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REVIEW

Menopause

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During menopause women may present with vasomotor symptoms and/or symptoms of genitourinary syndrome of menopause. Women with genitourinary syndrome of menopause may be treated with low-dose vaginal oestrogen rather than systemic oestrogen. Transdermal administration of oestradiol should be considered the first-choice treatment in women with moderate to severe vasomotor symptoms who have risk factors precluding oral administration. Non-hysterectomised women require addition of a progestogen to minimise the risk of endometrial hyperplasia and endometrial cancer associated with unopposed oestrogen exposure. Micronised progesterone can minimise the metabolic impact and side-effects associated with progestogens. Menopausal hormone therapy is most effective when initiated within 10 years of the final menstrual period and before the age of 60. Use of menopausal hormone therapy for longer than 10 years needs an ongoing audit of benefits versus risks, but there is no clearly determined cessation date.

Introduction

Menopause is defined as the cessation of menses as determined by the date of the final menstrual period. This diagnosis can only be made retrospectively after 12 consecutive months of amenorrhoea.[1] Menopause typically occurs between 45 and 55 years of age and most women experience vasomotor symptoms (VMS) or genitourinary syndrome of menopause (GSM). Although more than 80% of women experience menopausal symptoms, there is much variance in their personal experience of menopausal changes.[2]

Symptoms

VMS (episodes of sudden, intense warmth, known as hot flashes, or drenching sweats, called night sweats) are the hallmark symptoms of menopause, but menopausal symptoms may also include GSM (symptoms of vaginal dryness, burning, pruritus, dyspareunia, vaginal discharge, bleeding or spotting), as well as loss of libido, skin and hair changes, mood swings, sleep disturbances, muscle aches and joint pain, depression, and poor cognitive performance.[2,3,4] After menopause, women may be at increased risk of cardiovascular disease, osteoporosis, metabolic changes and weight gain.[3]

Symptoms may start in the perimenopause or in the postmenopausal period and may last from five to eight years, and for some women they will never disappear.[5]

Management

Menopause management revolves around minimising disruptive symptoms and preventing long term complications.[2,4] Menopausal hormone therapy (MHT) is most beneficial when initiated within 10 years of the final menstrual period and before the age of 60, as this timing helps lower the risk of stroke, systemic embolism, and transient ischaemic attack.

Patient education and non-prescription treatments

Patients should be encouraged to stop smoking, especially if considering MHT. A healthy diet is recommended to maintain a healthy weight and women should aim to do 150 minutes of cardiovascular exercise per week and two to three days of weight-bearing exercise.[2] For mild hot flashes, behavioural measures such as using fans, lowering room temperature, heat-friendly clothing (dressing in layers), and avoiding triggers such as stress and spicy foods may be helpful.[6]

First-line treatment for GSM includes the use of vaginal lubricants and vaginal moisturisers. Lubricants may be water-based, silicone based or oil-based and provide short-term relief, particularly for vaginal dryness during intercourse. They are used only at the time of sexual activity.[7] Vaginal moisturisers offer longer lasting effects and can be used daily or several times a week, typically two or three times per week.[7] These products are typically bio-adhesives and hyaluronic acid is often used as a key ingredient in vaginal moisturisers.[7]

Menopausal hormone therapy

MHT is the general term used to describe oestrogen use (for women who have undergone hysterectomy) and combined oestrogen-progestin therapy (for women with an intact uterus).[4] The primary role of MHT is to relieve hot flashes but oestrogen supplementation also relieves sleep disturbances, mood lability/depression and in some cases joint aches and pains.[4] Oestrogen is available in many forms, including oral tablets, transdermal patches, topical gels, lotions and vaginal rings. Women being treated for moderate to severe menopausal VMS usually require systemic oestrogen, that can be administered either transdermally or orally. Such treatment often alleviates symptoms of GSM in addition to VMS. Women being treated only

for GSM may be treated with low-dose vaginal oestrogen rather than systemic oestrogen.[4]

Oestrogens

It is preferable to use 17-beta oestradiol over conjugated equine oestrogens because it is bioidentical to the main oestrogen secreted by the ovary.[4] The general approach is to start with lower doses, such as transdermal oestradiol (0,025 mg) or oral oestradiol (0,5 mg/day) and to titrate up until symptom relief is achieved or the maximum recommended dose is reached.[4]

Lower doses are linked to reduced vaginal bleeding and breast tenderness, have fewer effects on coagulation and inflammatory markers, and demonstrate a more favourable risk profile for stroke and venous thromboembolism, with less impact on serum lipid concentrations compared to standard-dose therapy. Transdermal routes should be considered as they have the least impact on coagulation and are unlikely to increase the risk of venous thrombosis or stroke above that in non-users.[5,8] Transdermal therapy is also the treatment of choice in women with diabetes, hypertriglyceridaemia, migraine without aura, gallbladder disease, and liver disease.[6]

Progestogens

Women with an intact uterus need addition of progestogen to prevent endometrial hyperplasia and uterine cancer associated with unopposed oestrogen therapy. The progestogen can be added as oral or transdermal therapy or as a progestogen IUS.[1,2,6] Micronised progesterone has a more selective effect on progesterone receptors and results in less interaction with androgenic and mineralocorticoid receptors compared to other progestogens. Micronised progesterone is associated with a reduced metabolic impact and fewer adverse effects compared with other progestogens.

