to consult a women's health expert in a perimenopausal or menopausal patient include:

- Patients experiencing menopause symptoms under the age of 40
- Bleeding after 12 months of amenorrhea
- Recurring urinary tract infections (UTIs)
- Debilitating fatigue
- Severe mood changes



Clinical Management

Providers should evaluate each patient with perimenopause or menopausal symptoms individually and refer to the following treatment options to determine the best approach.

Treatment Option	Description
Hormone Therapeutics	<p>Providers should discuss medical treatments such as menopausal hormone therapy (MHT) and its indications, benefits, and risks.</p> <ul style="list-style-type: none"> • Systemic menopausal hormone therapy (HT) is deemed as the most effective treatment for vasomotor symptoms.
Alternatives to Hormone Therapeutics	<p>Providers may consider discussing alternatives to hormonal therapeutics such as pharmacologic therapies (i.e., antidepressants, SSRIs and SNRIs) for vasomotor symptoms or complementary alternative medicines (i.e., herbal therapies, like ginseng, soy, vitamin E).</p> <ul style="list-style-type: none"> • Despite its efficacy, not all patients are candidates for HRT so providers should be sure to verify there are no contraindications prior to recommending HRT. • There is mixed evidence on the use of alternative medicines to treat menopause symptoms so providers should consider all risks, benefits, indications in a shared-decision making platform.
Other Medications	<p>Providers should also explain other medications that can help manage specific symptoms like antidepressants for mood or sleep aids.</p> <ul style="list-style-type: none"> • Clinicians should make patients aware that Navy Policy OPNAVINST 3591.1F Small Arms Training and Qualification notes that <i>“weapons and/or ammunition shall not be issued to any individual with a psychiatric diagnosis for which medication is necessary, unless recommended for a waiver. Psychiatric conditions requiring medications with a Selective Serotonin Reuptake Inhibitor (SSRI) that are determined to be stable shall normally be recommended for a waiver.”</i>
Therapy	<p>Providers should review cognitive behavioral therapy (CBT) or other therapies as an option to manage negative thoughts and enhance mood, related to menopause.</p> <ul style="list-style-type: none"> • Cognitive behavioral therapy for insomnia (CBT-I) is considered an effective treatment for individuals experiencing insomnia and menopause. • Moderate or severe depressive symptoms generally require pharmacologic treatment in addition to psychotherapy. For consistent psychological symptoms, refer patients to seek a mental health provider for further evaluation.
Further Evaluation For Vaginal Bleeding	<p>Providers should review indications with the patient for further evaluation. Any significant change in menstrual cycle may require further evaluation, including:</p> <ul style="list-style-type: none"> • Vaginal bleeding more often than every three weeks • Excessive and heavy menstrual bleeding • Spotting between periods • Vaginal bleeding of any amount after menopause • Nonhormonal medical management of abnormal uterine bleeding can include tranexamic acid and nonsteroidal anti-inflammatory agents. • Hormonal medical management options include low-dose oral contraceptives, cyclic oral progestogens, depot medroxyprogesterone acetate injections, the levonorgestrel releasing intrauterine system, and gonadotropin releasing hormone agonists.



Additional Resources

PROVIDER RESOURCES

- [National Library of Medicine](#) and [The Menopause Society](#) are sources of reliable health information regarding perimenopause and menopause.
- [Menopause Health Questionnaire](#) is a tool developed by the North American Menopause Society for clinicians to gather patient information related to menopause.
- [Menopause \(The Basics\)](#) and [Menopause \(Beyond the Basics\)](#) are evidence-based resources clinician can share with service women to improve understanding of menopause signs, symptoms, and treatment

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