LIVING WELL

# What Nobody Tells You About Perimenopause

The transition can be long, changeable and poorly mapped-but you have more options than supplements, silence or simply waiting it out.

## The rules stop behaving

Your period arrives early, then disappears, then returns heavier. Sleep becomes unreliable. You feel hot for no apparent reason, or discover that sex suddenly hurts. The unsettling part is not merely that your body has changed. It is that several changes can arrive together, without a neat announcement explaining what connects them.

This is perimenopause, also called the menopausal transition: the years leading up to menopause, when the ovaries begin making less estrogen and progesterone. It usually starts in your 40s, although it can begin earlier, and it may last several years. Menopause itself is reached only after 12 months without a period. Until then, you are in the transition-even if your cycle has become wildly unpredictable.

What nobody tells you is how broad that transition can feel. Periods may become shorter, longer, lighter, heavier or irregular. Hot flashes and night sweats may appear. You may struggle to fall asleep or return to sleep after waking, and prolonged poor sleep can feed fatigue and memory problems. Mood changes can show up as anxiety, irritability or feeling unusually moody.

There can also be vaginal dryness, discomfort during sex, urinary incontinence or urinary tract infections. A 2024 review of menopause guidelines found that the symptoms most consistently linked with this stage included hot flashes, disturbed sleep, musculoskeletal pain, reduced sexual function or desire, and mood disturbance. Perimenopause is not one feeling. It is a shifting collection of them.

## The map has missing pieces

You might reasonably expect medicine to have a detailed playbook specifically for this stage. It does not. The same 2024 review examined 26 guidance documents and found that recommendations focused specifically on perimenopause were scant. That matters because advice drawn from people who are already postmenopausal may not answer every question you have while periods and hormone levels are still changing.

The evidence gap is especially visible around hormone therapy. A 2017 systematic review included 22 studies and 43,637 women, but none focused on perimenopausal women. Most participants were postmenopausal American women, and the average age in most studies was over 60. The review could not adequately assess the risks of long-term hormone therapy in perimenopausal women or postmenopausal women younger than 50.

That does not mean nothing is known. It means the certainty is uneven. Strong evidence in older or postmenopausal groups cannot automatically settle every decision for someone in the middle of the transition. Your age, whether you still have a uterus, your symptoms, medical history and the particular form of therapy can all matter to a treatment discussion.

It also explains why two people can receive different advice without either conversation necessarily being careless. Menopausal hormone therapy (MHT) is not one uniform intervention: it may involve estrogen alone or estrogen with progesterone or progestin, delivered as pills, patches, gels, sprays, creams, tablets or rings. A broad claim that hormones are simply "safe" or "dangerous" strips away the details that determine the balance.

Hormones can be effective symptom relief without being a general defence against ageing.

## Relief is not the same as a cure-all

For hot flashes, hormone therapy has the strongest evidence. A 2021 umbrella review covering 60 systematic reviews found that MHT reduced both the frequency and severity of vasomotor symptoms-the clinical term for hot flashes and night sweats. It also found benefits for fractures and several other outcomes. But the overall quality of the included reviews ranged from moderate to poor, and the effects varied between estrogen-only and combined therapy.

The same review found increased risks for stroke and venous thromboembolism, meaning blood clots in the veins, along with other harms for some forms of therapy. Another long-term review found that combined therapy increased several risks, although it noted that women with intolerable symptoms may decide that relief outweighs the small absolute risk associated with short-term, low-dose use when they have no specific reason to avoid it.

Hormone therapy is not suitable if you are pregnant or may be pregnant, have unexplained vaginal bleeding, or have had certain cancers, a stroke, heart attack or blood clots. Liver disease can also rule it out. If you still have a uterus, a clinician may recommend estrogen with progesterone or progestin rather than estrogen alone; after removal of the uterus, estrogen alone may be considered.

The crucial distinction is purpose. High-quality guidelines consistently support systemic MHT for hot flashes and menopause-associated mood disturbance. They do not recommend it for

cognitive symptoms or to prevent dementia or cardiometabolic disease. Hormones can be effective symptom relief without being a general defence against ageing. Those are different promises, and only the first is supported.

Non-hormonal options exist too. Certain antidepressants, an antiseizure medicine, a blood-pressure medicine and a medicine designed for hot flashes may be considered; some can also help sleep. Cognitive behavioural therapy (CBT), a form of talk therapy, is an option for sleep difficulty. Vaginal dryness may respond to a water-based lubricant, while painful sex caused by menopausal vaginal changes can also be treated with medicines.

## Natural does not mean proven

The supplement aisle offers a seductively simple story: your hormones are changing, so a plant, cream or powder will restore balance. The evidence does not support that confidence. Phytoestrogens, herbs and other dietary supplements have not been clearly shown to relieve menopausal symptoms, and little is known about their long-term safety. Some can cause harmful effects or interact with medicines.

Studies of soy and red-clover isoflavones have produced inconsistent results. Flaxseed products were no better than a placebo for reducing hot flashes. Research on black cohosh has also been inconsistent, and a review found insufficient evidence to support it. Rare cases of serious liver damage have been reported among people taking commercial black cohosh products, although it remains uncertain whether the herb caused them.

The evidence for custom-mixed "bioidentical" hormones is no more reassuring. They have not been shown to work better or be safer than conventional hormone therapy, and their contents may vary from batch to batch. Calling a hormone natural does not remove its biological effects or make personal medical history irrelevant.

Even apparently positive nutrition research requires restraint. A 2022 meta-analysis found that nutritional interventions appeared to improve depression and anxiety scores during and after the menopausal transition. But the interventions varied widely, the studies had significant differences and risk of bias, and researchers could not establish which approaches produced the effect. "Promising" is not the same as knowing what works.

Movement has somewhat firmer, though still limited, support. A 2024 analysis of 11 randomized trials involving 1,005 participants found that mind-body exercise-including yoga, tai chi and mindfulness-based approaches-was associated with improvements in sleep, anxiety, depressive mood, fatigue and bone mineral density. The results for several outcomes varied substantially between studies, so this is an option to explore, not a promised

transformation.

## Make next week more specific

You do not need to prove that every difficult day comes from perimenopause before asking for help. If changes are affecting daily life, a clinician can discuss your symptoms, medical and family history, preferences, and the benefits and risks of available options. Unexplained vaginal bleeding needs medical attention rather than being written off as part of the transition.

Go into that conversation with priorities rather than a demand for one universal fix. Name what is disrupting your life most: hot flashes, sleep, mood, bleeding, vaginal discomfort, sex or bladder problems. Ask what options target that problem, what risks apply to your history and what the evidence can-and cannot-say about someone at your stage of the transition.

For the coming week, make one immediate change you can actually carry. If hot flashes are the problem, dress in removable layers and put a portable fan in your bag. Avoiding alcohol, spicy foods and caffeine may also help because they can worsen menopausal symptoms. This is not a cure, and it does not replace care when symptoms are disrupting your life. It is a practical way to make the next hot flash less in charge of your day.

Perimenopause is not one feeling. It is a shifting collection of them. You may not be able to make the transition predictable, but you can stop treating every symptom as something you are expected to endure without support.

## Where this comes from

- Menopause

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/menopause.html
- Hormone Therapy for Menopause

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- Menopausal Symptoms: In Depth | NCCIH

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