Patient-Centered Approaches to Contraception in Perimenopause Webinar Q&A

August 26, 2025

Menopause Characteristics

1. Do you think the shorter menopause transition and reduced vasomotor symptoms experienced by Asian women could be linked to their diets being higher in estrogen?

The SWAN study (Study of Women's Health Across the Nation), a large, longitudinal study conducted in the United States from 1996 to 2013, examined differences in menopause experiences across racial, ethnic, and geographic groups, including Asian American women. While the study observed variations in menopause characteristics—such as the onset, duration of hot flashes, and vasomotor symptoms—it primarily focused on documenting these differences rather than linking them directly to dietary factors like estrogen consumption. For more detailed insights, PubMed offers numerous papers from the SWAN study that delve into ethnic-specific menopause experiences.

2. Is it just African American or Black women worldwide? Like African descent?

The SWAN study specifically investigated the menopause experiences of African American women living in the United States, alongside other racial and ethnic groups like Asian-American and white women. The findings reflect data from African American women in the United States rather than globally or across all women of African descent. For worldwide comparisons or studies outside the United States, additional research would be required.

3. Why use "pathophysiology" to define a process that all people with a uterus will undergo?

Menopause is often studied through the lens of pathophysiology because it involves biological changes with identifiable physiological effects, such as hormonal shifts and symptoms like hot flashes. The SWAN study's focus was to better understand these physiological processes and their variations across different groups. While menopause is a universal experience for individuals with a uterus, describing it in terms of pathophysiology allows researchers to analyze its mechanisms and impacts systematically.

4. If a patient is having heavy menstrual flow in perimenopause, how would you tease that in determining if it's due to perimenopause versus fibroids/polyps, etc.?

Heavy menstrual flow during perimenopause can result from structural causes, non-structural causes, or both. Structural problems include endometrial polyps, adenomyosis, submucous and intramural fibroids, and endometrial hyperplasia (and rarely, endometrial cancer). Non-structural problems include coagulopathy, anovulation, thyroid conditions, endometritis, and iatrogenic (due to medications). The PALM-COEIN mnemonic for abnormal uterine bleeding can be useful to remember these causes: P-polyp, A-adenomyosis, L-leiomyoma, M-malignancy. Non-structural C-coagulopathy, O-ovulatory, E-endometrial, I-iatrogenic, N-not otherwise classified. Heavy bleeding in perimenopause should be carefully assessed for structural abnormalities. Diagnostic tools include:

- Clinical history: Assess symptoms like irregular bleeding patterns, intermenstrual or post-coital bleeding, pelvic pain, dyspareunia, and bulk symptoms (e.g., pelvic pressure) due to uterine fibroids.
- Imaging: Pelvic ultrasound can identify fibroids, polyps, or endometrial thickening.
- Endometrial biopsy (EMB): Consider EMB for individuals ≥ 45 years old, or younger if risk factors (e.g., obesity, unopposed estrogen exposure) are present.
- Lab tests: Evaluate for anemia and thyroid dysfunction.

5. Is it often difficult to distinguish perimenopausal menstrual changes from AUB? Many patients get referred for EMB due to concerns about endometrial hyperplasia. Can you speak more about this?

Distinguishing perimenopausal changes from abnormal uterine bleeding (AUB) can be challenging due to overlapping symptoms (e.g., irregular bleeding). Key considerations include:

- Risk factors for hyperplasia: Obesity, unopposed estrogen exposure, polycystic ovary syndrome (PCOS), or tamoxifen use.
- EMB thresholds: Persistent or heavy bleeding, intermenstrual bleeding, or bleeding in patients ≥ 45 years old warrants evaluation.
- Imaging: Pelvic ultrasound can help identify structural causes (e.g., fibroids, polyps).

Careful history and diagnostic testing are necessary to guide referrals for EMB.

EMB is recommended for individuals with the following:

- Age ≥ 45 with AUB.
- Younger than 45 years old with risk factors such as obesity (BMI > 30), unopposed estrogen exposure, or persistent AUB.
- Postmenopausal bleeding: Always requires an EMB.

6. Any benefits for a uterine ablation procedure?

Endometrial ablation (EA) is an important and underused technology that can reduce or stop all uterine bleeding. Its main advantage is that it is an office or surgicenter procedure that is much safer than hysterectomy. EA is most beneficial for individuals with heavy menstrual bleeding who:

- Do not wish to preserve fertility.
- Have no significant structural abnormalities (e.g., large fibroids).
- Prefer non-hormonal treatments or have contraindications to hormonal therapy.

