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MENOPAUSE FAQ's
Frequently Asked Questions

Introduction

Please take the time to read through these FAQs after your appointment. Some may apply to you, while others may not. We strongly recommend reading this because it can save you time and help reduce unnecessary worries!

Q: I am bleeding on the new hormones that were prescribed to me.
A: This is a common side effect when starting hormone therapy. Typically, this occurs in the first six months after starting hormone therapy or sometimes after changing the dose. This is because the uterine lining is being stimulated by the hormones you're taking. Often, it can mean the estrogen dose is too high, or the progesterone dose is too low.

If your bleeding is light, please note it on a calendar and we'll discuss this at your follow-up. If you're having significant bleeding and soaking pads, please stop your medications and give us a call or send a message through the portal.

To help stop the bleeding, we might discontinue the hormones for a short time and then resume them with a slightly lower dose of estrogen or maybe a higher dose of progesterone. Other forms of management might include ordering a pelvic ultrasound and/or sometimes a uterine biopsy, which is usually not necessary. We may also do a pelvic exam to visualize any cervical polyps that could be newly bleeding with the addition of hormones.

Q: My breasts are tender on the hormones.
A: Unfortunately, this can also be normal, especially at first. We encourage you to continue at your dose to see if this sensation goes away after the first few weeks. Sometimes nipples can be sensitive. If this does not go away after several weeks, we may lower your estrogen dose. Try decreasing caffeine, using ibuprofen as needed.

Q: My hormone therapy is not helping.
A: Please give your medications at least 8–12 weeks to fully take effect. When starting at lower initial doses, we might increase the dose at three months, and then it could take another three months to reach full steady-state beneficial effects. When you have your follow-up, the dose may be adjusted. It might mean that the dose was too low for you, or that the route was not the best one for you. Please be patient, because finding the right medication type and dosing can sometimes take a few tries.

Q: I am having side effects from the nightly progesterone.
A: Sometimes progesterone can make women feel sleepy or irritated. If this is you, please give the office a call and we will try to change your medications according to your side effects. This is uncommon but can be a side effect in a small percentage of women. For women who do not like the progesterone, a progestin IUD can be an option.

One alternative approach is to take the progesterone 2-3 hours before bedtime. The blood levels gradually increase, and ideally we want the peak level to be about the time you go to sleep, which also allows the hormone effect to wear off before it's time to wake up. This can help reduce morning sleepiness. Prescription sleeping pills are designed to peak quickly, within half an hour, and wear off within a few hours. Progesterone acts more slowly.

Q: I am noticing hair thinning or new onset of acne.
A: This can happen when starting estrogen or testosterone. If you are on topical testosterone, we can consider stopping or reducing the dose, as this is a known side effect. As the testosterone leaves your body, your hair will regrow and your acne will diminish. You can also add biotin and zinc supplements if you like. Estrogen is particularly good for hair, so try to stay with it. Remember that hair regrowth can take up to a full year, so be patient.

Q: I am noticing a change in my mood.
A: This can be normal for a short period of time. If it’s truly affecting your life, please feel free to stop the medication and call the office. It can be helpful if you note what symptoms you had and when they started in relation to the medications. At your next appointment, we’ll also see if there are any underlying mental health concerns that might need to be addressed separately.

Q: I am having breakthrough bleeding on continuous birth control pills (BCP).
A: Continuous BCP is when you only take the active hormone pills and do not take any of the placebo pills. Spotting when on this program can happen. If it is bothersome and/or heavy, STOP wherever you are in the pack, wait until the bleeding ends, then wait 3-4 more days and restart where you left off. This allows any built-up lining to shed.

Q: I am having bleeding with a progesterone IUD.
A: This can be normal for up to 3-6 months – pain and cramping past 1-2 months is not typical, however, and you should see the provider for an IUD string check and/or have a uterine ultrasound done for placement confirmation.

Q: I am on Duavee and I feel that I need more estrogen or it’s not helping.
A: Please give the medication 8–12 weeks to see if it will take full effect. Duavee is a unique form of hormone therapy. The estrogen is a form of Premarin and its dose is 0.45, which is a little lower than the 0.625 dose commonly used. In some cases, we use Duavee and then add an additional low dose of estrogen to help safely achieve the right beneficial effects.

Q: I see my estrogen level came back high and I am on postmenopausal hormone therapy.
A: Normally, we don’t need to check estrogen levels to manage most women using hormone therapy. We do need to periodically check testosterone levels if you’re using that. Many studies show a poor correlation between estrogen blood levels and the relief of menopausal symptoms. If you’re taking what seems like a good dose of estrogen and still not doing well, a blood level can be helpful.

Many hormone gurus and clinics check hormone levels quite often, sometimes monthly! They check saliva levels, urine levels, and even do hair analyses. These tests are rarely necessary and can be quite expensive, generating a lovely income for the guru.

Q: I see my estrogen level came back low and I am on postmenopausal hormone therapy.
A: If you feel wonderful on your dose, then there is nothing that we need to do with this! It is working just fine and there is no need to treat to a lab value. If it is low and you still have symptoms, this means that we can increase the dose and hopefully get your symptoms under better control.

Q: I see that my testosterone is low on my labs – what do I do?
A: Lower testosterone levels are "normal" postmenopausal. If you're experiencing bothersome low libido, we can consider adding testosterone at your next appointment. If you're not experiencing low libido, then we usually do not advise testosterone, but there are exceptions to this. The use of testosterone is not as well standardized as the use of estrogen and progesterone.

Q: I'm having trouble sleeping.
A: Remember sleep hygiene tips. Go to bed and wake up at the same time every day. Have a pre-bedtime routine. Keep the room cool and dark. Use white noise. Use the bed for sleep and sex only! Do not watch TV while in bed and ideally do not have a TV in the bedroom. Try adding 250 to 500 mg of magnesium oxide at bedtime and/or 5 mg of melatonin. Try a meditation app or bedtime app that you enjoy. Oral natural progesterone can also help sleep; this was addressed in an earlier Q&A.

Q: My labs showed perimenopause – what does that mean?
A: This means you are in the transition from pre-menopause to menopause. This term is often used incorrectly as there is no standard definition of perimenopause. We diagnose this in women usually in their 40s, whose periods are no longer regular every month. Maybe the cycle is shorter, maybe longer, or irregular, or even skipping periods, and also there are some hot flashes and night sweats that come and go. Keep track of your periods and symptoms with a journal or app as this can be helpful down the road. Note your symptoms and any improvements if you start medication for this issue. Once you enter "peri-menopause," it can be 1-3 years or so before true menopause begins.

Q: My bone density showed osteopenia – what do I do?
A: If on estrogen replacement, then that is considered treatment for osteopenia. Make sure that you are also taking over-the-counter Vitamin D 1,000–2,000 units daily and 600-1,200 mg calcium (depending on dietary calcium intake). Be sure to include some weight-bearing activity. We highly encourage women with this condition to learn as much as they can about lifestyle changes and bone health. A fracture later in life is common and can be quite devastating to your quality of life. It can take years of proper bone health activities to help lower that risk.

Q: My bone density showed osteoporosis.
A: This is a serious diagnosis and requires specialized medical testing and discussion of treatment options.

Q: What is the DUTCH test
A: This is a made-up test ordered by hormone gurus and natural practitioners. It is expensive, extremely difficult to interpret, and is NOT ordered by traditional physicians. It stands for "dried urine testing for comprehensive hormones". Sometimes it includes a saliva test. Very popular online and heavily marketed. Probably generates income for the provider offering it.