VA/DOD Clinical Practice Guidelines

MENOPAUSE

Provider Summary

Version 1.0 | 2026

VA/DOD CLINICAL PRACTICE GUIDELINE MENOPAUSE

Department of Veterans Affairs
Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical trial and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of a particular clinical situation.

These guidelines are not intended to represent Department of Veterans Affairs nor TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 1.0 – 2026

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Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DOD) Evidence-Based Practice Work Group (EBPWG) was established in 2004, with a mission to use clinical and epidemiological evidence to improve population health within the Veterans Health Administration (VHA) and Military Health System (MHS) and develop clinical practice guidelines (CPGs) for the VA and DOD populations.(1) This CPG is intended to provide healthcare providers with a practical framework by which to evaluate, treat, and manage menopause, address the individual needs and preferences of patients, and improve clinical outcomes.

In 2025, the VA and DOD initiated the creation of the Menopause CPG, based on evidence reviewed from January 1, 2015, to June 30, 2025. This CPG uses the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach, reflecting a rigorous application of the methodology.(2) Therefore, the strength of some recommendations may have been modified based on the confidence in the quality of the supporting evidence (see Evidence Quality and Recommendation Strength).

The system-wide goal of evidence-based guidelines is to improve the patient's health and well-being. To that end, this CPG is intended to guide providers who care for patients along management pathways supported by evidence. Successful implementation of this CPG will result in:

- Accurate assessment of the patient's menopausal status and, in collaboration with the patient, determining the most appropriate treatment plan;
- Minimization of preventable complications and morbidity using early screening and risk assessments;
- Emphasis on the use of informed, patient-centered care;
- Optimization of daily functioning, functional independence, health outcomes, and quality of life

Scope of the CPG

This CPG is intended for use by all clinical professionals who provide health care to individuals experiencing perimenopause or menopause.

A. Populations Included in this Guideline

This CPG is intended for individuals with naturally occurring or surgically/iatrogenically induced perimenopause or menopause. Individuals under 40 with natural menopause should be evaluated by specialists.

Recommendations

The following recommendations were made using a systematic approach considering four domains as per the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach as detailed in the section on Methods and Appendix A in the full 2026 VA/DOD Menopause CPG. These domains include the confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient or provider values and preferences, and other implications as appropriate (e.g., resource use, equity, acceptability, feasibility, subgroup considerations).

A. Key Takeaways/Highlights

- The Work Group developed a total of 43 evidence-based recommendations, including 5 strong recommendations, 25 weak recommendations, and 13 insufficient evidence recommendations focused on the management of menopausal symptoms and improving patient outcomes. The recommendation topics include:
    - Diagnosis of Perimenopause and Menopause
    - Management of Menopausal Symptoms
        - Vasomotor Symptoms
        - Sleep Symptoms
        - Depressive and Anxiety Symptoms
        - Cognitive Symptoms and Dementia
        - Genitourinary Syndrome of Menopause (GSM) and/or Sexual Dysfunction Symptoms
        - Bone Health
        - Overweight and Obesity Management
    - Safety
        - Cardiovascular Disease Risk
        - Breast Cancer Risk

B. Evidence-Based Clinical Practice Recommendations with Strength and Category

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Diagnosis of Perimenopause and Menopause		1.	We suggest against using laboratory testing (e.g., anti-müllerian hormone and/or follicle-stimulating hormone) for the diagnosis of menopause and perimenopause.	Weak against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Management of Menopausal Symptoms	Vasomotor Symptoms	2.	In women with a uterus, we recommend systemic estradiol and progesterone for the treatment of vasomotor symptoms.	Strong for	Reviewed, New-added
		3.	In women with a uterus, we suggest the use of conjugated estrogen with bazedoxifene for the treatment of vasomotor symptoms.	Weak for	Reviewed, New-added
		4.	In women without a uterus, we suggest the use of systemic estradiol monotherapy for the treatment of vasomotor symptoms.	Weak for	Reviewed, New-added
		5.	For the treatment of vasomotor symptoms of menopause, we suggest against the use of progestogen monotherapy.	Weak against	Reviewed, New-added
		6.	We recommend cognitive behavioral therapy (CBT) to manage vasomotor symptoms related to menopause.	Strong for	Reviewed, New-added
		7.	We suggest elinzanetant or fezolinetant for vasomotor symptoms in menopausal women.	Weak for	Reviewed, New-added
		8.	There is insufficient evidence to favor fezolinetant or elinzanetant versus hormone therapy for vasomotor symptoms.	Neither for nor against	Reviewed, New-added
		9.	We suggest selective serotonin reuptake inhibitors (SSRIs)/serotonin-norepinephrine reuptake inhibitors (SNRIs) or gabapentin as non-hormonal options for menopausal vasomotor symptoms based on patient characteristics and preferences.	Weak for	Reviewed, New-added
		10.	For menopausal vasomotor symptoms, in patients without a contraindication to hormone therapy, we suggest hormone therapy over either venlafaxine or gabapentin.	Weak for	Reviewed, New-added
		11.	There is insufficient evidence to recommend for or against the following complementary and integrative health (CIH) interventions for menopausal vasomotor symptoms: • Acupressure • Acupuncture • Tai Chi/Qigong • Yoga	Neither for nor against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Management of Menopausal Symptoms (cont.)	Vasomotor Symptoms (cont.)	12.	There is insufficient evidence to recommend for or against the following supplements and nutraceuticals for menopausal vasomotor symptoms: • Amino Acids • Black Cohosh • Danggwijagyaksan • Fenugreek • Giant Fennel • Ginseng • Kamishoyosan • Maca • Magnesium • Melatonin • Probiotics • Red Clover • Resveratrol + Equol • Salvia • Soy Supplements • Succinate	Neither for nor against	Reviewed, New-added
	Sleep Symptoms	13..	There is insufficient evidence to recommend for or against menopausal hormone therapy used solely for sleep symptoms.	Neither for nor against	Reviewed, New-added
	Depressive and Anxiety Symptoms	14.	We recommend cognitive behavioral therapy (CBT) to treat depressive and/or anxiety symptoms during perimenopause and menopause.	Strong for	Reviewed, New-added
		15.	We recommend mindfulness-based stress reduction (MBSR) for menopause-related depressive and/or anxiety symptoms (See VA/DOD CPG for Major Depressive Disorder [MDD]).	Strong for	Reviewed, New-added
		16.	In perimenopausal women, we suggest menopausal hormone therapy to treat depressive symptoms, depending on patient characteristics and preferences (For patients with Major Depressive Disorder [MDD], see VA/DOD CPG for MDD).	Weak for	Reviewed, New-added
		17.	For depressive symptoms during perimenopause or menopause, we suggest exercise (e.g., mind-body exercise, aerobic activity, or combination).	Weak for	Reviewed, New-added
		18.	For depressive symptoms during perimenopause or menopause, there is insufficient evidence to recommend for or against the use of phytoestrogens (e.g., soy supplements)	Neither for nor against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Management of Menopausal Symptoms (cont.)	Cognitive Symptoms and Dementia	19.	There is insufficient evidence to recommend for or against menopausal hormonal therapy (MHT) used solely for the prevention of dementia.	Neither for nor against	Reviewed, New-added
		20.	We suggest against the use of menopausal hormonal therapy (MHT) solely for treatment of cognitive symptoms in perimenopausal and menopausal women.	Weak against	Reviewed, New-added
	GSM and/or Sexual Dysfunction Symptoms	21.	We suggest local (non-systemic) vaginal and/or systemic estrogen therapy, for the management of sexual dysfunction in menopause, especially related to vaginal dryness and dyspareunia.	Weak for	Reviewed, New-added
		22.	For genitourinary syndrome of menopause (GSM), we suggest treatment with local (non-systemic) vaginal estrogen.	Weak for	Reviewed, New-added
		23.	For breast cancer survivors, we suggest local (non-systemic) vaginal estrogen therapy for the treatment of genitourinary syndrome of menopause (GSM).	Weak for	Reviewed, New-added
		24.	For dyspareunia, we suggest local (non-systemic) vaginal estrogen and/or vaginal dehydroepiandrosterone (DHEA).	Weak for	Reviewed, New-added
		25.	For vaginal dryness, we suggest local (non-systemic) vaginal estrogen, vaginal DHEA, vaginal moisturizers, or ospemifene.	Weak for	Reviewed, New-added
		26.	We suggest transdermal testosterone for the treatment of sexual dysfunction in menopause, especially related to interest, desire, and/or arousal.	Weak for	Reviewed, New-added
		27.	For the treatment of Hypoactive Sexual Desire Disorder (reclassified in the DSM-5 as Female Sexual Interest/Arousal Disorder) in perimenopause and menopause, we suggest flibanserin.	Weak for	Reviewed, New-added
		28.	For dyspareunia, there is insufficient evidence to recommend for or against the use of vaginal moisturizers.	Neither for nor against	Reviewed, New-added
		29.	For genitourinary syndrome of menopause (GSM), we suggest against the use of vaginal lasers.	Weak against	Reviewed, New-added
	Bone Health	30.	In post-menopausal women with risk factors for osteoporosis, we suggest conjugated estrogen/bazedoxifene as an option to increase bone mineral density based on patient characteristics and preferences.	Weak for	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Management of Menopausal Symptoms (cont.)	Bone Health (cont.)	31.	In post-menopausal patients, we suggest dietary calcium and/or calcium supplementation to increase bone mineral density.	Weak for	Reviewed, New-added
		32.	In post-menopausal patients without osteoporosis, there is insufficient evidence to recommend for or against Vitamin D3 for primary improvement of decreased bone mineral density or fracture.	Neither for nor against	Reviewed, New-added
		33.	For primary prevention of fracture in post-menopausal patients without documentation of osteoporosis or osteopenia, there is insufficient evidence to recommend for or against bisphosphonates.	Neither for nor against	Reviewed, New-added
		34.	In post-menopausal patients with osteopenia, there is insufficient evidence to recommend for or against raloxifene to reduce fracture risk and improve bone mineral density.	Neither for nor against	Reviewed, New-added
	Overweight and Obesity Management	35.	In post-menopausal women with overweight or obesity, we suggest a calorie-restricted diet for weight management, depending on patient characteristics and preferences (see the VA/DOD CPG for the Management of Overweight and Obesity in Adults).	Weak for	Reviewed, New-added
		36.	We suggest exercise for peri-menopausal or post-menopausal women for reduction of weight and/or waist circumference (e.g., aerobic activity, resistance training, or combination).	Weak for	Reviewed, New-added
		37.	In post-menopausal women, there is insufficient evidence to recommend for or against any of the following dietary approaches for weight management: • High protein • Intermittent fasting • Low fat • Mediterranean • Paleolithic • Vegan (with soy supplementation)	Neither for nor against	Reviewed, New-added
Safety	Cardiovascular Disease Risk	38.	For the primary prevention of post-menopausal cerebrovascular events, we recommend against oral estrogen or estrogen and progestogen.	Strong against	Reviewed, New-added
		39.	For primary prevention of post-menopausal cardiovascular disease (CVD), we suggest against oral menopausal hormone therapy, whether it is estrogen alone or with progestogen, and whether it is low-dose or conventional dose.	Weak against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Safety (cont.)	Cardiovascular Disease Risk (cont.)	40.	For women less than 60 years old and less than 10 years from the onset of menopause with established cardiovascular disease (CVD) and significant vasomotor symptoms, we suggest consideration of systemic estrogen-containing therapies based on the lack of evidence for increased cerebrovascular and cardiovascular morbidity and mortality.	Weak for	Reviewed, New-added
	Breast Cancer Risk	41.	For hormone-positive breast cancer survivors, we suggest against the use of systemic hormone therapy.	Weak against	Reviewed, New-added
		42.	For women with an intact uterus taking systemic estrogen, there is insufficient evidence to recommend for or against any one of the following progestogen formulations over another to modify breast cancer risk: • Oral Drospirenone • Transdermal, or 52 mg levonorgestrel intrauterine device (LNG IUD) • Oral micronized progesterone • Oral medroxyprogesterone acetate (MPA) • Oral or transdermal Norethindrone acetate	Neither for nor against	Reviewed, New-added
		43.	When selecting a progestogen in women with an intact uterus taking systemic estrogen, there is insufficient evidence to recommend any one of the following progestogen formulations over another for protection against endometrial cancer: • Oral Drospirenone • Transdermal, or 52 mg levonorgestrel intrauterine device (LNG IUD) • Oral micronized progesterone • Oral medroxyprogesterone acetate (MPA) • Oral or transdermal Norethindrone acetate	Neither for nor against	Reviewed, New-added

