Royal College of Nursing

Menopause

RCN guidance

CLINICAL PROFESSIONAL RESOURCE

Third edition

Acknowledgements

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Notes

It is recognised that services and care may be provided by registered nurses and midwives, health care support workers, assistant practitioners, nursing associates and student nurses and midwives, and student nursing associates. For ease of reading, the terms nursing' and 'nurses' are used throughout this document.

The RCN recognises and embraces our diverse gender society and encourages this guideline to be used by and/or applied to people who identify as non-binary, transgender or gender fluid.

The RCN also recognises that not all those born female or male, will identify with the same gender nouns but for ease of reading, use the term 'woman' and where appropriate, acknowledge non-binary terms. This guidance applies to people who do not identify as women and includes those with a cervix.

This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact corporate.communications@rcn.org.uk

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Introduction

To provide support and advice to women it is important that all health care professionals understand the changes that women face at the time of their menopause and the issues related to improving health after menopause.

Those working specifically in women's health need to understand the safety and efficacy of modern therapy options and be aware of the myriad of complementary therapies. They also need to balance these options with the fact that for many women the menopause is an event that needs no intervention and they can use this time and opportunity to give lifestyle and health advice to provide healthy and safe ageing.

This publication aims to help all health care professionals gain awareness of these issues by reviewing what happens to the body during menopause and in the post-menopausal stage, examining the impact of these changes on women, and outlining the options for health after menopause. It also builds on the guidance published by he National Institute for Health and Care Excellence (NICE) on the management of the menopause (NICE, 2024).

Staff who work in women's health should recognise that there is much more to the subject than can be described here, and the reference section signposts additional sources for obtaining a deeper understanding of the subject. The main aim here is to encourage nurses to be more knowledgeable about the options available to women at and beyond menopause. By acting as women's advocates, nurses can ensure that women (and their partners) have access to unbiased and accurate information. Delanerolle G et al., (2025) provides some practical tips and areas that need to be considered.

A key advance, highlighted in the NICE guidance (NICE, 2024) was the need to have menopause specialists, their role is critical in enhancing the expertise available to women, and the role development has been progressing well in recent years, with standards set out by the British Menopause Society (BMS, 2024). The RCN, in collaboration with the BMS, published guidance on this. Details of how nurses can become experts in menopause support and management are contained in the publication *Nurse Specialist in Menopause* (RCN, 2022 (due to be updated later in 2025)).

It is always important to recognise that for many reasons the impact of the menopause may differ greatly for individuals. People who identify themselves as non-binary, transgender or from intersex communities may experience menopausal symptoms, and their menopause may be different. Recent NICE guidance (2024) has also suggested that transgender women and those who have used hormones as part of gender affiriming treatment in the past will need referral to specialists.

Equally, health care professionals need to understand that the perceptions of the menopause may also differ in relation to disability, age, race and cultural background, religion, sexual orientation and/or partnership status. There is evidence that menopause age and symptoms can be affected by race and ethnicity, which needs to be taken into account when supporting and/or counselling women (BMS, 2023). The key is to always consider an individual in their own circumstances and support them according to their particular needs.

Visit the RCN's clinical web page on menopause at: **rcn.org.uk/clinical-topics/womens-health/menopause**

1. The menopause

The menopause is defined as a physiological event thus:

> Ovarian failure due to loss of ovarian follicular function accompanied by oestrogen deficiency resulting in permanent cessation of menstruation and loss of reproductive function.

NICE defines menopause as:

> Menopause is when a woman stops having periods as she reaches the end of her natural reproductive life. This is not usually abrupt, but a gradual process during which women experience peri-menopause before reaching post-menopause (NICE, 2024).

The transitional phase known as peri-menopause describes the time leading up to a woman's final menstruation, and the endocrinological, biological, and clinical features of the approaching menopause. The length of this transition is usually about four years, but is shorter in smokers compared to non-smokers. However, 10% of women do not experience this phase and menses may stop abruptly.

The median age for menopause is 51 years, over an age range of 39–59 years, however this varies with ethnicity (BMS, 2023).

Changes in ovarian function

During a woman's middle age the exhaustion of the oocyte (egg) store in the ovaries leads to reduced production of the female hormone oestrogen. This in turn increases the production of gonadotrophin, the hormone released by the pituitary gland to stimulate the ovaries to produce oestrogen.

A woman's ovary becomes less responsive to gonadotrophin several years before her menstrual periods cease. As a result there is continuous decrease in oestrogen, but also a gradual increase in levels of follicle stimulating hormone (FSH) and luteinising hormone (LH) in the blood, both of which are produced by the pituitary gland to stimulate the ovaries. The unresponsiveness of the ovary results in anovulatory cycles, where no eggs are produced by the ovaries.

Throughout the menopausal transition these hormone levels can fluctuate markedly from pre- to post-menopausal values. Oestrogen can be markered high at this point if there are out-of-phase luteal cycles.

Eventually the follicles (the sacks which develop oestrogen and eggs) cease to work. Insufficient oestrogen results in lack of stimulation of the endometrioum (womb lining), menstrual periods stop, and FSH and LH levels are persistently elevated.

Terms used in the menopause

Other terms commonly used now include:

- POI – premature ovarian insufficiency or menopause in women under 40 – see page 7
- climacteric – another term for menopause; this period is frequently termed the climacteric or peri-menopause but is increasingly referred to as the menopausal
- premature menopause – age 40 to 45

- natural menopause – occurs in the vast majority of women as physiological development
- induced menopause – menopause may be induced through medication or treatment or permanently damaged by treatments, usually for carcinogenic illness (pelvic radiation or chemotherapy)
- surgical menopause – menopause that occurs earlier than expected when both ovaries are surgically removed.

2. Diagnosing menopause

Some of the questions most commonly asked by women are: "Is it the change? Can I have a blood test? When is the menopause going to start? How long will it take? Can bloods tell me this?" In practice, it is rarely useful to perform blood tests as hormone levels fluctuate widely over a very short time span, making the results confusing and unreliable. Blood tests (for FSH) are usually only indicated when a premature menopause or POI is suspected in a younger woman, or to rule out conditions – such as anaemia or thyroid disease that may cause similar symptoms – or when there may be diagnostic doubt.

The best way to diagnose the menopause is by taking a thorough history of symptoms and menstrual irregularities (Holloway et al., 2025). The current **NICE guidance** is that blood tests are not required to diagnose menopause (NICE, 2024).

Table 1: Biochemistry assessment

NICE recommends using the follicle stimulating hormone (FSH) blood test to diagnose menopause in the following groups of women, provided they are not taking combined oestrogen and progestogen contraception or high-dose progestogen, as the diagnostic accuracy of the FSH blood test may be confounded by these treatments:

- women aged over 45 years with atypical symptoms
- women between 40–45 years with menopausal symptoms, including a change in their menstrual cycle
- women younger than 40 years in whom premature menopause is suspected.

Contraception at peri-menopause

Women should be informed that effective contraception should be used in the peri-menopause, although there is a natural decline in fertility. The usual advice is that a woman who has her menopause before the age of 50 should use contraception for two years, and for one year after the age of 50 (FSRH, 2023).

The risks and benefits of each contraceptive method should be discussed on an individual basis. The Faculty of Sexual and Reproductive Healthcare's (FSRH) clinical guidance on contraception for women aged 40 and above provides more detailed information on current evidence and recommended advice.

Further information can be obtained from the FSRH's clinical guidance *Contraception for Women aged over 40 years* (2023), which can be downloaded at: **fsrh.org**

The 52mg levonorgestrel intrauterine device (52mg LNG-IUD) is the only IUD that is licenced to provide contraception and endometrial protection as part of HRT. However, current guidance supports the use of any 52mg LNG-IUD for both purposes off licence for five years (FSRH, 2023). Women should be fully informed of this. She should have instructions on what is used as contraceptive and part of HRT.