However, EA is not recommended for individuals with endometrial hyperplasia or suspected malignancy. It does not address menopausal symptoms and may complicate future endometrial assessments.

7. Are researchers not seeing changes/decreases in the high rates of miscarriage in that 40-44 age range? Since women are more active and healthier now?

Despite improved health and activity levels among women, miscarriage rates in the 40-44 age range remain high due to age-related factors like declining ovarian reserve and increased chromosomal abnormalities in eggs. While lifestyle factors can enhance overall reproductive health, they cannot fully counteract the biological effects of aging on fertility. Research continues to explore interventions to improve outcomes for older individuals seeking pregnancy.

8. As a comparison to the chance of pregnancy over 40 (~30%), do you know the chance of a pregnancy occurring in younger folks?

The chance of pregnancy in younger individuals (e.g., 20s–early 30s) is significantly higher; 20–25% per cycle for those actively trying to conceive, resulting in an 80% chance of pregnancy over a 12-month period. Fertility gradually declines with age, dropping to around 5–10% per cycle by the early 40s, largely due to reduced ovarian reserve and egg quality.

Diagnosing Menopause

9. Where do the FSH lab-draw recommendations and level guidelines that you presented come from?

The recommendations for using biochemical markers to diagnose menopause come from The Menopause Society (formerly the North American Menopause Society (NAMS)) guidelines and the Spiroff-Fritz textbook on GYN Endocrinology and Infertility. Historically, multiple follicle-stimulating hormone (FSH) tests are conducted to avoid inaccuracies from ovulatory surges. A single FSH level of 30 mIU/mL or higher, combined with an estradiol level of 20 pg/mL or lower, is diagnostic of menopause.

This assumes that the individual is not using any exogenous hormones and includes individuals who use copper IUDs and barrier methods.

10. Is FSH affected by HRT similarly to CHCs?

Yes, hormone replacement therapy (HRT) can suppress FSH levels depending on the dose and formulation, similar to combined hormonal contraceptives (CHCs). For accurate FSH testing, individuals should discontinue HRT for 6 weeks prior to testing to avoid confounding results.

11. How will patients know they have transitioned through menopause if they are on a combined hormonal method that prevents menses?

According to *Contraceptive Technology* (22nd edition, page 591), "FSH levels may be affected by use of CHCs. Due to the potential of false negative results after only 7 hormone free days, FSH levels should be drawn while off of CHC for at least 2 weeks (preferably 6 weeks if the patient is able to use a reliable back-up method). If the FSH level is subsequently elevated on two occasions at least 6-8 weeks apart, contraception can be discontinued."

12. How soon can you check FSH levels in someone using depot-medroxyprogesterone acetate (DMPA) if they have amenorrhea?

According to *Contraceptive Technology* (22nd edition, page 591), "FSH levels are not usually impacted by DMPA. In perimenopausal women, if FSH is suppressed, the levels generally return to baseline prior to the next injection. FSH can be checked on the day of injection and 13 weeks later at the next injection. If both FSH levels are > 30 mIU/mL, contraception can be stopped."

13. Does a hormonal IUD influence FSH? If so, how would you confirm menopause in a patient using a hormonal IUD or other progestin-only methods of contraception, including contraceptive implants?

Progestin-only methods such as Mirena®, other levonorgestrel intrauterine devices (LNG-IUDs), progestin-only pills (POPs), and implants do not consistently suppress ovulation and do not affect FSH levels, which rise naturally during menopause transition. Consequently:

- FSH and estradiol levels can be used to confirm menopause in individuals using these methods.
- A high FSH level (≥ 30 mIU/mL) combined with a low estradiol level (≤ 20 pg/mL) is diagnostic of menopause.

For Mirena® IUD users who experience amenorrhea due to the device, lab testing is particularly useful to distinguish menopause from IUD-related effects. These tests are reliable because Mirena® does not suppress the natural rise in FSH associated with menopause.

If a copper IUD is in place, menopause can often be assessed clinically, as most users continue to have regular menstrual periods. Hormonal testing (FSH and estradiol) can also confirm menopause prior to removing any long-acting contraceptive device.

IUDs and Menopause Transition

14. You mentioned removing Paragard® after 1 year. You did not say the same for Mirena® or Kyleena®. Could they stay in longer to help with symptoms?