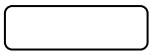
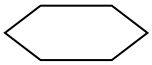
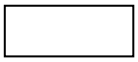
[a] For additional information, please refer to **Determining Recommendation Strength and Direction** in the full CPG.
[b] For additional information, please refer to **Recommendation Categorization** in the full CPG

Algorithm

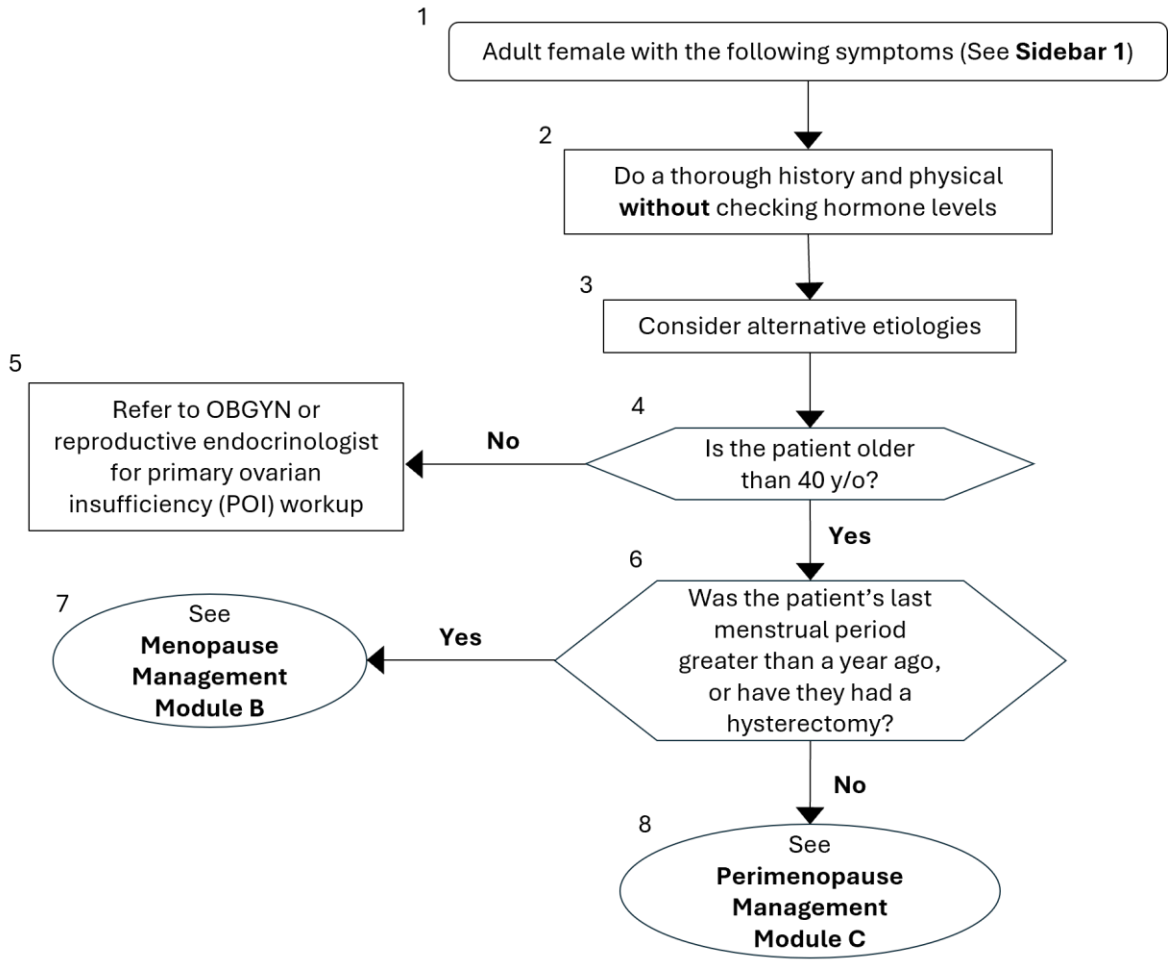
This CPG's algorithm is designed to facilitate understanding of the clinical pathway and decision-making process used in menopause management. This algorithm format represents a simplified flow of the management of individuals with naturally occurring or surgically/iatrogenically induced perimenopause or menopause, helping to foster efficient decision-making by providers. It includes:

- An ordered sequence of steps of care;
- Recommended observations and examinations;
- Decisions to be considered; and
- Actions to be taken.