Premature ovarian insufficiency (POI)

Premature ovarian insufficiency (POI) is the loss of ovarian function before the age of 40. It affects approximately 4% of women before the age of 40 (ESHRE, 2024).

Women with POI may present with no periods, irregular periods, sub-fertility or menopausal symptoms. In any woman under 45 years of age menstrual irregularity lasting longer than three months should be investigated.

POI can be as a result of radiotherapy, chemotherapy or surgery, other causes include genetic, autoimmune, infective and some where there is no established cause as yet.

POI can be a devastating diagnosis, and affected women have special needs because they are facing the end of their fertility potential and will suffer the systemic consequences of oestrogen deprivation. Short-term menopausal symptoms are variable but may include hot flushes, night sweats, decreased libido, vaginal dryness and psychological symptoms. In the long term, women with POI are at increased risk of developing cardiovascular disease (CVD), osteoporosis and cognitive decline (Bailey and Holloway, 2025).

To alleviate short-term symptoms and reduce the long-term health risks of POI, oestrogen replacement therapy is recommended until the average age of natural menopause, at least the average age of 52 (NICE, 2024 and ESHRE, 2024) and is given in the form of HRT or the combined hormonal contraception (CHC).

Further information on management of POI can be found at NICE (2024) and the European Society of Human Reproduction and Embryology (ESHRE) *Guideline on the Management of Premature Ovarian Insufficiency* (2024).

Women with spontaneous POI have a reduced (about 5%) chance of becoming pregnant naturally. No medical intervention can increase this and the only treatments are egg donation, surrogacy or adoption. However, it is important to remember that spontaneous pregnancies can occur, even after many years of amenorrhoea, and if pregnancy is not desired it is important to use contraception.

Further information on infertility treatments can be obtained from the Human Fertilisation and Embryology Authority (**hfea.gov.uk**), The Fertility Network (**fertilitynetworkuk.org**) and the Daisy Network (**daisynetwork.org**).

For more information on diagnosing, management of POI and the risks and benefits, visit: **eshre.eu/Guidelines-and-Legal/Guidelines/Premature-ovarian-insufficiency**.

Surgical menopause

Surgical menopause may be performed for many conditions such as cancer, endometriosis, fibroids, and risk-reducing surgery for women with BRCA (the term used to define genetic linked breast and ovarian cancers). The impact of surgical menopause can be that the symptoms of menopause are increased and more intense with an increased risk of long-term health problems which can be alleviated with long-term use of HRT unless it is contraindicated. Women who are due to undergo surgery that will make them menopausal should have the risks of this (cardiovascular, bone and neurological) discussed with them prior to surgery (NICE, 2024). Women with surgical menopause also lack testosterone so may need replacement. These women may be under the care of a specialist in menopause (see *Nurse Specialist in Menopause* (RCN, 2022 (due to be updated later in 2025)) for further information about such specialists).

3. Menopause symptoms

The fall in oestrogen levels that occurs at the menopause can cause a wide range of symptoms. The frequency and number of symptoms are individual and some women only have minimal impact on their quality of life while others may find that they experience a greater impact that needs some interventions to help. The experience of symptoms can have a detrimental effect on the ability to work and menopause is increasingly seen as an occupational health issue. For further information please go to: **rcn.org.uk/Professional-Development/publications/rcn-menopause-position-statement-uk-pub-011-282**. Symptoms can have a detrimental effect on the wellbeing of women and long-term oestregen deficiency can have serious health consequences. However, recent studies suggest that younger women with symptoms are at more risk of CVD and increased risk of dementia later on in life (ESHRE, 2024).

Changes in menstrual pattern

As anovulatory cycles begin to predominate, the length of the menstrual cycle begins to vary and gaps of several weeks or months may occur between menstrual periods. Most women find their periods become lighter during the peri-menopause, but some experience more frequent and heavier bleeding. Because of the possibility of renewed follicular activity, women can become pregnant even at this stage of life and they should be advised to continue with contraception.

Immediate effects of oestrogen deficiency

It is estimated that about three quarters of women in the UK experience vasomotor symptoms. These symptoms are:

- hot flushes
- night sweats
- palpitations
- headaches.

Vasomotor symptoms are commonly worst in the two or three years before periods stop, and may continue for many years afterwards for some women.

Psychological problems

Psychological symptoms may relate to hormone changes, changes in brain chemistry, the impact of physical symptoms (night sweats impacting on sleep) and other life events. Life stresses at this age, as well as past problems, are an obvious causative factor. Many women do not realise that the following symptoms are very normal at this stage of life and fear they may be on the verge of a breakdown:

- loss of confidence
- depressed mood
- irritability
- forgetfulness
- difficulty in concentrating
- panic attacks.

Mid-life is a time of transition and stressful life events from divorce to a second career and changing caring responsibilities, combined with physical changes can result in feeling overwhelmed. A number of studies have identified that menopause significantly impacts mood and mental health, including higher stress levels and depression. Anxiety and panic attacks are also reported during menopause with hormonal changes and physical symptoms, such as sleeplessness, affecting biological functioning – especially for women with bipolar illness. Women with schizophrenia may be at increased risk of an episode as their production of oestrogen decreases, and some antipsychotic medications like Sulpiride and Risperidone may cause periods to stop which can be mis-diagnosed as menopause.

It is important to encourage women to talk about mental wellbeing and encourage them to seek the right support and help. Some women with previous hormone-related issues such as postnatal depression and/or premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) may be at higher risk of developing issues around the menopause.

Genital-urinary symptoms of menopause

Urogenital symptoms

The vagina and distal urethra are oestrogen dependent tissues. Falling oestrogen levels in post-menopausal women leads to a marked drop in vaginal and vulval capillary blood supply; the skin appears red and dry (atrophic vaginitis or genitourinary symptoms of menopause (GSM)). Additionally, there is a loss of collagen from the underlying tissues. These two factors cause the vaginal epithelium to become thinner and less elastic and the vagina narrower and shorter. As secretions lessen, the pH levels change and the vagina becomes more susceptible to infection (atrophic vaginitis). This is a progressive condition affecting many women but often undiagnosed (Briggs, 2022). Common symptoms include:

- - vaginal dryness
  - dyspareunia (discomfort or pain during sex)
  - bleeding
  - vaginitis
- urinary problems
  - frequency
  - urgency
  - dysuria.

The personal nature of these symptoms mean that women may not volunteer this information and it is important for nurses to assess and offer management choices.

Skin changes

Generalised connective tissue atrophy oestrogens help maintain the epidermis, so changes in the skin, nails and hair are common when oestrogen levels fall. Women may find their skin becomes dry, inelastic and is easily broken or bruised. The loss of thickness and elasticity is largely due to a decline in collagen levels. Other symptoms of connective tissue atrophy are brittle nails, hair loss, muscular aches and bone and joint pain.

Long-term effects of oestrogen deficiency

Cardiovascular disease

Cardiovascular disease (CVD) is the collective term for angina, myocardial infarction, stroke, and peripheral vascular disease. Despite an overall reduction in CVD in recent years, it is still the leading cause of avoidable death in both men and women (WHO, 2025).

In comparison to men, women are more likely to be under diagnosed, and less likely to be on an appropriate treatment, and as such are at an increased risk of dying from CVD.

CVD is also age dependent. Less common in premenopausal women, the prevalence of CVD increases after the menopause. It is also known that women with a premature menopause, especially those with surgical oophorectomy, have an increased risk of coronary heart disease. By the time women reach 60 years of age, CVD will be the most common cause of death (NICE, 2024).

The needs of women with established ischamic heart disease and ongoing symptoms should be assessed under a shared care arrangement as they benefit from low dose transdermal oestrogen and non-andogenic progestogen.