Yes, hormonal IUDs like Mirena® or Kyleena® can stay in longer than the typical timeframe for pregnancy prevention, as they provide endometrial protection through progestogen release. This makes them beneficial for patients transitioning to estrogen therapy during menopause.

Unlike Paragard®, which is non-hormonal and typically removed within a year after menopause, Mirena® and Kyleena® can remain in place for extended periods to prevent endometrial hyperplasia while estrogen therapy is used.

15. Is there any time when progesterone needs to be added if the patient is taking estrogen and has a Mirena® in place?

No, additional progesterone is not necessary if an individual has a Mirena® IUD in place while taking estrogen therapy. If it has not expired, the Mirena® provides adequate progestogen release to stabilize the uterine lining and prevent endometrial hyperplasia. This eliminates the need for supplemental progestin, as the levonorgestrel released by the Mirena® effectively protects the endometrium.

This makes the Mirena® an excellent complement to estrogen therapy for managing vasomotor symptoms and other menopause-related concerns. It can be kept in place for extended periods, even beyond its approved timeframe for contraception, if it continues to provide endometrial protection.

Hormonal Therapy

16. Do you ever offer hormone replacement to patients with severe vasomotor symptoms who are still in perimenopause if symptoms are not well controlled with combined OCPs?

Yes, HRT can be considered for perimenopausal individuals with severe vasomotor symptoms not adequately managed by oral contraceptive pills (OCPs). Options include:

- Switching to menopausal hormone therapy (MHT): Use lower-dose estradiol therapy with progestogen for endometrial protection.
- Adjunctive non-hormonal therapies: selective serotonin reuptake inhibitors (SSRIs), selective norepinephrine reuptake inhibitors (SNRIs), or gabapentin can be added to address vasomotor symptoms (VMS).

A thorough assessment of risks and benefits is essential before transitioning to HRT.

17. If prior patients wanted LNG-IUD and treatment for VMS, would you consider ET?

Absolutely. An LNG-IUD like Mirena® is an excellent complement to estrogen therapy (ET) for treating VMS. The IUD provides localized progestogen to protect the endometrium, allowing safe use of systemic estrogen (e.g., an estrogen patch). The IUD can remain in place for an extended period—well beyond its use for pregnancy prevention—making it an effective option for bridging hormonal therapy during menopause.

18. If a patient didn't want to continue the pill, would it be okay to switch to non-hormonal contraception and start a more traditional EP HT?

Yes, switching to non-hormonal contraception (e.g., copper IUD, barrier methods) is appropriate if the individual no longer needs hormonal contraceptive benefits. Estrogen plus progestin hormone therapy (EP-HT) can then be initiated to manage menopausal symptoms, provided the individual has no contraindications.

Ensure the individual's endometrium is protected via progestogen if they still have a uterus.

19. We have a good number of perimenopausal women with neurobehavioral symptoms but no VMS, yet they want menopausal hormone therapy and not combined oral contraceptives (COCs). Is it OK to start MHT without VMS?

Yes, MHT can be initiated for neurobehavioral symptoms (e.g., mood swings, cognitive changes) even in the absence of vasomotor symptoms, provided there are no contraindications. Tailoring therapy to address the individual's specific concerns while monitoring long-term risks is key.

20. Can you clarify again why the estrogen in oral contraception can help with vasomotor symptoms versus the estrogen in patches or rings?

Estrogen in oral contraception (ethinyl estradiol) is at higher doses compared to MHT formulations, which helps suppress ovulation and minimize the hormone fluctuations that trigger vasomotor symptoms. MHT estrogen patches/rings are designed for lower doses to mimic physiologic levels, which may not fully suppress symptoms triggered by fluctuating ovarian hormones.

21. I have heard some people suggest that ethinyl estradiol does not effectively manage the symptoms of peri/menopause, but I have not found this to be true. Is there any reason to use both CHC as well as a pure estradiol patch/gel/pill?

Adding pure estradiol to CHC is not recommended to manage hot flashes. If symptoms are only partially controlled with CHC, options include:

- Increasing the estrogen dose in the contraceptive pill (e.g., from 20 to 30 micrograms of ethinyl estradiol).
- Switching to continuous use of CHC to avoid hormone-free intervals, which can trigger hot flashes.

Alternatively, adjunctive non-hormonal therapies like SSRIs, SNRIs, gabapentin, or venlafaxine can help manage vasomotor symptoms without adding estradiol. These approaches align with evidence-based guidelines.