The algorithm is a step-by-step decision tree. Standardized symbols are used to display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed.(3) Sidebars provide more detailed information to assist in defining and interpreting elements in the boxes.

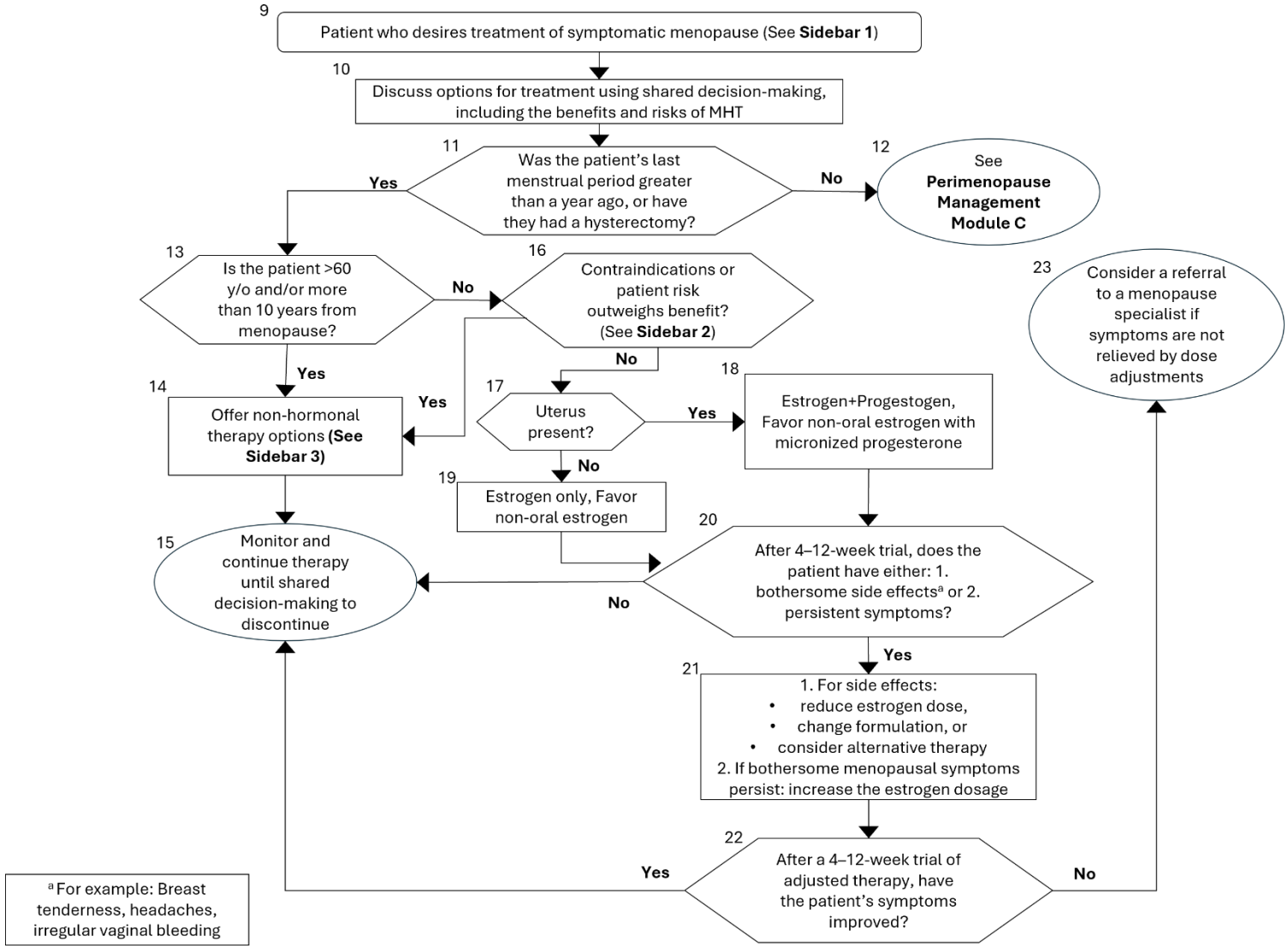
Shape	Description
	Rounded rectangles represent a clinical state or condition.
	Hexagons represent a decision point in the guideline, formulated as a question that can be answered "Yes" or "No".
	Rectangles represent an action in the process of care.
	Ovals represent a link to another section within the algorithm

Module A: Perimenopause and Menopause Diagnosis



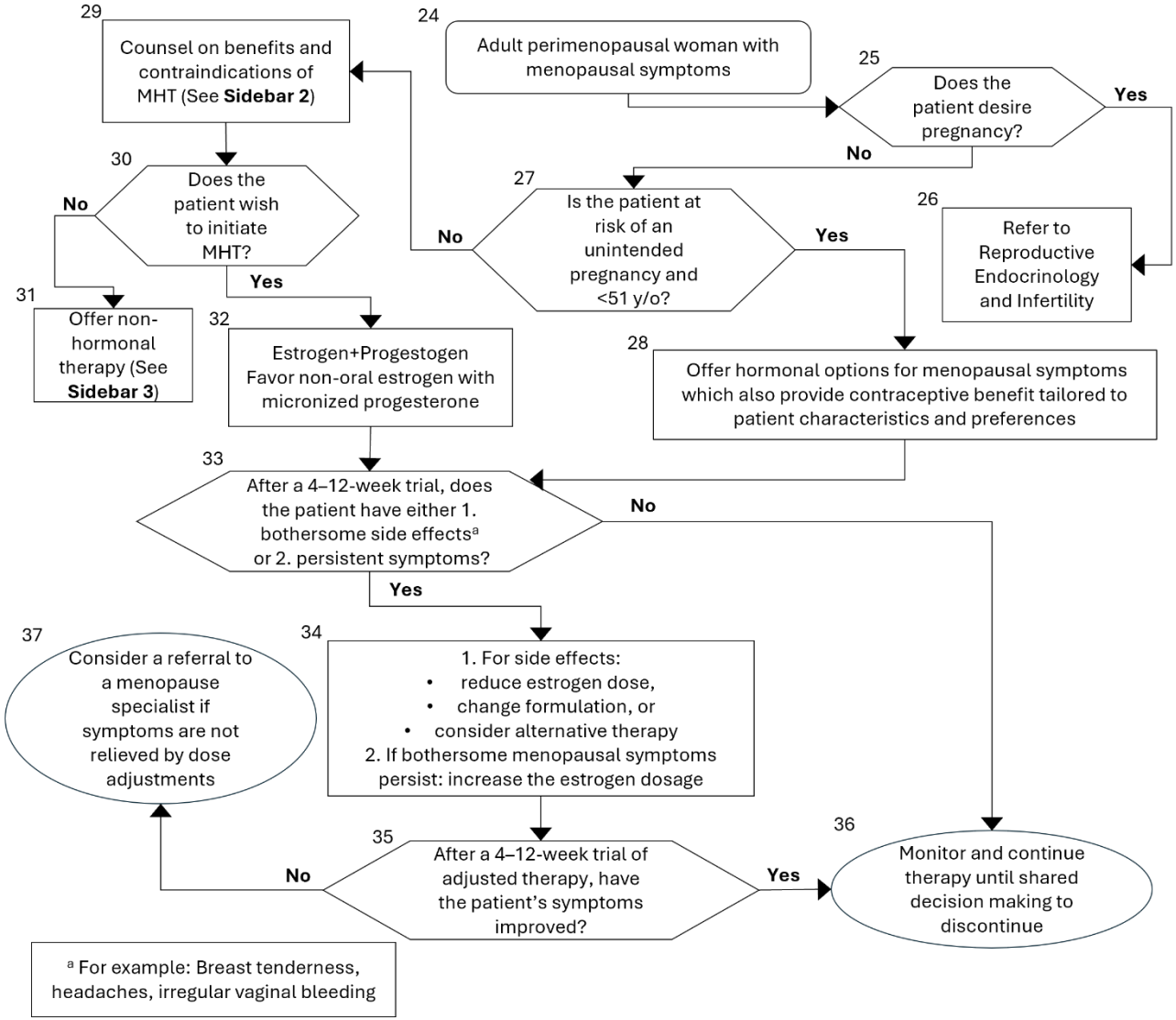
Abbreviations: OBGYN: obstetrician-gynecologist; POI: primary ovarian insufficiency; y/o: years old