There is evidence that mortality following myocardial infarction is lower for women using HRT so it should not automatically be discontinued but the type of HRT may need to be reviewed (BMS, 2024).

Irrespective of age, prior to commencing HRT, every woman should have a health assessment to identify CVD risk factors like hypertension, diabetes mellitus, smoking, dyslipidemia, obesity and metabolic syndrome (IMS, 2017). Where risk factors are identified lifestyle changes and pharmacological intervention should be introduced, ideally in the peri-menopause.

Where actual CVD is identified this should be aggressively managed (Read et al., 2014).

Key points

- All peri-menopausal women should have an individual CVD risk assessment. Where modifiable risk factors are identified women should receive lifestyle advice (smoking cessation, weight management, healthy diet, increased regular exercise).
- Ensure that menopausal women and health care professionals involved in their care understand that HRT does not increase cardiovascular disease risk when started in women aged under 60 years and does not affect the risk of dying from cardiovascular disease.
- Health care practitioners need to be aware that the presence of cardiovascular risk factors is not a contraindication to HRT as long as they are optimally managed (NICE, 2024).
- HRT is not contraindicated in women with hypertension and in some cases treatment may even reduce blood pressure.
- In women with premature ovarian insufficiency, hormone therapy is recommended until at least the average age of the natural menopause.

Further information is available at: **thebms.org.uk/wp-content/uploads/2024/12/22-BMS-TfC-Management-of-menopause-for-women-with-CVD-DEC2024-A.pdf** and **thebms.org.uk/wp-content/uploads/2024/03/21-BMS-TfC-HRT-after-myocardial-infarction-MARCH2024-A.pdf**

Osteoporosis

Osteoporosis is a condition of the skeleton in which bone strength is compromised, predisposing the woman to an increased risk of fracture and subsequent disability (NOS, 2017). Women are at greater risk of osteoporosis due to the decrease in oestrogen production at the menopause, which accelerates bone loss. The prevalence of osteoporosis increases markedly, from approximately 2% at 50 years of age to almost 50% at 80 years of age. In England and Wales, more than two million women have osteoporosis (NICE, 2024) **https://cks.nice.org.uk/topics/osteoporosis-prevention-of-fragility-fractures/background-information/prevalence**. The most common fracture sites are the femoral neck, forearm and spine (NICE, 2019a).

As oestrogen levels decline, the risk of osteoporosis increases. The disease leads to weakness in the skeleton which can mean that bone fractures much more easily. Treating the affects of osteoporosis has huge financial implications for the NHS, and in personal and emotional terms for the individual and for carers.

Bone is a living tissue that is constantly remodelling itself. Old bone is broken down by osteoclasts and rebuilt by osteoblasts. In childhood osteoblasts work faster, enabling the skeleton to increase in density and strength, with bone mass reaching a peak by the late 20s. The balance between breakdown and formation remains stable until around the age of 35, when bone loss increases as part of the natural ageing process. After menopause, as oestrogen levels decline, bone turnover is increased and the reformation of bone cannot keep up with its breakdown. The end result is skeletal loss, leading to osteoporosis.

Factors influencing the development of osteoporosis

The failure to reach optimal peak bone mass and/or accelerated bone loss in later life increases an individual's risk of osteoporosis. Peak bone mass is influenced by a combination of factors including race, heredity, diet, exercise, alcohol consumption, smoking and hormones.

Factors increasing the risk of fragility fractures (NICE, 2017c)

- Age (risk of fracture increases with age).
- Low levels of oestrogen due to primary hypogonadism, premature menopause or prolonged anorexia nervosa.
- Long-term use of oral corticosteroid therapy.
- Low body mass index (<19 kg/m2).
- Maternal history of hip fracture.
- Smoking.
- History of previous fragility fracture.

Other risk factors include increased use of alcohol, immobility, hyperthyroidism and conditions associated with the poor absorption of food, such as coeliac disease. Women should be advised on preventon stategies that include weight bearing exercise, including calcium in their diet and taking a 10mcg vitamin D supplement.

Young women (under the age of 40) experiencing menopause need particular advice about osteoporosis prevention and a baseline bone densitometry should be performed. Older women who had an untreated early menopause should also be assessed for risk of fracture.

Testing for osteoporosis

Testing for osteoporosis involves measurement of bone mineral density (BMD) with a dual energy X-ray absorptiometry (DEXA) scan, usually of the hip and spine. A fracture risk assessment tool has been developed by the World Health Organization and is increasingly used by health professionals to identify those people at increased risk of osteoporotic fracture (FRAX, 2010), but this is not suitable for women with premature ovarian failure (POF). NICE also has guidelines, *Surveillance of Osteoporosis: Prevention of Fragility Fractures* (NICE, 2019a).

Where a secondary cause of osteoporosis is suspected, diagnostic procedures may also include blood cell count, erythrocyte sedimentation rate, serum calcium, albumin, phosphate, alkaline phosphate and liver transaminases.

Treatment for osteoporosis

The main aim of treatment is to prevent fragility fractures. NICE has published technology appraisals relating to specific osteoporosis treatments (NICE, 2019).

Everyone should consider vitamin D supplements of 10mcg, from November to March. People from minority ethnic groups with dark skin such as those of African, African-Caribbean and South Asian origin might not get enough vitamin D from sunlight in summer so they should consider taking a daily supplement containing 10µg vitamin D throughout the year (NHS, 2020).

4. The psychosocial impact of the menopause

Confidence and sexuality

Some women view the menopause with confidence as an end to periods, pre-menstrual syndrome and contraceptive worries, and the start of the next enjoyable phase of their lives.

Others can be less positive as they struggle to deal with the impact of the loss of fertility and other physical symptoms, alongside the coincidental problems which arise in later middle age such as:

- children leaving home (or even returning home after some time away)
- increasing dependence of elderly parents
- fear of redundancy
- impending retirement
- a sense of failed expectations.

Life-changing events such as these coupled with troublesome menopausal symptoms, including vaginal dryness, lowered self esteem and body image, and the possibility of a faltering relationship, can all have a negative effect on a woman's view of her sexuality.

As health care professionals we should be alert to potential problems and be proactive in acknowledging that sexuality has an important part to play in every woman's life. We should always view a woman and her symptoms holistically, and link discussion about sexuality with other health problems. Asking open-ended questions can help establish such links.

Cultural differences

Different cultures view the menopause in different ways, which may affect women's social standing or the attitudes of others towards them.

In Eastern cultures, the older woman becomes a well-respected member of the family group, to whom younger family members frequently turn for advice. Loss of regular bleeding is beneficial for some Muslim women and Orthodox Jewish women, as they are no longer seen as 'impure' during menstruation and can enter the temple, handle and prepare food, or continue to have sexual intercourse throughout the month.

Conversely, in some cultures the menopause is viewed negatively, as it signals the end of fertility and the loss of a woman's 'usefulness' for procreation. Western society has a somewhat negative attitude towards women ageing, particularly with the so-called loss of femininity and the attractiveness associated with it. Culture, ethnic group and socio-economic status are all linked into the overall wellbeing of women and the symptoms that they may experience.

More information is available at: **thebms.org.uk/wp-content/uploads/2023/06/20-BMS-TfC-Menopause-in-ethnic-minority-women-JUNE2023-A.pdf**

Menopausal symptoms also vary significantly between countries and amongst different ethnic and religious groups within the same countries. Symptom data is difficult to compare because of varying cultural, dietary and lifestyle factors and the differences in language used to describe climacteric symptoms – for example, in Japanese there is no word to describe a hot flush and women have a significantly later menopause. The SWAN – *Study of Women's Health Across the Nation studies* (SWAN, 2017) demonstrates wide variation in women's symptoms between different ethnic groups in terms of symptoms, attitudes and general health at the menopause. A *Health of the Nation* report (NHS, 2024) found that women of colour are less likely to be prescribed HRT, demonstrating an ongoing health inequity.