22. What is the main difference clinically for CC versus CS estrogen progestogen therapy (EPT)?

- **CC (continuous combined):** Estrogen and progestogen are given daily without breaks, suppressing the endometrium and minimizing the likelihood of vaginal bleeding.
- **CS (continuous sequential):** Estrogen is given daily, but progestogen is cycled (e.g., 12–14 days/month). This regimen mimics the natural menstrual cycle and is intended to result in a few days of scheduled withdrawal bleeding after cycling off the progestin. It is used in the perimenopause and early menopause while there is still some amount of endometrial activity. Otherwise, the continuous combined regimen is preferred to avoiding bleeding entirely.

GLP-1 and Weight Gain

23. What are your thoughts on the use of GLP-1 for weight management during the perimenopausal period?

GLP-1 agonists are effective for weight management and can be used during the perimenopausal period for individuals seeking help with weight loss. However, they do not address vasomotor symptoms like hot flashes or night sweats. Evidence from the NAMS position statement shows that weight loss, exercise, relaxation techniques, or avoiding triggers do not improve vasomotor symptoms.

While GLP-1 agonists can aid in weight management, they should not be expected to treat symptoms related to menopause.

24. A lot of patients are concerned about perimenopausal or menopausal weight gain and question weight gain from HRT. What are your thoughts on this?

Evidence shows that HRT does not cause additional weight gain. While individual experiences vary, concerns about HRT-related weight gain are often based on misconceptions.

Estrogen doses in HRT are much lower than those in oral contraceptives, so significant weight gain is not expected. Short-term water retention may occur during the initial adjustment period, but this resolves within a few months and is not fat gain. For individuals concerned about physiological menopausal weight gain, GLP-1 agonists may be considered if they meet criteria for obesity, but HRT itself is not responsible for weight gain.

Withdrawal Bleed

25. If a patient is on CHC and is 50 and is NOT having a withdrawal bleed even when allowing for 7-day placebo pills or a 7-day break from patch, ring, etc., are they any more likely to be in menopause than someone who is still having a withdrawal bleed?

No. Amenorrhea that occurs in an individual using a CHC method or DMPA is the result of progestin-induced endometrial suppression…that is, it is a pharmacologic side effect. Individuals using CHCs have suppression of FSH and luteinizing hormone (LH) levels, and any markers of natural menopause are lost while taking the medication.

To confirm menopause, the individual can stop CHC for 6 weeks and test FSH levels. An FSH level of 30 mIU/mL or higher, followed by a second test 6 weeks later showing similar results, is diagnostic of menopause.(See question #11, above.)

Discontinuing HRT

26. How do you have conversations about cessation of HRT? I've had patients get really upset when trying to counsel them. Why stop the HRT?

Conversations about stopping HRT should be patient-centered and individualized, focusing on the individual's goals, concerns, and perceptions of risks versus benefits.

Understanding their specific worries—such as bone health or symptom recurrence—can help guide the discussion. For individuals over 60 or on HRT longer than 10 years, NAMS guidelines recommend evaluating risks and benefits, though many individuals perceive the benefits to outweigh the risks and may choose to continue therapy.

Transitioning off HRT can be done gradually or abruptly, depending on individual preferences. Addressing underlying concerns (e.g., anxiety or bone loss) with alternative treatments like SSRIs, SNRIs, or other therapies may help ease the process.

27. Are migraines with aura a contraindication for MHT?

Migraines with aura are generally considered a contraindication for estrogen-containing MHT due to the increased risk of stroke.

Non-estrogenic options, such as progestogen-only therapies or non-hormonal treatments (e.g., SSRIs, SNRIs), can be considered based on the individual's symptoms and preferences.

Depo-Provera: Depot-Medroxyprogesterone Acetate (DMPA)

28. How many years can women use Depo?

Women can use Depo-Provera (DMPA) for extended periods, including up to menopause, as long as it aligns with their contraceptive needs and health goals.

29. How concerning is it, as far as bone density loss, if a peri-menopausal client comes in asking to start Depo?

Bone density loss is a known side effect of Depo-Provera (DMPA), but it is reversible after discontinuation.

Starting Depo in the peri-menopausal period is acceptable, and any bone loss during this transition overlaps with the bone loss expected during menopause, rather than being additive.

30. Since DMPA decreases bone density and bone density starts to go back to normal when stopping, wouldn't we want people to ideally switch to another method earlier (like 40/45) to give them a chance to go back to normal before menopause, which will further impact bone density?

Stopping Depo before menopause is not necessary, as bone density loss during Depo use overlaps with menopausal bone loss and does not result in additive effects.