Module B: Menopause Management



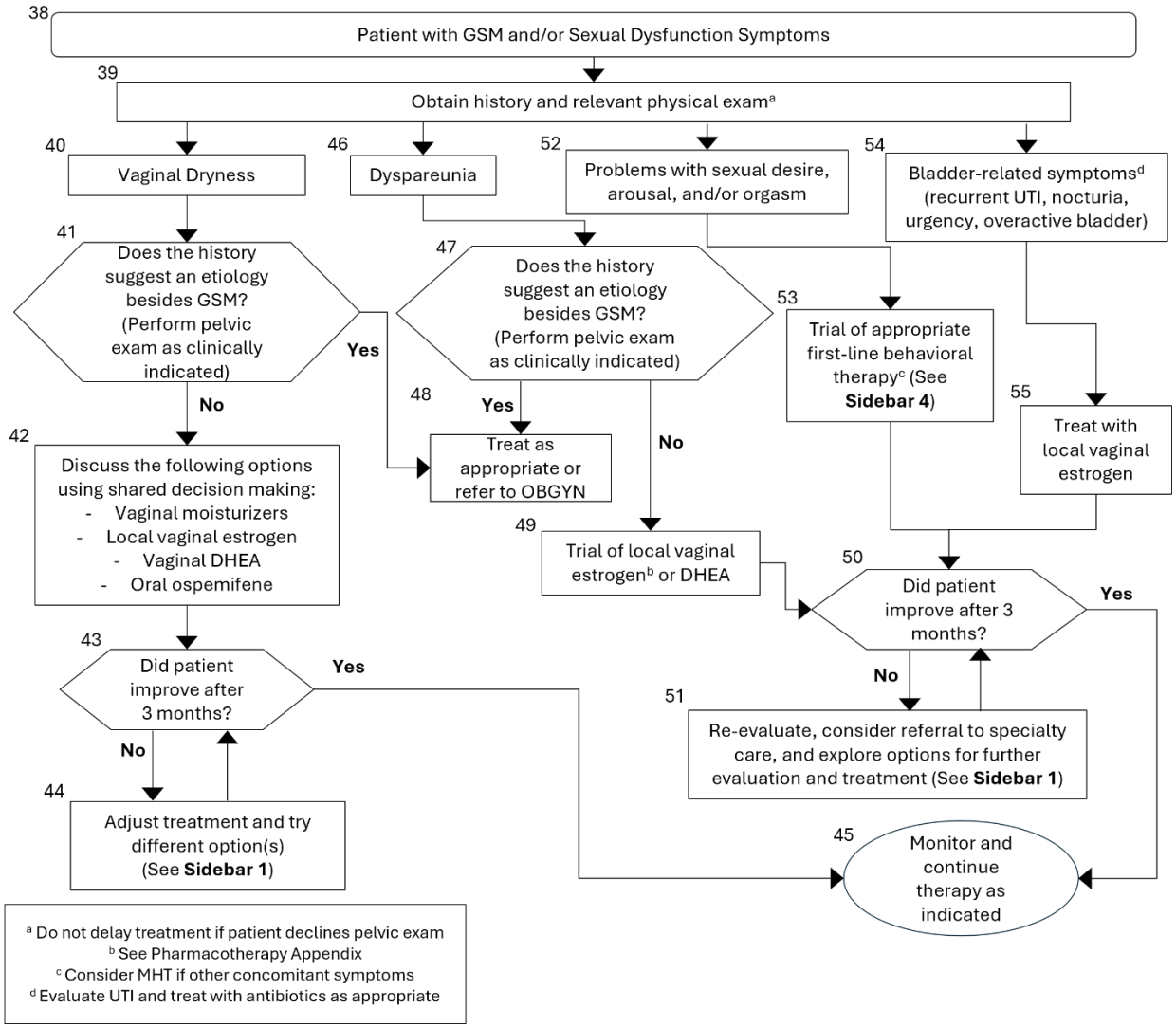
Abbreviations: MHT: menopausal hormonal therapy; y/o: years old

Module C: Perimenopause Management



Abbreviations: MHT: menopausal hormonal therapy; y/o: years old

Module D: Genitourinary Syndrome of Menopause (GSM) and/or Sexual Dysfunction Symptoms Treatment



Abbreviations: DHEA: dehydroepiandrosterone; GSM: genitourinary syndrome of menopause; MHT: menopausal hormonal therapy; OBGYN: obstetrician-gynecologist; UTI: urinary tract infection

Sidebar 1: Treatment Options for Menopausal Symptom Management							
Symptoms	**Behavioral Interventions**	**Dietary Interventions**	**Exercise & Physical Therapy**	**Local Hormonal Therapies**	**Systemic Menopausal Hormonal Therapy**	**Other Prescription Therapies**	**Over-The-Counter & Non-prescription Therapies**
Vasomotor Symptoms (hot flashes, night sweats)	✓				✓	✓	
	• Systemic Hormone Therapy: The most effective treatment for appropriately selected patients (**Recommendations 2-5, Appendix H, Section A**). • Behavioral Interventions: Includes provider-mediated therapies such as CBT, tobacco cessation, and mindfulness (**Recommendation 6**). Self-directed strategies, including trigger avoidance, cooling therapies, weight loss, and exercise, are common but not strictly evidence-based. • Other Prescription Therapies: Include NK3 antagonists (**Recommendation 7**), gabapentin, and SSRI/SNRI. See **Appendix H, Section C**.						
Urinary Symptoms (incontinence, overactive bladder, recurrent urinary tract infections)	✓	✓	✓	✓		✓	✓

	• Local Estrogen Therapy: Strong evidence supports its use in postmenopausal women for recurrent UTIs, non-infectious dysuria, urinary urgency/frequency, and urge incontinence. Evidence for stress urinary incontinence is mixed (**Appendix H, Section B**)
	• Behavioral & Physical Interventions: Pelvic floor muscle exercises, physical therapy, bladder training, weight loss, and avoidance of bladder irritants are recommended.
	• Pharmacologic, Dietary, & Surgical Interventions:
	  ◦ OAB/Urge Incontinence: Outside the scope of this CPG; however, anticholinergics, antimuscarinics, and beta-3 agonists are options.
	  ◦ Recurrent UTIs Prevention: Suppressive antibiotics used nightly or post-coital, vaginal estrogen, cranberry juice (100% pure unsweetened juice), Methenamine, D-mannose, and cranberry tablets (that contain proanthocyanidins have been shown to decrease recurrent UTIs. Prolapse and Stress Urinary Incontinence: Consider specialist evaluation and surgical management as appropriate.						