Nurses talking to women from the many cultures present in the UK need to be sensitive to these differing attitudes and symptoms.

Keeping women informed

All women approaching the menopause should have the opportunity to learn about the changes they may experience and the potential benefits to be derived from HRT, and offered alternatives if HRT is not appropriate.

Health professionals need to keep abreast with changes in the management of the menopause in order to maintain the standard of care to women, and to make sure that their clients and patients have access to unbiased and accurate information.

There is currently a push on menopause from many companies, celebrities and endorsements on products. It is important that women have access to balanced information written by specialists such as Women's Health Concern.

5. Lifestyle advice and choices for women at menopause

Many women only consult health care practitioners for advice about their health when they are approaching or are at the menopause. They have concerns about living well for the rest of their lives, and some say that they do not want to grow old the way their mother or grandmother did. When women present with these concerns it is a good opportunity to review their lifestyle with them.

Women want sensitive, unbiased and up-to-date information, and an explanation of normal menopausal changes. General health advice is the same throughout a woman's life, but there is a particular emphasis on certain factors for menopausal woman, primarily the effects that the menopause has on cardiovascular and bone health as well as the day-to-day symptoms of menopause and a fear of dementia.

The key areas to cover are:

- smoking status
- diet and nutrition
- exercise, including balance and strength training
- alcohol consumption
- weight control
- psychological aspects of the menopause
- reinforcing breast awareness
- encouraging attendance for national cervical, breast and bowel screening programmes
- assessing cardiovascular risk
- osteoporosis risk assessment
- reducing the impact of symptoms
- contraception and sexual health needs
- assessment of pelvic floor and female cancers.

Healthy living

Smoking cessation

Smoking has many negative effects:

- cigarette smoking can increase the risk of having a heart attack by two or three times; coronary heart disease (CHD) is the most common cause of death in women
- smokers are 1.5 times more likely to have a stroke
- smoking tends to increase blood cholesterol levels and adversely effects the HDL/LDL ratio
- smokers have an increased level of atherosclerosis in their coronary arteries
- smoking leads to an earlier menopause – up to two years earlier when compared with non-smokers
- smokers are at greater risk of developing osteoporosis
- smokers are more likely to experience vasomotor symptoms.

Nurses should be aware of smoking cessation initiatives and resources available to support women who want to stop smoking. Ongoing evidence suggests that smokers are more likely to stop with support from smoking cessation programmes, and women should be signposted to local services.

Diet and nutrition

Nutrition is important for all women around the time of the menopause, and a healthy, balanced diet should be low in fat, low in salt and rich in calcium.

Facts about nutritional health – calcium and salt:

- high salt intake is linked with the development of high blood pressure
- it should be possible to get all the calcium needed from a healthy diet; adults need 700mg a day, although those with osteoporosis may need more (ROS, 2025)
- vitamin D is necessary for the effective absorption of calcium from the gut, most being obtained from direct sunlight; a smaller amount is obtained from the diet. Supplements of 10mcg vitamin D may be necessary for for some women (NICE, 2017d).

Facts about nutritional health – fats:

- saturated fatty acids raise blood cholesterol levels
- total fat consumed should be reduced, with no more than one third of calories coming from fat
- saturated fats should be replaced with polyunsaturated fat and monounsaturated fat
- cholesterol is mainly made in the liver from the saturated fats in food
- polyunsaturated fatty acids have been found to help lower the amount of low density lipoproteins in the blood.

Facts about nutritional health – general:

- diet should be high in fruit and vegetables, containing at least five fist-sized portions daily
- fruit and vegetables contain antioxidant vitamins and minerals which are crucial in preventing the damaging effects of free radicals
- smokers use antioxidants faster
- include at least two portions of fish a week, one of which should be oily fish
- maintaining a healthy weight is important as obesity is a major risk factor for CHD and is associated with high blood pressure, increased risk of endometrial cancer, heart attacks, heart failure and diabetes. Women should aim for a health body mass index (BMI) of 20–25.

Weight management

It is not inevitable that women will put on weight at the menopause, but many do. This is due in part to a decline in muscle mass and a subsequent slow-down in the basal metabolic rate, combined with a failure to reduce food and alcohol intake when taking little or no exercise.

Women should be advised to:

- eat a healthy diet
- exercise regularly; start slowly and gradually increase
- lose extra weight slowly and steadily.

New NICE guidance (2025) details support and onward referrals for women with a BMI of 35 and above.

Weight gain can cause distress and can contribute to cancer risks as well as menopause symptoms, such as breast and endometrial cancer. Weight may also have an impact on the pelvic floor and women should be given information and support on weight management strategies (Bailey, 2025).

Further detail is available at: **thebms.org.uk/wp-content/uploads/2023/06/19-BMS-TfC-Menopause-Nutrition-and-Weight-Gain-JUNE2023-A.pdf**

Exercise

The following key points relate to the importance and benefits of exercise:

- regular exercise is necessary to remain active, healthy and independent
- physical activity reduces both the risk of developing CHD and of having a stroke by lowering blood pressure
- exercise increases energy levels, muscle strength and bone density
- exercise can reduce stress, anxiety and likelihood of depression
- exercise helps weight loss and improves sleep
- weight-bearing exercise such as brisk walking, dancing, skipping, aerobics, tennis and running stimulates bone to strengthen itself
- cycling and swimming are both good cardiovascular exercises
- exercise should be varied and should be taken for at least 30 minutes on five or more days of the week for maximum benefit
- regular exercise may help to reduce hot flushes.

Further information is available at: **thebms.org.uk/wp-content/uploads/2023/06/18-BMS-TfC-MenopauseNutritionandWeightGain-TopTenTips-JUNE2023-A.pdf**

Alcohol

It is recommended that women drink no more than three units of alcohol a day, with a weekly consumption of fewer than 14 units. One to two alcohol-free days per week are recommended.

The following are useful facts about alcohol:

- keeping alcohol levels low can lower the risk of heart disease and stroke
- too much alcohol is damaging to bone turnover
- heavy drinking increases the risk of heart disease and stroke, and raises blood pressure which can lead to depression, stress, difficulty in sleeping and relationship problems. It

can also cause dementia

- alcohol can trigger vasomotor symptoms at menopause and increased alcohol intake can increase the risk of breast cancer.

Patients may be supported to reduce alcohol intake through a referral to local support services or through signposting to the national drinkaware programme: **drinkaware.co.uk**

Psychological aspects

Hormone-related low mood, anxiety, tiredness, loss of concentration and memory problems are all common experiences during or after the menopause. To help these aspects, note that:

- regular mental stimulation seems to maintain cognitive ability
- regular exercise can make sleeping easier
- a balanced diet will ensure an adequate intake of essential minerals and vitamins
- social activity improves mental function
- concentration can be improved with crosswords, puzzles, quizzes, and talking therapy
- learning new skills or languages improves mental function
- adequate fluid intake
- decrease smoking and alcohol.

Recent NICE guidance (2024) suggests that cognitive behavioural therapy (CBT) may also be of help with these symptoms.

Reducing the impact of symptoms

There are a number of simple measures that may reduce the impact of some symptoms of the menopause. Women have found the following measures helpful:

- hot flushes may be triggered by particular activities such as smoking, eating spicy foods, and drinking alcohol and caffeine and avoiding or modifying a known trigger may help. Wearing natural fabrics that can 'breathe' and using lightweight cotton bedding may also help
- exercise can help general wellbeing and mood as well as improving stamina and fitness
- relaxation or stress reduction techniques will improve coping strategies
- cognitive behavioral therapies, including counselling may help to deal with life events that are causing anxiety
- vaginal symptoms may be relieved by regular use of vaginal moisturisers, water-based lubricant during sex, or non-systemic oestrogen.

