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Menopause misinformation is harming care

Symptoms should be prioritised ahead of testing

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A societal transformation of attitudes and beliefs surrounding menopausal hormone therapy (MHT) has outpaced provider education, leaving primary care specialties unprepared to deliver this care.[1] In the UK, MHT is more commonly referred to as hormone replacement therapy (HRT). Internationally, however, the term MHT is increasingly preferred because it more accurately reflects the full range of treatments used to manage symptoms and health effects of menopause, emphasising the importance of individualised care.[2]

A cultural shift has arisen owing to several converging factors: an increased awareness of the potential benefits of MHT,[3] a better understanding of the risk profile of MHT,[4] and a destigmatisation of menopause through press, social media, and celebrity coverage.[5] As women are increasingly empowered to seek relief for menopausal symptoms, there has been a sharp rise in services that aim to address this growing demand. Although no global quantitative data are available regarding the increased uptake of these services, a recent Canadian report of aggregate health insurance claims indicates that the use of MHT in women aged 45 to 65 increased by 21% from 2020 to 2023.[6] Further, studies in Sweden,[7] Wales,[8] and England[9] demonstrate a substantial rise in the prescribing of MHT—up to 50% over recent years. Digital health technologies that are available direct to consumer (such as mobile applications, telehealth clinics, podcasts, and websites) have targeted menopause management, raising concerns about the reliability and potential commercial bias of the information.[10 11] A decade ago, the global "femtech" market was valued at $500m (£375m; €430m); today, it is estimated at $28bn and is continuing to grow.[12] One of the most troubling trends arising from this surge is the promotion of routine hormone panel testing for the evaluation of menopausal symptoms—often including serum, salivary, or urine assays for oestradiol, progesterone, testosterone, dehydroepiandrosterone, thyroid hormones, and even cortisol. These tests can cost hundreds of dollars and are marketed to patients and clinicians as necessary for "individualising" hormone therapy.[13 14] Many women who access this type of testing are unaware of the limited supporting evidence and are influenced by trust in their healthcare provider.[15] In reality, these tests are of limited clinical use because there is no clearly defined therapeutic window for MHT, and some testing techniques do not offer accurate or precise assessment of hormone levels.[16]

Beyond questions of clinical validity, the utility of hormone testing is constrained by the physiology of the menopause transition. Perimenopause is characterised by highly variable day to day fluctuations in oestradiol and follicle stimulating hormone levels that contribute to vasomotor symptoms, sleep disturbance, mood changes, and cognitive concerns. Observance of "normal" hormone levels can lead to underdiagnosis and undertreatment of women with symptoms. Postmenopause is defined by a predictable drop in oestradiol and rise in follicle stimulating hormone; however, there is no definitive test to differentiate this from perimenopause. The principle of evidence based practice is that a test should only be done if the result will directly guide patient care. For perimenopause and menopause, hormone testing offers no reliable way to determine who will benefit from treatment, when the final menstrual period will occur, or whether it is safe to discontinue contraception. Clinical guidelines from the British Menopause Society, National Institute for Health and Care Excellence, American College of Obstetricians and Gynecologists, The Menopause Society, and Endocrine Society agree: in women over age 45 presenting with validated symptoms of menopause, including menstrual irregularity, menopause is a clinical diagnosis, and hormone testing is unnecessary.[17 -21]

Despite this, many women now present with detailed hormone panels from wellness providers or online services. When this testing is used to make treatment decisions, it can mislead women into believing they are not candidates for MHT or prompt the use of unsupported interventions.[22] In our experience, these panels are often used to justify taking compounded hormone regimens or supplements based on marginal deviations from hormone thresholds that are not grounded in evidence.[16 23] Compounded bioidentical hormone therapy lacks standardisation and regulatory oversight and has not been tested for safety or efficacy.[23] There is concern that inconsistencies in the quantities of oestrogen or progestogen in compounded bioidentical hormone therapy regimens can result in endometrial hyperplasia or carcinoma, particularly in women with an intact uterus who are receiving inadequate progestogen.[24]

Symptom driven approach needed

There is a growing recognition that menopause care is most effective when grounded in an approach that is symptom driven and patient centred. Vasomotor symptoms, insomnia, mood changes, and vaginal dryness are best assessed by a thorough clinical history rather than by hormone levels. For women under 60 or within 10 years of menopause onset, MHT is the most effective treatment for vasomotor and genitourinary symptoms, with a favourable safety profile in appropriately selected patients.[25] While hormone panel testing and associated misinformation can muddy the waters of clinical decision making,

we maintain that treatment decisions should be guided by clinical response and patient preferences.

Routine hormone panel testing in the management of menopause symptoms is not supported by current evidence and does not improve care—whether before starting MHT, or to titrate dosing.[26] Until we can establish individualised target hormone levels by accounting for pharmacokinetics, receptor specific pharmacodynamics, and differentiating between endogenous and exogenous hormones, there is no role for commercial hormonal panel testing to guide therapy. In the meantime, such testing offers only a false sense of precision. Although innovation is needed, the normalisation of hormone panel testing could be a symptom of a larger problem: the commercialisation of women's health and a movement away from evidence based practice. For midlife women, effective treatment begins not with numbers, but with listening.

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