Sidebar 1: Treatment Options for Menopausal Symptom Management							
Symptoms	**Behavioral Interventions**	**Dietary Interventions**	**Exercise & Physical Therapy**	**Local Hormonal Therapies**	**Systemic Menopausal Hormonal Therapy**	**Other Prescription Therapies**	**Over-The-Counter & Non-prescription Therapies**
Sleep Disturbance or Insomnia	✓		✓			✓	✓
	• Behavioral Therapy: Cognitive behavioral therapy for insomnia (CBT-I) is the primary recommended treatment for menopause-related insomnia. • Other strategies that align with the standard of care for the general population include exercise, mindfulness and relaxation techniques, sleep hygiene, melatonin, and prescription sleep aids. See also VA/DOD CPG for the Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea. • MHT may improve sleep if related to vasomotor symptoms. (**Recommendation 13**).						
Depressive/Anxiety Symptoms	✓		✓		✓*	✓	
	• Behavioral and Pharmacologic Therapy: Antidepressants and psychotherapy (e.g., CBT, mindfulness-based stress reduction [MBSR]) are the primary treatments for depression and anxiety (Recommendations **14-15**). In patients with a DSM diagnosis of Major Depressive Disorder, see also VA/DOD CPG for the Management of Major Depressive Disorder. • Systemic Hormone Therapy: Effective in treating depressive symptoms during perimenopause, not post menopause. (**Recommendation 16**) • Lifestyle: Physical exercise can improve depressive symptoms in both peri- and postmenopausal patients. (**Recommendation 17**)						
Altered Cognition ("Brain Fog", poor memory)	✓		✓				
	• Behavioral and Physical Interventions: Evidence is limited, though CBT and/or physical exercise may have a small, positive effect on menopause-related cognitive symptoms. Evidence does not support the use of estrogen/progestogen therapy solely for the treatment of cognitive symptoms (**Recommendation 20**).						

Sidebar 1: Treatment Options for Menopausal Symptom Management							
Symptoms	**Behavioral Interventions**	**Dietary Interventions**	**Exercise & Physical Therapy**	**Local Hormonal Therapies**	**Systemic Menopausal Hormonal Therapy**	**Other Prescription Therapies**	**Over-The-Counter & Non-prescription Therapies**
Dyspareunia	✓		✓	✓	✓		✓
	• Hormonal & OTC Therapies can improve lubrication and consequently reduce dyspareunia when related to poor lubrication. Interventions effective for vaginal dryness include systemic or local estrogen, DHEA, lubricants, and moisturizers. (Recommendations **21, 24, 28**) • Behavioral Interventions: Strategies to improve arousal may enhance natural lubrication and decrease discomfort (see **Sexual Concerns** below). • Physical Interventions: Pelvic floor physical therapy and dilator therapy can address pelvic floor myalgia and vaginodynia causing dyspareunia. • Dyspareunia is commonly secondary to vaginal dryness (see **Vaginal Dryness** below).						
Vaginal Dryness				✓	✓	✓	✓

	• Local vaginal and Systemic Hormone Therapies: Can effectively address vaginal dryness regardless of sexual activity.
	  • Local Estrogen: Preferred for isolated vaginal symptoms. May be used alone or as an adjunct to systemic estrogen.
	  • Vaginal DHEA: Demonstrated efficacy for vaginal dryness.
	  • Ospemifene: An oral SERM with estrogen agonism within vaginal tissue (**Appendix H, Sections A** and **B**).
	• OTC Therapies: Vaginal moisturizers and lubricants are effective for personal use and during sexual activity (**Recommendation 25**).						

Sidebar 1: Treatment Options for Menopausal Symptom Management							
Symptoms	**Behavioral Interventions**	**Dietary Interventions**	**Exercise & Physical Therapy**	**Local Hormonal Therapies**	**Systemic Menopausal Hormonal Therapy**	**Other Prescription Therapies**	**Over-The-Counter & Non-prescription Therapies**
Sexual Concerns (Difficulty with Arousal/Libido/Orgasm)	✓					✓	
	• Behavioral: Sexual skills training, CBT, mindfulness-based interventions, sex therapy, and couples therapy can address symptoms related to interest, arousal, and/or orgasm regardless of menopausal status. • Pharmacotherapy: Transdermal testosterone and flibanserin have demonstrated a modest but positive effect on total satisfying sexual encounters. (Recommendations **26-27**) Evidence for testosterone therapy is limited to postmenopausal women, and its use is considered off-label (**Appendix H, Section A**). Current evidence does not support the use of systemic estrogen and/or progestogen for improving sexual interest, arousal, or orgasm. Testosterone pellets should be avoided. • Treating conditions that cause sexual pain is likely to indirectly improve arousal and interest by reducing barriers to intimacy. See **Dyspareunia**.						
Loss of Bone Density/Fractures	✓	✓	✓		✓		✓
	• OTC and Dietary Interventions: Dietary or supplemental calcium is recommended as it may increase bone mineral density (**Recommendation 31**). Vitamin D is often recommended, although supporting evidence is limited (**Recommendation 32**). • Systemic Hormone Therapy: Estrogen-containing systemic hormone therapy is effective in decreasing bone resorption (**Recommendation 30**). • Lifestyle Interventions: Weight-bearing exercise and the avoidance of alcohol and tobacco are important behavioral interventions. • Pharmacotherapy: The choice of first-line prescription medication depends on the degree of bone loss and the patient's risk profile. While comprehensive osteoporosis management is outside the scope of this CPG, standard therapies include bisphosphonates, denosumab, and anabolic agents (Recommendations **33** and **34**).						

Sidebar 1: Treatment Options for Menopausal Symptom Management							
Symptoms	**Behavioral Interventions**	**Dietary Interventions**	**Exercise & Physical Therapy**	**Local Hormonal Therapies**	**Systemic Menopausal Hormonal Therapy**	**Other Prescription Therapies**	**Over-The-Counter & Non-prescription Therapies**
Weight Gain/Difficulty Losing Weight		✓	✓			✓	
	• Lifestyle Interventions: The management of obesity during menopause is similar to that in the general population. Exercise and a calorie-restricted diet have been shown to be effective (Recommendations **35** and **36**). • Pharmacotherapy: Medical therapies for obesity are outside the scope of this CPG, but standard options include GLP-1 receptor agonists and other weight-management medications. See also VA/DOD CPG for the Management of Adult Overweight and Obesity.						
Abnormal Uterine Bleeding					✓*	✓*	✓*
	Postmenopausal bleeding or undiagnosed AUB requires immediate evaluation (often including pelvic ultrasound and endometrial biopsy). Systemic estrogen therapy is contraindicated until the evaluation is complete. Irregular cycles and AUB are common in perimenopause and can be managed similarly to premenopausal women. Strategies tailored to perimenopause include: • LNG-IUD (52 mg): Provides endometrial protection when used with systemic estrogen, for up to 5 years, while also offering contraception and treating AUB. • Cyclic MHT (taking progestogen 14 days per month) induces scheduled withdrawal bleeding and limits unscheduled breakthrough bleeding. Synthetic progestins may offer better bleeding control than micronized progesterone, but may not prevent pregnancy. For patients who require birth control, we recommend validating that the selected progestin is an FDA-approved contraceptive. • Combined or Progestin-only Oral Contraceptives: Effective for regulating bleeding and preventing pregnancy, but may be less effective than MHT for treating severe vasomotor symptoms. • Non-Hormonal Therapies: NSAIDs and tranexamic acid (TXA) continue to offer benefit for AUB during perimenopause.						

	• Consider referral to a provider privileged to perform endometrial sampling.

***For perimenopausal patients only**

Abbreviations: AUB: Abnormal Uterine Bleeding; CBT: Cognitive Behavioral Therapy; CBT-I: Cognitive Behavioral Therapy for Insomnia; CPG: Clinical Practice Guideline; DHEA: Dehydroepiandrosterone; DSM: Diagnostic and Statistical Manual of Mental Disorder; FDA: Food and Drug Administration; GLP-1: Glucagon-like peptide-1; LNG-IUD: Levonorgestrel-releasing Intrauterine Device; MBSR: Mindfulness-Based Stress Reduction; MHT: Menopausal Hormonal Therapy; NK3: Neurokinin-3; NSAIDs: Nonsteroidal Anti-inflammatory Drugs; OAB: Overactive Bladder; OTC: Over The Counter; SERM: Selective Estrogen Receptor Modulator; SNRIs: Serotonin-Norepinephrine Reuptake Inhibitors; SSRIs: Serotonin Reuptake Inhibitors; TXA: Tranexamic Acid; UTIs: Urinary Tract Infections; VA/DOD: Department of Veterans Affairs/Department of Defense

Sidebar 2: Contraindications to Systemic Menopausal Estrogen Therapy[†]

Absolute Contraindications:

- Active or recent arterial thromboembolic disease (e.g., stroke and MI)
- Active or recent DVT or PE
- Active or severe hepatic impairment or disease
- Known CVD and age > 60 years old and/or >10 years after menopause onset
- Breast cancer or history of breast cancer, except in appropriately selected patients being treated for metastatic diseases
- Estrogen-dependent neoplasia
- Known anaphylactic reaction or angioedema related to estrogen use
- Known or suspected pregnancy
- Protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders
- Undiagnosed abnormal genital bleeding

Exercise caution for:

- Patients at risk for but without CVD, and utilize a validated cardiovascular risk calculator (PREVENT[a], ASCVD, and/or VA Women CVD Risk Score[b])
- Patients on thyroid replacement therapy should have thyroid function monitored
- Patients with gallbladder disease (as estrogens increase the risk of gallbladder disease)
- Patients with history of DVT, PE, stroke, or MI
- The development of severe hypercalcemia, loss of vision, severe hypertriglyceridemia, or cholestatic jaundice (discontinue estrogen)

For patients with absolute contraindications or where caution should be exercised, refer to the appropriate specialist(s) for individualized counseling and shared decision-making.