A self care factsheet is available at: **selfcareforum.org/menopause**

Screening

Breast awareness

Breast cancer is the most common cancer in women, with a woman's lifetime risk being one in seven women (Cancer Research UK, 2020). The exact cause of breast cancer is not fully understood, but certain risk factors will predispose women to develop the disease. Breast and cervical screening should be offered in line with national programmes and in addition to bowel screening. No additional screening is needed. Health care professionals should therefore aim to educate women about these risks factors, helping to support them in addressing those that are modifiable.

Health care professionals, women and their partners can access posters, leaflets and information booklets that inform women about the breast screening programme from the information resources section of the NHS breast screening (BSP) programme website at: **gov.uk/topic/populationscreening-programmes/breast**. A British Sign Language DVD and audio CD set, as well as information for women with learning difficulties, are also available.

Cervical screening

Cervical screening aims to detect pre-cancerous abnormalities which may, if left untreated, progress into cervical cancer. The cervical screening programme invites women and those with a cervix between the ages 25-64 for routine screening every five years. More information is available at: **gov.uk/guidance/cervical-screening-programme-overview** (RCN, 2024, Gov.uk, 2024).

HRT and cervical screening

After the menopause the vagina and cervix undergo atrophic change. Atrophic epithelium can have a detrimental effect on the quality of sample obtained and samples taken in the post-menopausal woman, with basal and para basal cells being present at the surface.

Local oestrogen HRT has a beneficial effect on the vaginal and cervical epithelium. This beneficial effect may enable a more adequate sample to be obtained, especially if a sample has been reported as inadequate or it has been difficult due to pain using the speculum.

Hormone replacement therapy (HRT)

HRT will effectively relieve hot flushes and sweats, decrease low moods, may improve vaginal dryness (especially local products) and may help with some of the others symptoms which women may experience around the time of the menopause. It will also have a positive effect on bone density, delaying the skeletal loss which occurs after the menopause and preventing subsequent osteoporotic fractures (NICE, 2024).

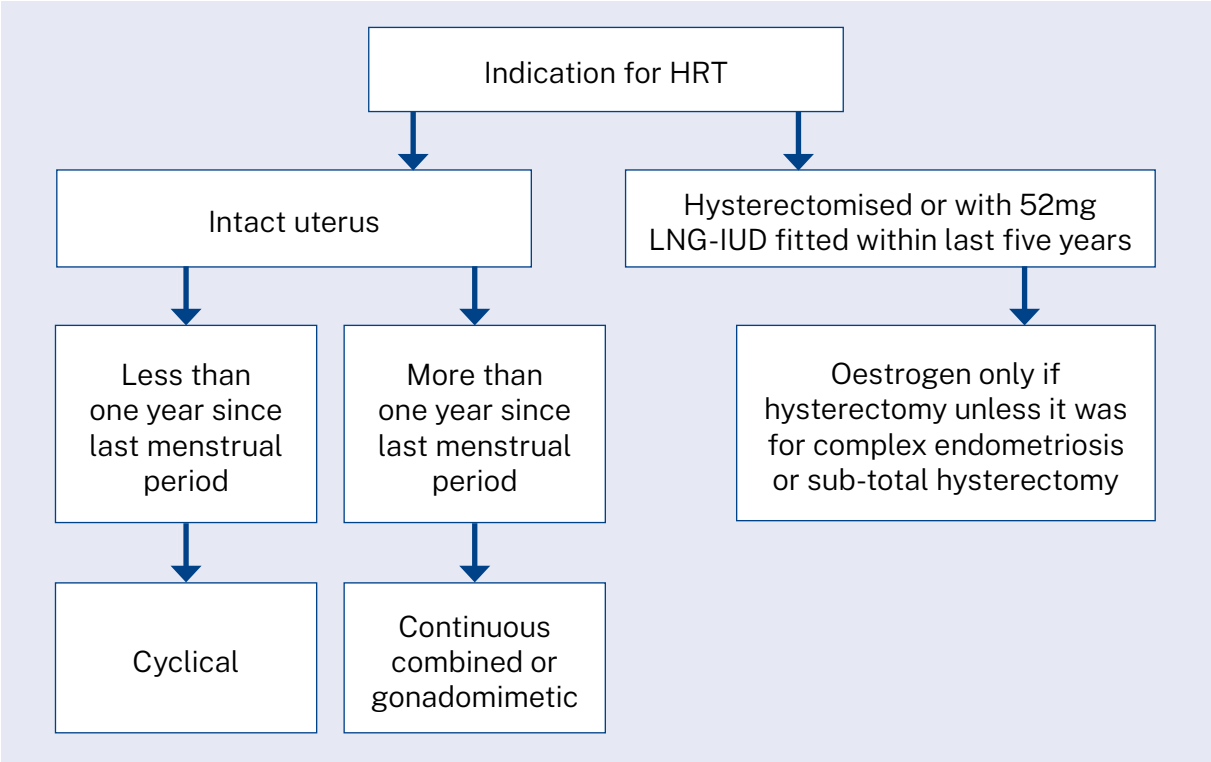
HRT usually comprises two hormones – oestrogen and progestogen. Women who have had a hysterectomy may use oestrogen on its own, whereas women with an intact uterus need to use a combination oestrogen/progestogen regimen. This is to prevent endometrial hyperplasia (thickening of the womb) which may occur with oestrogen-only therapy (BMS, 2022).

Progestogens are given in one of three ways:

- cyclical – usually resulting in a monthly bleed, given for peri-menopausal women
- tricyclical – usually resulting in bleeds every three months. Specialist initiation only if women are progesterone intolerant and have an increased risk of endomerial hyperplasia and need uterine monitoring, not for routine practice
- continuous – 'no-bleed' therapy (some irregular bleeding initially) for post-menopausal women.

HRT can also be given as a gonadomimetic – a synthetic hormone which comprises oestrogenic, progestogenic and androgenic properties.

Figure 7: Regimens of hormone replacement therapy



Who might use HRT?

There are several groups of women where the use of HRT might be indicated:

- those experiencing symptoms of the menopause, such as hot flushes, sweats or genitourinary symptoms
- those who have had an early menopause or POI
- as a second-line therapy for osteoporosis protection in women over 50 years old.

Who should not use HRT?

Very few women cannot take HRT, but the following are contraindications (Rymer, 2000):

- current, past, or suspected breast cancer

- known or suspected oestrogen-dependent cancer
- undiagnosed vaginal bleeding
- untreated endometrial hyperplasia
- previous idiopathic or current venous thromboembolism (deep vein thrombosis or pulmonary embolism), unless the woman is already on anticoagulant treatment
- active or recent arterial thromboembolic disease (for example angina or myocardial infarction)
- active liver disease with abnormal liver function tests
- pregnancy.

Further details are available at: **https://cks.nice.org.uk/topics/menopause/prescribing-information/hormone-replacement-therapy-hrt**

Women with conditions considered as contraindications may still receive HRT under the care of a specialist clinic, if the benefits outweigh potential risk.

The benefits of HRT

The benefits of HRT include:

- relief of vasomotor symptoms
- relief of some psychological symptoms
- reduced urogenital atrophy
- reduction in osteoporotic fracture
- reduced incidence of colorectal cancer
- cardio vascular protection.

(NICE, 2024)

The risks of HRT

The risks of HRT include:

- a slight increased risk of breast cancer with long-term use **nice.org.uk/guidance/ng23/resources/incidence-of-medical-conditions-with-and-without-hrt-a-discussion-aid-pdf-13553199901**
- NICE (NG23, 2024) states that the risk of venous thromboembolism (VTE) is increased by oral HRT compared with baseline population risk and the risk of VTE association with HRT is greater for oral than transdermal preparations
- the risk associated with transdermal HRT given at standard therapeutic doses is no greater than baseline population risk.