A first-choice option is oral micronised progesterone (200 mg per day for 12 days per month designed to mimic the normal luteal phase of premenopausal women or 100 mg per day continuous treatment). It is recommended to take micronised progesterone at night as some of the metabolites are associated with somnolence.[4]

Micronised progesterone is not associated with adverse lipid effects and may offer benefits for the cardiovascular system and possibly the breast.[4] Although medroxyprogesterone acetate is the most extensively studied formulation for endometrial protection, it was associated with an excess risk of coronary heart disease and breast cancer when administered with conjugated oestrogen in the Women's Health Initiative (WHI).[4]

Non-hormonal therapies

Non-hormonal options for treatment of menopausal hot flashes include the use of selective serotonin reuptake inhibitors (SSRIs) including paroxetine, escitalopram, citalopram, sertraline and fluoxetine, as well as serotonin and noradrenaline reuptake inhibitors (SNRIs) such as venlafaxine and desvenlafaxine.[4,5] For patients with depression as main concern, treatment is started with an SSRI. However, where VMS are the major symptoms and depression or mood symptoms are mild, treatment is started with MHT. For women in whom both depression and VMS are severe, both oestrogen and an SSRI should be considered.[4]

Duration of MHT

MHT may be considered for otherwise healthy, symptomatic women who are within 10 years of menopause or younger than 60 years of age and do not have contraindications to MHT (history of breast cancer, coronary heart disease, previous venous thromboembolism or stroke, active liver disease, unexplained vaginal bleeding, high-risk endometrial cancer or transient ischaemic attack).[4]

The optimum dose and duration of MHT should be determined according to the severity of a woman's symptoms as well as her response to therapy[8] and may be continued for as long as women maintain their health status, and contraindications do not develop. Whilst the benefits outweigh the risks, arbitrary limits should not be placed on the dose or duration of MHT.[8]

Conclusion

Menopause is a physiological transition associated with significant symptomatic and long-term health consequences. Management should be individualised, with lifestyle measures and non-prescription therapies forming the foundation of care. Menopausal hormone therapy remains the most effective treatment for vasomotor and genitourinary symptoms, with optimal benefit observed when initiated within 10 years of the final menstrual period and before the age of 60. Transdermal oestradiol, in combination with micronised progesterone in non-hysterectomised women, offers a favourable efficacy and safety profile.

Therapy selection must consider individual risk factors, contraindications, and patient preferences, with non-hormonal options recommended for those unable or unwilling to use MHT. Duration of therapy should generally be limited to three to five years, although extended use may be considered in select patients after careful risk–benefit assessment. A personalised, evidence-based approach supported by shared decision-making remains essential to optimising outcomes and maintaining quality of life in women during menopause.

References

1. Moodley SP, Jaff N. Clinical guideline Menopausal hormone therapy. South African Society of Obstetricians and Gynaecologists. 2023. Available from https://sasog.co.za/wp-content/uploads/2024/05/Clinical-Guideline-menopausal-HT-draft-July-2023.pdf.
2. Peacock K, Carlson K, Ketvertis KM, Doerr C. Menopause (Nursing). StatPearls [Internet]. 2023 Dec 21. Available from: https://www.ncbi.nlm.nih.gov/books/NBK507826/. Accessed 20 Aug 2025.
3. Genazzani AR, Divakar H, Khadilkar SS, et al. Counseling in menopausal women: How to address the benefits and risks of menopause hormone therapy. A FIGO position paper. South African General Practitioner. 2024;5(1):14-28. https://doi.org/10.36303/SAGP.0397.
4. Martin KA, Barbieri RL. Treatment of menopausal symptoms with hormone therapy. In UpToDate. Accessed 13 Aug 2025.
5. De Villiers T. The management of vasomotor symptoms of menopause (VMS) with menopausal hormone therapy (MHT). Current Opinion in Endocrine and Metabolic Research. 2022;27:100420. https://doi.org/10.1016/j.coemr.2022.100420.

6. Koothirezhi R, Ranganathan S. Postmenopausal syndrome. Available from: https://europepmc.org/article/nbk/nbk560840. Accessed 20 Aug 2025.
7. Carlson K, Nguyen H. Genitourinary Syndrome of Menopause. InStatPearls [Internet] 5 Oct 2024. StatPearls Publishing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK559297/.
8. Hamoda H, Panay N, Pedder H, Arya R, Savvas M. The British Menopause Society & Women's Health Concern 2020 recommendations on hormone replacement therapy in menopausal women. Post Reproductive Health. 2020;26(4):181-209. https://doi.org/10.1177/2053369120957514.