[a]https://professional.heart.org/en/guidelines-and-statements/prevent-calculator

[b]https://www.vawomencvdriskcalculator.org/

[†]This sidebar incorporates a combination of FDA-approved language as well as evidence-based language within the CPG.

Abbreviations: ASCVD: atherosclerotic cardiovascular disease; CVD: cardiovascular disease; DVT: deep vein thrombosis; MI: myocardial infarction; PE: pulmonary embolism; PREVENT: Predicting Risk of Cardiovascular Disease EVENTs; VA: Veterans Affairs

Sidebar 3: Non-hormonal Treatment Options for Vasomotor Symptoms

Generic Name	Brand	Mechanism	Usual Dosing	Comments
Fezolinetant	VEOZAH	NK3RA	45 mg daily	• Hepatic lab tests at baseline, 1, 2, 3, 6, and 9 months; do not initiate in patients with baseline enzyme elevations • Contraindicated in known cirrhosis, severe renal impairment
Elinzanetant	LYNKUET	NK1RA and NK3RA	120 mg daily at bedtime	• May cause somnolence and may be useful for nocturnal symptoms • Hepatic lab tests at baseline and 3 months; do not initiate in patients with baseline enzyme elevations • Avoid in patients with history of seizure disorder • Although indicated for menopausal hot flashes,

Generic Name	Brand	Mechanism	Usual Dosing	Comments
				if patient has risk of pregnancy, this drug is contraindicated.
Citalopram*	CELEXA	SSRI	10 to 20 mg daily (start with 10 mg daily)	
Escitalopram*	LEXAPRO		10 to 20 mg daily (start with 10 mg daily)	
Paroxetine*	PAXIL		10 to 25 mg daily	• Contraindicated with tamoxifen (reduced tamoxifen exposure) • If pregnancy is a concern, consider alternative SSRI
Paroxetine mesylate	BRISDELLE		7.5 mg daily	Contraindicated with tamoxifen (reduced tamoxifen exposure)
Desvenlafaxine*	PRISTIQ	SNRI	100 to 150 mg daily Start with 25 to 50 mg daily	
Venlafaxine*	EFFEXOR		37.5 mg to 150 mg daily Start with 37.5 mg daily	
Gabapentin*	NEURONTIN	Gabapentinoid	900 to 2400 mg daily Start with 100 to 300 mg daily at bedtime, increase to twice daily	May be useful for nocturnal symptoms

Note: Consult prescribing information for more details. Antidepressants may also be effective for co-occurring depression in addition to vasomotor symptoms.

*Off-label

Abbreviations: mg: milligram; NK1RA: Neurokinin-1 Receptor Antagonist; NK3RA: Neurokinin-3 Receptor Antagonist; SNRI: Serotonin-norepinephrine Reuptake Inhibitor; SSRI: Selective Serotonin Reuptake Inhibitor

Sidebar 4: Treatments for Genitourinary Syndrome of Menopause and Sexual Dysfunction
Vaginal Dryness • Vaginal moisturizers/vaginal lubricants • Local vaginal and/or systemic estrogen • Vaginal DHEA • Oral ospemifene
Dyspareunia • Local Vaginal Estrogen • Vaginal DHEA • Vaginal moisturizers • Pelvic floor physical therapy
Diminished or Absent Desire, Arousal, and/or Orgasm • Behavioral Therapy (ACT, Couples Therapy, Sex Therapy, CBT) • Transdermal Testosterone • For patients meeting criteria of HSDD/FSIAD and <age 65, offer Flibanserin
Bladder-related Symptoms • Evaluate for active urinary tract infection and treat as appropriate • Local vaginal and/or systemic estrogen • Pelvic floor physical therapy • Bladder training

Abbreviations: ACT: Acceptance and Commitment Therapy; CBT: cognitive behavioral therapy; DHEA: dehydroepiandrosterone; FSIAD: Female Sexual Interest and Arousal Disorder; HSDD: hypoactive sexual desire disorder

Sidebar 5: Common Menopausal Hormone Therapies (Standard Dosing)			
Hormone & Route	**Brand**	**Components**	**Usual Dosing**
Local therapies			
Estrogen (vaginal cream)	• ESTRACE • PREMARIN VAGINAL	• Estradiol 0.01% • Conjugated Equine Estrogen (0.625 mg/g)	0.5- 1 g vaginally daily for 2 weeks, then 1-3x per week
Estrogen (vaginal ring)	ESTRING	2 mg estradiol ring (7.5 mcg/day)	One ring every 90 days
Estrogen (vaginal insert)	• VAGIFEM • IMVEXXY	4 mcg or 10 mcg (Imvexxy only) estradiol insert	One insert daily for 2 weeks, then 1 insert 2x per week
Systemic therapies			
Estrogen only (oral)	• ESTRACE • MENEST • PREMARIN	• Estradiol • Esterified Estrogen • Conjugated Equine Estrogen (CEE)	One tablet daily (doses vary)
Estrogen only (patch)	• MINIVELL • VIVELLE-DOT • CLIMARA • MENOSTAR	Estradiol	One patch once or twice weekly (doses vary)
Estrogen only (vaginal ring)	FEMRING	Estradiol	0.05 or 0.1 mg/day ring every 90 days

Sidebar 5: Common Menopausal Hormone Therapies (Standard Dosing)			
Hormone & Route	**Brand**	**Components**	**Usual Dosing**
Progesterone/ Progestin only (oral)	• PROMETRIUM • PROVERA	• Micronized progesterone • Medroxyprogesterone acetate	One tablet daily or in cyclic fashion (doses vary)
Progestin only (intrauterine)	• MIRENA • LILETTA	Levonorgestrel 52 mg IUDs	One device for up to 5 yrs
Combination Estrogen and Progesterone/ Progestin (oral)	• BIJUVA • ANGELIQ • FEMHRT • PREMPRO • PREMPHASE • ACTIVELLA	• Estradiol/progesterone • Estradiol/Drospirenone • Ethinyl estradiol/ Norethindrone acetate • CEE/Medroxyprogesterone • CEE/Medroxyprogesterone • Estradiol/Norethindrone acetate	One tablet daily (doses vary)
Combination Estrogen and Progestin (patch)	• COMBIPATCH • CLIMARAPRO	• Estradiol/norethindrone • Estradiol/levonorgestrel	One patch once or twice weekly (doses vary)
Note: In women with a uterus, systemic (not local) estrogen therapy **must** be dosed in combination with a progestogen (progestin or progesterone), either as a combination product or estrogen only with a progestogen-only option. See **Appendix H** in the full CPG.			