The use of HRT and breast cancer is complex and has many risk factors. The guide before has the numbers, but these need to be taken into context with other risks such as weight. Further information is available at: **thebms.org.uk/wp-content/uploads/2022/12/12-BMS-TfC-Fast-Facts-HRT-and-Breast-Cancer-Risk-NOV2022-A.pdf**

NICE guidance (2024) has a table of risks and benefits from HRT. These include:

- no change to mortality with HRT
- slight increased risk of breast cancer
- endometrial cancer – less on continous combined HRT, encourage women to change as appropriate but need to ensure balance of hormones is correct
- ovarian cancer very small raised risk
- no increase in CHD
- may increase dementia if over 65 when started
- improvement muscle mass and strength
- decreased risk of osteoporosis
- risk of stroke not increased with transdermal HRT
- no change in women with diabetes
- risk of venos thromboembolism not increased by transdermal HRT.

Side effects

Minor side effects are common in the first few weeks of HRT treatment. Women are advised to persevere during this period. After this settling time side effects can be minimised by adjusting doses, and the types or routes of HRT. Such side effects may include:

- breast tenderness
- nausea
- leg cramps
- spotting/change in bleeding.

Side effects may be related to the progestogen component; for example, symptoms similar to premenstrual tension such as headaches, irritability, and bloating. These can often be resolved by changing the type or route of progestogen dose (Holloway et al., 2025).

Figure 9: Routes of administration for hormone replacement therapy

Oestrogen	Progestogen	Testosterone
Spray		
Tablet	Tablet	
Patch/gel	Patch (with oestrogen)	Gel off license
Implant	Intrauteine 52mg LNG-IUD	
Vaginal – local	Vaginally miscronised progestrogen off license	DHEA vaginal only

Bleeds

Women who have had a period in the last year (even irregularly) and who start HRT will be prescribed a cyclical form of HRT which usually results in a monthly withdrawal bleed. Oestrogen given daily and progestrone given for 12-14 days a month. An alternative to this is the 52mg levonorgesterol intrauterine device (52mg LNG-IUD) which can be used as part of HRT and can give no bleed therapy to women who are still peri-menopause.

Women who are post-menopausal and have had at least one year since their last period, in or around 54 years old, may use a continuous combined form of HRT. This is described as 'period free' or 'no bleed', as the aim of the treatment is to have no bleeding at all. However, the settling phase can take three to four months, during which it is common to experience some breakthrough bleeding.

Bleeding on HRT is a common issue and to help manage this the BMS has produced a bleeding on HRT guidance, available at: **thebms.org.uk/publications/bms-joint-guidelines/management-of-unscheduled-bleeding-on-hormone-replacement-therapy-hrt**

Initiating and monitoring HRT

Nurses are often involved with decision making about HRT, with baseline investigations of women and the ongoing monitoring of their treatment.

NICE (2024) suggests that the monitoring of women on HRT should take place every three months until they are stable and then yearly after this. Nurses within all environments can undertake this. The RCN has developed guidance on the role of the specialist nurse in menopause care (RCN, 2017a).

Before initiating HRT, the prescriber may request some of the following investigations:

- blood pressure – it has become established practice to record women's blood pressure as a baseline measurement and in ongoing monitoring; there is no evidence to suggest that blood pressure will be altered simply by the use of HRT (NICE, 2019)
- weight – useful as a baseline measurement. Being overweight will not in itself preclude the use of HRT
- pelvic examination – not routinely performed before treatment, but clinically indicated in women with a history of fibroids, ovarian cysts, pelvic pain, abnormal vaginal bleeding, endometriosis, prolapse or urinary leakage
- breast examination – not routinely indicated but may be clinically indicated before HRT use in women with symptomatic disease, personal or family history of breast cancer.

Other investigations that may be performed include:

- follicle stimulating hormone (FSH) – not usually helpful for diagnosis, but can be useful in women with early menopause (serial tests), POI, women with hysterectomy and ovarian conservation or if the symptoms are not characteristic
- thyroid function – when flushes do not improve on HRT or if thyroid disease is suspected on clinical examination
- lipid profile – women with a family history of coronary heart disease

- thrombophilia screen – women with a personal or family history of venous thrombosis
- bone densitometry – women considered at high risk of osteoporosis
- endometrial assessment – women with abnormal vaginal bleeding (pelvic examination, ultrasound and/or hysteroscopy and biopsy).

Regular assessments of blood pressure, weight, symptom control and bleeding should be included as well as time for the woman to ask questions or raise any anxieties she may have. Each visit is the opportunity to re-evaluate the need for treatment and consider the safety of continuing. NICE (2024) suggest that the follow up is three monthly and then yearly. In between this time women should have contact details if they have queries. This becomes even more crucial when women have been on HRT for over five years after the age of 50. It also provides an opportunity to discuss other health issues and encourage an attitude of health promotion post-menopause.

Hormone replacement therapy and osteoporosis

Women who are on HRT for menopausal symptoms will continue to benefit from osteoporosis prevention whilst on treatment.

Although HRT is a proven effective treatment for the prevention of bone loss, it is only specifically indicated in:

- women with a premature menopause
- post-menopausal women with an increased risk of fracture who are unable to tolerate other treatments (Royal Osteoporosis Society's Position statement on hormone replacement therapy in the prevention and treatment of osteoporosis).

HRT may be the treatment choice for menopausal women needing bone protection, especially those who have an early menopause or have their ovaries removed before they reach the age of 45. Other groups for whom HRT is recommended for bone preservation include women with Turner Syndrome, diseases of the pituitary gland, and women with amenorrhoea (no periods) because of anorexia nervosa or over-exercise.

Locally applied oestrogen

Vaginally administered oestrogen may be prescribed, even to women in whom systemic HRT is contraindicated. Weakly absorbed oestriol or oestradiol preparations used at the correct dose will not cause endometrial proliferation, treating only the local vaginal symptoms (NICE, 2024). Vaginal oestrogen should not be used as a lubricant prior to sex, but rather used on a regular, twice-weekly basis for relief of vaginal dryness. Long-term use is agreed by NICE with no monitoring of the endometrium or progestrogen needed. Women with breast cancer may be able to use local oestrogens – seek specialist advice.

A novel treatment for vaginal symptoms is Dehydroepiandrosterone, better known as DHEA, a steroid hormone and can be used daily as a pessary. Contraindications are similar to vaginal oestogen usage and not to be used with oestrogen vaginally.

Ospemifene is a second treatment option for women who do not have a response or who cannot use vaginal pessaries. It is a selective oestrogen receptor modulator that has an oestrogen-like effect in the vagina, increasing the cellular maturation and mucification of the vaginal epithelium. It is taken as a tablet daily.

For more information on GSM and vaginal products please go to: **practicenursing.com/content/clinical-focus/vaginal-symptoms-in-the-menopause-cause-impact-and-treatment-combination-options**

Prescribed alternatives to HRT

These are not first line treatments but may be used with selective women who can not take hormones. It needs to be remembered that these mainly work on vaso-motor symptoms and are generally off license. They do not work on bone protection or vaginal symptoms.

Selective serotonin reuptake inhibitors (SSRIs) and seratonin and norepinephrine reuptake inhibitors (SNRIs)

Emerging evidence that there are a variety of mechanisms and hormones involved in hot flushes has lead to trials of medication that have previously been used as SSRI anti-depressants. Studies have shown these provide relief of hot flushes in some women, although the treatment remains unlicensed currently. Treatments include venlafaxine in lower doses of 37.5mg-150mg daily, paroxetine, fluoxetine and citalopram. The treatments can improve depression, however some such as paroxitine may have some interaction with Tamoxifen (BMS, 2022) (Kelly et al., 2010).