For individuals continuing Depo into their 40s, checking a serum estradiol level may help determine if low-dose estrogen add-back therapy (e.g., micronized estradiol 0.3–0.6 mg daily) is appropriate to reduce bone loss. In general, supplementation is considered if the estradiol level is less than 25 pg/mL.

General Questions

31. What are the symptothermal and 2-day methods?

Both are fertility awareness-based methods (FABMs; also referred to as natural family planning methods) for contraception or conception.

- Symptothermal method: Combines tracking basal body temperature, cervical mucus changes, and other ovulatory signs to identify fertile windows.
- 2-day method: Focuses solely on cervical mucus monitoring. If mucus is present today or yesterday, fertility is likely.

Both are natural family planning methods for contraception or conception.

32. It looks like the NAMS MenoPro app is no longer available. Can you recommend an alternative? Couldn't someone who has the NAMS MenoPro app share the app with someone else for access?

The NAMS MenoPro app was discontinued due to challenges in maintaining updates with new medications and changing guidelines.

Alternatives include the NAMS hormonal and non-hormonal treatment statements, which are recent and evidence-based. These guidelines, along with tools like decision trees and dosing tables available in presentations, are excellent resources for managing menopause symptoms. Sharing the app is not feasible as it is no longer supported.

33. What are your thoughts on using spironolactone for menopausal patients with hypertension (or without HTN)?

Spironolactone can be used off-label for menopausal individuals to address symptoms like acne or hirsutism, and it can also help manage hypertension due to its mild diuretic and anti-androgen effects.

For individuals without hypertension, spironolactone may still be prescribed if there are indications such as fluid retention or androgen-related symptoms. Its use should be individualized based on individual needs and monitored for potential side effects, such as hyperkalemia.

34. If a person is using a vaginal estrogen for vaginal atrophy and dryness (correctly referred to as genitourinary syndrome of menopause [GSM]), could they also use the vaginal lubricant like Luvena, and if so, how would you do that?

Vaginal estrogen can be safely combined with vaginal moisturizers like Luvena to address dryness. Topical vaginal estrogen is the most effective treatment for GSM symptoms.

Note that moisturizers are for daily use to prevent symptoms of vaginal dryness and irritation. They are different from "intimate (sexual) lubricants", such as Astroglide and others, which are intended to make intercourse more comfortable. Moisturizers do not help with intercourse (they often clump) and lubricants don't provide a day-long reduction in vaginal dryness.

35. Are there any heightened concerns around hysterectomies and their effect on perimenopause?

Hysterectomies can affect perimenopause depending on whether the ovaries are removed.

- If ovaries are preserved: Individuals often transition to menopause naturally and experience typical perimenopausal changes.
- If ovaries are removed (bilateral oophorectomy): Surgical menopause occurs abruptly, often leading to more severe symptoms like vasomotor instability and bone loss.

Individuals with surgical menopause will benefit from earlier initiation of MHT to mitigate symptoms and long-term risks.

36. Is there a specific pill recommended to manage premenstrual mood swings?

Any oral contraceptive provided to individuals with premenstrual mood swings should be used in a continuous regimen (no hormone-fee interval) as there will be no "premenstrual" time frame in which to experience premenstrual syndrome (PMS) symptoms. Drospirenone-containing pills (e.g., Yasmin, Yaz) are often recommended for managing perimenstrual mood swings due to their anti-androgenic and mild diuretic effects.

SSRIs or SNRIs can also be used adjunctively if mood symptoms persist despite hormonal therapy. Individualized treatment should be guided by the individual's overall health and specific symptoms.

37. Can you speak briefly about the cash cost of any of these options? I am finding that oral estradiol and some of the generic SSRIs are reasonable, but estradiol patch and other formulations seem pricey. Even patients with insurance seem to struggle getting adequate coverage.

Individuals with no or limited health insurance coverage can benefit from discount programs like GoodRx or manufacturer coupons, which can reduce out-of-pocket costs for these therapies. Here are some examples:

- Oral estradiol: Typically affordable, with cash prices ranging from $10–$30 per month depending on the formulation and pharmacy.
- Generic SSRIs: Medications like fluoxetine or sertraline often cost $4–$20 per month at major retailers offering generic drug programs.

- Estradiol patches: These are more expensive, often ranging from $60–$150 per month without insurance, depending on the brand and dosage.
- Other formulations (e.g., vaginal rings, creams): Prices vary widely, with rings costing $150–$300 and creams around $30–$60 per tube.