Abbreviations: CEE: conjugated equine estrogen; IUD: intrauterine device

Routine Care

Topic	Peri-Menopause: Age 40-50+ (starts with changes in the length of menstrual bleeding or time between periods and lasts up to 12 months after the last period)	Post-Menopause: Average Age: 51 (starting after one year without a period)
General Health Care Maintenance and Prevention	• Cancer risk assessment and screening as appropriate, including sex-specific cancers (e.g., breast and cervical) and non-sex-specific (e.g., colorectal) • Cardiovascular risk assessment and risk reduction, including reviewing sex-specific risk-enhancing factors (e.g., history of gestational diabetes, hypertensive disorders of pregnancy, autoimmune conditions) and promoting health behaviors (e.g., physical activity, control of blood pressure) • Screen for depression, anxiety, sleep disorders, and other mental health conditions • Other preventive care as indicated outside of sex-specific recommendations (e.g., vaccinations, diabetes, cognitive function) **Menopause occurring before the age of 40 is premature ovarian insufficiency and requires evaluation*	• Assess bone health (e.g., DEXA scan when age-appropriate and based on risk factors, calcium/vitamin D intake) • Continued management/screening for cancer and cardiovascular risk assessment and reduction as needed • Other preventive care as indicated outside of sex-specific recommendations (e.g., vaccinations, diabetes, cognitive function)
Menopausal Symptoms	• Ask about menopausal symptoms, including vasomotor symptoms, brain fog, vaginal dryness, sexual function concerns, urinary complaints, mood changes, sleep disturbances, and musculoskeletal complaints. (Many women begin having menopausal symptoms despite having monthly cycles)	• Assessment and management of menopausal symptoms, including hormone therapy (systemic and vaginal) and non-hormonal options • Assessment and management of urinary incontinence • Assessment of sleep disturbances • Assessment of sexual function

Topic	Peri-Menopause: Age 40-50+ (starts with changes in the length of menstrual bleeding or time between periods and lasts up to 12 months after the last period)	Post-Menopause: Average Age: 51 (starting after one year without a period)
	• Manage bothersome menopausal symptoms with treatment including hormone therapy (systemic and vaginal) and non-hormonal options ▪ Considerations: ▪ Do they have a uterus? ▪ Are there contraindications to MHT? ▪ Non-oral routes preferred Note: Can use MHT even if still having menstrual cycles.	
Contraception	Assess need for contraception (Contraception should be considered until amenorrhea for 1 year after previously regular menses or at least until age 50-55) **Menopausal hormone therapy does not prevent pregnancy*	N/A
Menses	Assessment and management of abnormal uterine bleeding ▪ Pelvic US ▪ Labs: HCG, CBC, TSH ▪ Gynecology consultation for consideration of endometrial sampling	• Evaluate all PMB with pelvic US (+/- endometrial sampling) • Endometrial biopsy may be omitted from the initial evaluation of a patient with postmenopausal bleeding when all of the following are present: ▪ A single episode of postmenopausal bleeding, ▪ A sonographically fully visualized endometrium with a thickness of 4mm or less, ▪ No risk factors strongly associated with malignancy* and, ▪ Access to prompt gynecologic care and follow-up **Factors strongly associated with increased risk of endometrial cancer:* ▪ *Exogenous estrogen use (e.g., supplements and hormone therapy with or without progestin)*

Topic	Peri-Menopause: Age 40-50+ (starts with changes in the length of menstrual bleeding or time between periods and lasts up to 12 months after the last period)	Post-Menopause: Average Age: 51 (starting after one year without a period)
		▪ *SERM use (e.g., tamoxifen)* ▪ *BMI >30* ▪ *Nulliparity* ▪ *Genetic predisposition to endometrial cancer (e.g., known or suspected Lynch or Cowden syndromes or family history of endometrial cancer)* ▪ *Black race (independent association with high-grade endometrial cancers)* ▪ *Diabetes mellitus* ▪ *Patients experiencing unscheduled bleeding more than 6 months after initiation of hormone therapy should undergo further evaluation*

Abbreviations: ACOG: American College of Obstetricians and Gynecologists; BMI: body mass index; CBC: complete blood count; DEXA: Dual-energy X-ray absorptiometry; HCG: Human chorionic gonadotropin; MHT: menopausal hormone therapy; mm; millimeter; PMB: postmenopausal bleeding; SERM: selective estrogen receptor modulator; TSH: Thyroid stimulating hormone; US; ultrasound

Pharmacotherapy

A. Systemic Menopausal Hormone Therapy

Brand Name[a]	Progesterone	Estrogen	Testosterone[b]	Available Dosages	Notes
Oral Estrogen					
Estrace	N/A	Estradiol	N/A	0.5 mg, 1 mg, 2 mg	
Menest	N/A	Esterified estrogen	N/A	0.3 mg, 0.625 mg, 1.25 mg, 2.5 mg	
Premarin	N/A	Conjugated equine estrogen	N/A	0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	

Brand Name[a]	Progesterone	Estrogen	Testosterone[b]	Available Dosages	Notes
Oral Estrogen Progesterone/Progestin Combinations					
Bijuva	Progesterone	Estradiol	N/A	0.5 mg estradiol/100 mg progesterone 1 mg estradiol/100 mg progesterone	
Activella	Norethindrone acetate	Estradiol	N/A	0.5 mg estradiol/0.1 mg norethindrone acetate 1 mg estradiol/0.5 mg norethindrone acetate	
Angeliq	Drospirenone	Estradiol	N/A	0.5 mg estradiol/0.25 mg drospirenone 1 mg estradiol/0.5 mg drospirenone	
Prempro	Medroxyprogesterone	Conjugated equine estrogen (CEE)	N/A	0.3 mg CEE/1 mg medroxyprogesterone 0.45 mg CEE/1.5 mg medroxyprogesterone 0.625 mg CEE/2.5 mg medroxyprogesterone 0.625 mg CEE/5 mg medroxyprogesterone	
Premphase	Medroxyprogesterone	CEE	N/A	0.625 mg CEE daily days 1 -14 with 0.625 mg CEE estrogens/ 5 mg medroxyprogesterone daily days 14 - 28	
Femhrt	Norethindrone acetate	Ethinyl estradiol	N/A	2.5 mcg/0.5 mg, 5 mcg/1 mg	
Duavee	Bazedoxifene	CEE	N/A	0.45 mg CEE/20 mg bazedoxifene	
Estrogen Patch					
Minivelle	N/A	Estradiol	N/A	0.025 mg, 0.0375 mg, 0.05 mg, 0.075 mg, 0.1 mg (per day)	Twice weekly

Brand Name[a]	Progesterone	Estrogen	Testosterone[b]	Available Dosages	Notes
Vivelle-Dot	N/A	Estradiol	N/A	0.025 mg, 0.0375 mg, 0.05 mg, 0.075 mg, 0.1 mg (per day)	Twice weekly
Climara	N/A	Estradiol	N/A	0.025 mg, 0.0375 mg, 0.05 mg, 0.06 mg, 0.075 mg, 0.1 mg (per day)	Weekly
Menostar	N/A	Estradiol	N/A	0.014 mg (per day)	Weekly
Estrogen-Progestin Patch					
Combi-patch	Norethindrone	Estradiol	N/A	0.05 mg estradiol/0.14 mg norethindrone (per day) 0.05 mg estradiol/0.25 mg norethindrone (per day)	Twice weekly
Climara Pro	Levonorgestrel	Estradiol	N/A	0.045 mg estradiol/0.015 mg levonorgestrel (per day)	Weekly
Estrogen Transdermal Gel/Spray					
EstroGel	N/A	Estradiol	N/A	0.75 mg/pump	
Elestrin	N/A	Estradiol	N/A	0.52 mg/pump	
Divigel	N/A	Estradiol	N/A	0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.25 mg/pouch	
EvaMist	N/A	Estradiol	N/A	1.53 mg/spray	
Estrogen Intravaginal Ring					
Femring	N/A	Estradiol	N/A	0.05 mg, 0.1 mg (per day)	*Systemic* not to be confused with Estring
Progesterone Oral					
Prometrium	Micronized Progesterone	N/A	N/A	100 mg, 200 mg	
Provera	Medroxyprogesterone acetate	N/A	N/A	2.5 mg, 5 mg, 10 mg	

Brand Name[a]	Progesterone	Estrogen	Testosterone[b]	Available Dosages	Notes
Levonorgestrel-Containing IUDs					
Mirena, Liletta	Levonorgestrel 52 mg IUD	N/A	N/A	52 mg dose IUDs only and for duration of up to 5 yrs	Off-label use of 52 mg IUD for endometrial protection when systemic estrogens are used.
Testosterone Transdermal Gel					
Androgel	N/A	N/A	1% testosterone	One tenth of 50 mg tube (5 mg or ~0.5 mL) per day	Off-label use of male product intended for symptoms of FSIAD. One tube should last 10 days. Appropriate monitoring is recommended.[c, d]

*Consistent with recommendations from ACOG, the Menopause Society, and the Endocrine Society, the Work Group supports using FDA-approved products whenever they are available, rather than compounded alternatives.