Clonidine

Clonidine was originally developed to treat hypertension, but can be effective in treating hot flushes in some women. Studies have shown that clonidine is better than a placebo at reducing the number and intensity of hot flushes. The recommended dose is 50-75mcg twice daily. Side effects include dry mouth and dizziness. This is currently the only prescribed alternative that is licensed for the treatment of hot flushes.

Gabapentin

Gabapentin is a gamma-aminobutyric acid analogue and is used to treat epilepsy and migraine. Limited early evidence shows it is better than a placebo at relieving hot flushes and sweats. It is not licensed for this indication.

Oxybutinin

Oxybutinin, normally for the treatment of an overactive bladder, can in some women reduce hot flushes. It is used for this off license and side effects may include stomach pain, diarrhoea, nausea, headaches, dry mouth and dry eyes. The usual dose is 2.5mg twice daily (BMS, 2022).

Fezolinetant

Fezolinetant is a Neurokinin 3 receptor antagonist, licensed to manage vasomotor symptoms, which are the commonest symptoms of menopause that women experience. Neurokinin antagonist medication influences changes in brain neurotransmitters which regulate the underlying process of vasomotor symptoms via the hypothalamo-pituitary-ovarian axis. Symptomatic women are more sensitive to changes in brain neurotransmitters. It is not available on the NHS but can be prescribed privately and will need monitoring of LFT prior to and after use.

Details of prescribable alternatives to HRT can be found at: **thebms.org.uk/wp-content/uploads/2022/12/02-BMS-TfC-Prescribable-alternatives-to-HRT-NOV2022-A.pdf**

Non-hormonal vaginal lubricants and moisturisers

Women may get relief from vaginal dryness by the regular use of vaginal moisturisers which can be purchased without prescription, although some are available on prescription. Lubricants, used at the time of sex, can help with dyspareunia.

It is important when looking at vaginal products to know the constitutions of them as some may cause irritation and change PH levels which can leave women prone to candidia. A list of current products ia available at: **practicenursing.com/content/clinical-focus/vaginal-symptoms-in-the-menopause-cause-impact-and-treatment-combination-options**

Libido and testosterone replacement

The drop in oestradiol level at the time of the menopause has a significant negative effect on sexual arousal and interest for some women. The post-menopausal ovary is an important source of androgen production, and total and free testosterone levels have been shown to be reduced by more than 40% in hysterectomised women with bilateral oophorectomy relative to menopausal women who have not undergone surgery.

Several studies have shown the benefit of testosterone therapy in post-menopausal women but mainly in those using oestrogen.

Before considering testosterone a full history needs to be taken. Women who are on oral HRT may benefit from switching to transdermal oestrogen which may free up testoterone and also ensure that there is no issue with vaginal atrophy, as this needs treating first. There are currently no licensed testosterone replacement therapy available in the UK. In its guideline, NICE (NG23) mentions: “At the time of publication (November 2024), testosterone did not have a UK marketing authorisation for this indication in women. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council’s Prescribing guidance: prescribing unlicensed medicines for further information. *Testosterone Replacement in Menopause* (BMS, 2022) is available at: **thebms.org.uk/wp-content/uploads/2022/12/08-BMS-TfC-Testosterone-replacement-in-menopause-DEC2022-A.pdf**

The therapeutic approach

The way in which menopause is perceived and experienced is influenced by its timing, personal meaning and severity of bodily symptoms which can mimic symptoms of chronic stress. Stressors may be external and circumstantial (for example redundancy, bereavement, acting as a carer) or internal (for example bitterness and regret at past choices or losses, fear of the future). Stressors may be exacerbated in the absence of positive mediators such as supportive relationships.

Specialist counselling can help promote emotional self management and a sense of personal control through validating the experience and supporting or introducing personal coping strategies which may lessen the impact of bodily symptoms. Challenging negative

thinking, developing coping strategies to reduce the impact of hot flushes and/or night sweats on daily life, guided imagery work and learning relaxation techniques have generally resulted in reduced problematic impact, increased sleep quality, increased self confidence, and a greater sense of optimism and empowerment.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is used to address a variety of different problems such as depression, premenstrual syndrome (PMS), and compulsive disorders, and aims to make sense of problems by sub dividing these to make it easier to see how these are connected and the effects. Typically issues are divided into parts of an event/experience to explore a particular situation, from which thoughts/physical feelings and emotions can be extracted and considered. These can then be translated into positive actions/action plans.

There have been promising trials of women with breast cancer who have CBT individually or in groups and find they are able to cope with the symptoms better after the sessions.

Further information can be found in *Cognitive Behaviour Therapy (CBT) for Menopausal Symptoms* available at: **thebms.org.uk/wp-content/uploads/2022/12/01-BMS-TfC-CBT-NOV2022-A.pdf**

Complementary approaches

NICE looked at alternatives and gives a summary within its guidance, there is a caution for women with hormone dependent cancers that they should always discuss alternatives with their health care provider.

It is suggested that there is a lack of evidence and clarity around alternatives and that the efficacy and safety of unregulated hormone preparations are unknown. There is a lack of information on safety, quality and purity of constituents in unregulated preparations may be unknown (NICE, 2015).

However, there are many preparations available. There is evidence that isoflavones or black cohosh may relieve vasomotor symptoms but interactions with other medicines have been reported (NICE, 2015)

There is some evidence that St John's Wort may help but there is uncertainty about:

- appropriate dosage
- persistence of effect
- variation in the nature and potency of preparations
- potential serious interactions with other medicines (including tamoxifen, anticoagulants and anticonvulsants) (NICE, 2015).

For further information please visit: **womens-health-concern.org/wp-content/uploads/2024/11/03-WHC-FACTSHEET-Complementary-And-Alternative-Therapies-NOV2024-B.pdf**

Figure 10: Common herbs used at the menopause

Herb	Comments
Black cohosh	Recognised as a menopausal treatment by WHO and German authorities. Data on effectiveness is mixed and there have been reports of liver toxicity
Evening primrose oil	Useful for breast tenderness
Ginkgo biloba	Little evidence improves menopause symptoms; can interact with warfarin and may cause bleeding
Ginseng	No better than placebo at relieving hot flushes; can cause PMB and interacts with warfarin and alcohol
Agnus castus (chasteberry)	No evidence
Sage	May cause bleeding; interacts with tamoxifen
St John's wort	Good for depression, irritability and fatigue and reducing anxiety; multiple drug interactions
Wild yam cream	Little data that it works as humans are unable to convert the active ingredients. Not suitable as progesterone is part of HRT.

Phytoestrogens

Phytoestrogens are naturally occurring, oestrogen-like compounds derived from plants. They have a similar chemical structure to oestrogen and bind to oestrogen receptors.

The two main dietary groups of phytoestrogens are lignans and isoflavones (see box). Lignans are found in cereals (oats and barley), seeds (linseed), fruits and vegetables, while isoflavones are found in beans and pulses (chickpeas, lentils and red clover), particularly soya beans and soy products. Evidence for the use of isoflavones for relief of menopausal symptoms is encouraging and further research is ongoing. Various dietary supplements of isoflavones are commercially available.

Isoflavins	Lignans
Chickpeas, legumes, lentils	Cereals (oats/barley)
Soya beans/soy-based products	Linseed
Tofu	Fruit and vegetables
Red clover	

Other considerations when advising women include:

- proton pump inhibitors or H2 receptor agonists may reduce efficacy of isoflavones
- antibiotic use reduces gut flora and may affect absorption of isoflavones and could therefore affect efficacy for approximately six weeks; increased intake of lacto acidophilus (probiotic) may help
- isoflavones may inhibit effect of some drugs metabolised by liver enzymes (Boullata, 2005)
- women receiving warfarin should be monitored regularly when changing their diet or commencing a dietary supplement
- in the absence of definitive research data, it is recommended that isoflavone supplements should not be used concomitantly with oestrogen, progestogen, or androgen therapy due to possible competitive inhibition.