[a] Brand names listed where applicable; generic equivalents may be available and/or required.

[b] Esterified estrogens/methyltestosterone (Estratest) is a non-FDA-approved combination MHT product with no clear advantage over alternatives for hot flashes. Even though there may be a modest benefit in sexual desire, oral testosterone/methyltestosterone is generally not recommended due to concern for adverse lipid effects and lack of long-term safety in women. In VA, non-FDA-approved products are not part of the medical benefits package.

[c]Androgen therapy monitoring is recommended to ensure physiological premenopausal levels. Serum testosterone monitoring is recommended. Additionally, lipids and liver function should be assessed at baseline and for the duration of therapy. Consider labs every six months. Injectable and implantable “pellet” formulations are not advised.

[d]See VA Formulary Advisory on Transdermal Testosterone for Hypoactive Sexual Desire Disorder (HSDD) in Postmenopausal Females. Available at: https://www.va.gov/formularyadvisor/DOC_PDF/CRE_Testosterone_HSDD_Clinical_Summary_Mar_2025.pdf

Abbreviations: CEE: conjugated equine estrogen; FSIAD: Female Sexual Interest and Arousal Disorder; IUD: intrauterine device; mcg: microgram; mg: milligram; mL: milliliter

B. Menopausal Therapy for GSM

Generic Name	Brand Name[a]	Usual Dosing	Notes
Vaginal Cream			
Estradiol 0.01%	Estrace	0.5- 1 g vaginally daily for 2 weeks, then 0.5- 1 g 1-3 times per week	Reusable applicator (cleanse with warm water and mild soap)
Conjugated equine estrogen 0.625 mg/g	Premarin Vaginal	0.5- 1 g vaginally daily for 2 weeks, then 0.5- 1 g 1-3 times per week	Reusable applicator (cleanse with warm water and mild soap)
Vaginal Ring			
Estradiol	Estring	2 mg ring (releases 7.5 mcg per day) inserted every 90 days	*Low dose vaginal estrogen*; not to be confused with Femring
Vaginal Insert			
Estradiol	Vagifem	10 mcg tablet vaginally daily for 2 weeks, then 10 mcg 2 times per week	Individual applicator for each tablet
Estradiol	Imvexxy	4 mcg or 10 mcg (1 insert) vaginally once daily for 2 weeks, then 4 mcg or 10 mcg 2 times per week	Soft gel vaginal insert; no applicator; insert ~2 inches into vagina with smaller end up
Prasterone	Intrarosa	6.5 mg insert vaginally at bedtime	Dehydroepiandrosterone (DHEA); converted to active androgens and estrogens in the vaginal tissue; single-use applicator
Oral tablet			
Ospemifene	Osphena	60 mg orally once daily	Oral, systemic SERM with estrogen agonist effect in the vaginal tissue; indicated for vaginal dryness and dyspareunia

[a] Brand name listed where applicable; generic equivalents may be available and/or required.

Abbreviations: DHEA: Dehydroepiandrosterone; g: gram; GSM: genitourinary syndrome of menopause; mcg: microgram; mg: milligram; SERM: Selective Estrogen Receptor Modulator

C. Non-Hormonal Treatment of Symptomatic Menopause

Generic Name[a]	Medication Class	Available Dosages	Notes
Fezolinetant	Neurokinin 3 Receptor Antagonist	45 mg	
Elinzanetant	Neurokinin 1, 3 Receptor Antagonist	60 mg	Available as 60 mg capsules, though 120 mg typical dose

Generic Name[a]	Medication Class	Available Dosages	Notes
Paroxetine Mesylate	SSRI	7.5 mg	
Paroxetine	SSRI	10 mg, 20 mg, 30 mg, 40 mg	Off-Label
Paroxetine ER	SSRI	12.5 mg, 25 mg, 37.5 mg	Off-Label
Citalopram	SSRI	10 mg, 20 mg, 40 mg	Off-Label
Escitalopram	SSRI	5 mg, 10 mg, 20 mg	Off-Label
Venlafaxine	SNRI	37.5 mg, 50 mg, 100 mg	Off-Label
Venlafaxine ER	SNRI	37.5 mg, 75 mg, 150 mg, 225 mg	Off-Label
Effexor XR	SNRI	37.5 mg, 75 mg, 150 mg	Off-Label
Desvenlaxfaxine	SNRI	25 mg, 50 mg, 100 mg	Off-Label
Gabapentin	GABA Analog	100 mg, 300 mg, 400 mg, 600 mg, 800 mg	Off-Label
Gabapentin ER	GABA Analog	300 mg, 600 mg	Off-Label
Oxybutynin XR	Anticholinergic	2.5 mg, 5 mg	Off-Label

[a] Brand name listed where applicable; generic equivalents may be available and/or required.

Abbreviations: CEE: Conjugated Equine Estrogen; ER or XR: extended release; GABA: Gamma-aminobutyric acid; mg: milligram; SNRI: Serotonin-norepinephrine Reuptake Inhibitors; SSRI: Selective Serotonin Reuptake Inhibitor

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Methods

This is a new VA/DOD evidence-based CPG. The methodology used in developing this CPG follows the *Guideline for Guidelines*, an internal document of the VA/DOD EBPWG updated in January 2026 that outlines procedures for developing and submitting VA/DOD CPGs.(4) The *Guideline for Guidelines* is available at http://www.healthquality.va.gov/policy/index.asp. A full description of this guideline's methodology is available at https://www.healthquality.va.gov/guidelines/cd/menopause/.

Patient-Centered Care

VA and DOD encourage providers to be sensitive to demographic, cultural, and other differences that affect patients' values, needs, and preferences, aimed at treating the condition while also optimizing the individual's overall health and well-being. Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in providers, and improve treatment adherence.(5,6) A whole health approach (https:/www.va.gov/wholehealth/) empowers and equips individuals to meet their personal health and well-being goals. Clear communication is essential and should be supported by evidence-based information tailored to each patient's needs. Guideline recommendations should be applied in a holistic approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities.

Shared Decision-Making

This CPG encourages providers to practice shared decision-making, a process in which providers, patients, and patient care partners (e.g., family, friends, caregivers) consider clinical evidence of benefits and risks as well as patient values and preferences to make decisions regarding the patient's treatment.(7) Shared decision-making is emphasized in "Crossing the Quality Chasm," an Institute of Medicine (now National Academy of Medicine [NAM]) report, in 2001 (8) and is a core component of a patient-centered, whole health approach. Providers must be adept at presenting information to their patients regarding individual

treatments, expected risks, possible outcomes, and levels and/or settings of care, especially where patient heterogeneity in weighing risks and benefits might exist. The VA and DOD have embraced shared decision-making. Providers are encouraged to use shared decision-making to individualize treatment goals and plans based on patient capabilities, needs, values, and preferences.

References

1. Evidence Based Practice Work Group Charter (2017).
2. Guyatt GH, Oxman AD, Kunz R, et al. GRADE guidelines: 2. Framing the question and deciding on important outcomes. *Journal of clinical epidemiology*. Apr 2011;64(4):395-400. doi:10.1016/j.jclinepi.2010.09.012
3. Society for Medical Decision Making Committee on Standardization of Clinical Algorithms. Proposal for clinical algorithm standards. *Med Decis Making*. Apr-Jun 1992;12(2):149-54.
4. Guideline for Guidelines (2019).
5. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. *J Fam Pract*. Sep 2000;49(9):796-804.
6. Robinson JH, Callister LC, Berry JA, Dearing KA. Patient-centered care and adherence: definitions and applications to improve outcomes. *J Am Acad Nurse Pract*. Dec 2008;20(12):600-7. doi:10.1111/j.1745-7599.2008.00360.x
7. Shared Decision Making Fact Sheet. 2013. https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf
8. Institute of Medicine Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. National Academies Press (US)

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Access to the full guideline and additional resources are available at the following link:

https://www.healthquality.va.gov/guidelines/cd/menopause/