(Food Standards Agency, 2003).

Contraindications

Isoflavones are not recommended for use during pregnancy or in women with undiagnosed vaginal bleeding. For women who have had hormone-dependent tumours such as breast cancer, it has not been established whether weekly oestrogenic supplements affect disease recurrence. Further studies are needed to determine the role and safety of phytoestrogens supplements in menopausal women.

6. Conclusions

The menopause is a natural phenomenon that occurs in most women, it is as different and individual as women are, and for some it is merely another change in their life cycle that will take place. For many women, it can be challenging and the symptoms may require some or significant management and support. Some women will experience POI and require specialist support, whist others may undergo surgical menopause as part of wider heath issues.

The requirements will vary, as identified throughout the guidance, and nurses are well placed to provide professional evidence-based support and referral to specialists where necessary.

Nurses have enormous potential to contribute to menopause care and will be working at differential levels of professional practice, from registration to enhanced, advanced and consutant level (RCN, 2024). The *Nurse Specialist in Menopause* (RCN, 2022, due to to be updated later in 2025) is a career opportunity for nurses engaged in women's health care, and provides a pathway to advancing nursing care in an area that can enhance the health and wellbeing of all women; both those who come in contact as patients and clients, those encountered in social, educational or employment environments, including partners and family and friends who may be concerned about the impact of the menopause.

The nurse specialist guidance recognised that women are seen in both primary and secondary care and by nurses of various disciplines, so the title of the nurse has been left deliberately broad to encompass all nurses who work at this advanced level of practice. It also acknowledges that nurses will be working at all levels within menopause services and is aimed at nurses who are running services for women with complex menopause.

> The role of the nurse specialist in menopause in managing and supporting women with menopause has been defined to take account of the need to:
>
> - facilitate a better understanding and the potential health implications of a wellmanaged menopause among all nurses coming in contact with women
> - lead and develop specialist menopause services
> - support these services and ensure they are linked with all areas of care.
>
> Taken from *Nurse Specialist in Menopause* (RCN, 2022).

Following the publication of the NICE guidelines (NICE, 2024) for the management of menopause the BMS has defined a specialist as:

A menopause specialist in the UK is defined as a health care professional who has obtained the British Menopause Society (BMS)/Faculty of Sexual Reproductive Health (FSRH) Advanced Menopause Certificate, or completed the (Royal College of Obstetrics and Gynaecology (RCOG)/BMS Advanced Training Skills Module (ATSM)* in Menopause Care (or equivalent, eg, the menopause and premature ovarian failure module of the subspecialty training programme in reproductive medicine) and who:

- is a member of the British Menopause Society (BMS)
- attends a National (BMS), European or International Menopause Society conference at least once every three years (BMS, 2017)
- provides a minimum of 100 menopause related consultations per year, of which at least

50 are new

- has the responsibility documented as part of their job plan and discussed at their annual appraisal.

*Please note the ATSM is only available currently to medical staff.

Health professionals wishing to register as a specialist do so at: **thebms.org.uk/niceguideline/menopause-specialists**

All nurses and midwives are encouraged to develop skills and knowledge to enhance best practice, provide advice and the appropriate support of women and their partners during this life event.

The RCN supports the need for all nurses, midwives and health care professionals to have a basic understanding of the symptoms and potential issues that may affect a woman wellbeing during this period. The RCN also supports the development of the nurse specialist in menopause role to provide an enhanced service for all women, but particularly those requiring specialist care for complex needs.

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Useful contacts and resources

Useful contacts

British Acupuncture Council www.acupuncture.org.uk

British Association for Counselling & Psychotherapy www.bacp.co.uk

Breakthrough Breast Cancer https://breastcancernow.org

British Homeopathic Association https://homeopathy-uk.org

British Menopause Society – a multidisciplinary professional organisation for health professionals working in the menopause field – quarterly journal. **www.thebms.org.uk** Menopause education for nurses. **thebms.org.uk/training/menopauseeducation-for-nurses**

Cancer Research UK www.cancerresearchuk.org

The Continence Foundation – provides information for health professionals and the public. **www.continence-foundation.org.uk**

COSRT – College of Sexual and Relationship Therapists www.cosrt.org.uk

Daisy Network – a support group for women suffering from premature menopause. www.daisynetwork.org

Faculty of Sexual and Reproductive Healthcare www.fsrh.org

Family Planning Association (FPA) – information for health professionals and the public on issues related to reproductive and sexual health. **www.fpa.org.uk**

The General Regulatory Council for Complementary Therapies www.grcct.org

Institute for Complementary Medicine www.naturaltherapypages.co.uk/association/institute_of_complementary_medicine

Institute of Psychosexual Medicine www.ipm.org.uk

The Menopause Exchange www.menopause-exchange.co.uk

Menopause Matters – aims to provide easily accessible up-to-date information about the menopause, menopausal symptoms and treatment options including HRT and alternative therapies. **www.menopausematters.co.uk**

Royal Osteoporosis Society – provides literature for health professionals and lay public on many issues related to osteoporosis. **https://theros.org.uk**

NHS England – cancer screening programmes (cervical, breast and bowel) can be accessed at **www.cancerscreening.nhs.uk**

Relate – co-ordinates the activities of local marriage guidance centres and relationship counselling for couples or families. **www.relate.org.uk**

Research Council for Complementary Medicine www.rccm.org.uk

RCN Direct – information and advice for RCN members. Tel: 0345 772 6100

Royal College of Obstetricians and Gynaecologists – menopause and women's health in later life. **www.rcog.org.uk/en/patients/menopause**

Women's Health Concern – provides information on women's health issues, particularly those relating to the menstrual cycle and the menopause. Local helplines available. **www.womens-health-concern.org**

Resources

NHS Wales Menopause Policy (2018) **www.nhsconfed.org/publications/nhs-wales-menopause-policy**

British Association for Applied Nutrition & Nutritional Therapy **www.bant.org.uk**

Devlin R (2019) How can we support patients through the menopause if the NHS can't support staff?, *Nursing Standard* website, 9 May. **https://rcni.com/nursing-standard/opinion/comment/how-can-we-support-patientsthrough-menopause-if-nhs-cant-supportstaff-148391**

NHS Employers (2020) *Menopause at work*. **www.nhsemployers.org/publications/guidance-menopause-work**

The NHS Live Well campaign contains easy-toaccess advice on healthy eating **www.nhs.uk/live-well**

Royal College of Nursing's Menopause clinical page **www.rcn.org.uk/clinical-topics/womenshealth/menopause**

Royal College of Nursing (2023) *RCN Position Statement on Menopause and You at Work* **www.rcn.org.uk/Professional-Development/publications/rcn-menopause-position-statement-uk-pub-011-282**

Royal College of Nursing (2024) *RCN Position Statement on Support for Women's Reproductive Health in the Workplace* **www.rcn.org.uk/About-us/Our-Influencing-work/Position-statements/rcn-position-womens-reproductive-health**

RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

Menopause impacts on most peoples' lives, men and women, and it is important that all nursing teams have a good understanding of how different menopause can be for individuals, and their families. This updated publication aims to support best evidence-based practice for health care professionals to renew and update their understanding of the potential physical and psychological impact on daily living and work/life of the menopause. It includes guidance on advice and care recommended to best support women though the menopause, where required.

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The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact **publications.feedback@rcn.org.uk**

Evaluation

The authors would value any feedback you have about this publication. Please contact **publications.feedback@rcn.org.uk** clearly stating which publication you are commenting on.

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