Laurie Birkholz, MD, NCMP

Knowledge of Clinical Trials Regarding Hormone Therapy and Likelihood of Prescribing Hormone Therapy

Objective: The aim of the study was to examine whether physicians who are better informed about large, published hormone therapy (HT) trials (eg, Women’s Health Initiative) are more likely to prescribe HT for menopausal symptoms.

Methods: 501 Ob/Gyns and PCPs completed an internet based survey.

Results:
- Ob/Gyns more knowledgeable of trials and more likely to prescribe.
- Male physicians more like to prescribe HT but not more knowledgeable about it than female physicians.

Conclusions: Physicians who are more knowledgeable about large, published HT trials are more likely to prescribe HT for menopausal symptoms.


Menopausal Symptoms
The Who:
- Hot flashes are reported by as many as 75% of perimenopausal women in the U.S.
- 25% of women have HF lasting > 5 yrs.
- 10% of women have HF lasting > 10 yrs.
- 72% of symptomatic US women are not receiving treatment.
- Since the Women’s Health Initiative (WHI) use of any HT formulation went from 22.4% to 4.7%.
Menopause Hormone Therapy: The Who & When

- The Women’s Health Initiative
- The overall goal of the WHI was to reduce coronary heart disease, breast and colorectal cancer, and osteoporotic fractures among postmenopausal women via prevention strategies and risk factor identification
- Average age: 63
- Average years since menopause: ~10
- 19.5% non-white
- 26.7% normal or underweight

WHI Design

- Hysterectomy
  - Yes N=10,739
  - Conjugated Equine Estrogen (CEE) 0.625 mg/d
  - Placebo
- No N = 16,608
  - Placebo
  - CEE 0.625 mg/d + Medroxyprogesterone acetate (MPA) 2.5 mg/day

WHI Outcomes
What was heard in 2002...
- Increased risk of breast cancer
- Increased risk of VTE
- Increased risk of CVD
- Oct 2013 JAMA published the ‘Menopausal Hormone Therapy and Health Outcomes During the Intervention and Extended Post-stopping Phases of the WHI Randomized Trials’
### WHI: Results
#### Invasive Breast Cancer

<table>
<thead>
<tr>
<th>Age</th>
<th>CEE + MPA HR (95% CI)</th>
<th>CEE HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 yr</td>
<td>1.34</td>
<td>0.76</td>
</tr>
<tr>
<td>60-69 yr</td>
<td>1.27</td>
<td>0.78</td>
</tr>
<tr>
<td>70-79 yr</td>
<td>1.25</td>
<td>0.88</td>
</tr>
</tbody>
</table>

The risk of breast cancer attributable to E+P is rare with an incidence of < 1.0 per 1000 women per year of use.

Source: Manson JE; Chlebowski RT; Stefanick ML; et al, *JAMA* 2013

#### Revised Global Consensus on MHT De Villiers TJ et al, Climacteric 2016

### WHI: Results
#### Pulmonary Embolus

<table>
<thead>
<tr>
<th>Age</th>
<th>CEE + MPA HR (95% CI)</th>
<th>CEE HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 yr</td>
<td>1.24</td>
<td>1.06</td>
</tr>
<tr>
<td>60-69 yr</td>
<td>1.14</td>
<td>1.45</td>
</tr>
<tr>
<td>70-79 yr</td>
<td>1.52</td>
<td>0.82</td>
</tr>
</tbody>
</table>

**Note:**

The risk of pulmonary embolus attributable to E+P is rare with an incidence of < 1.0 per 1000 women per year of use.

Source: Manson JE; Chlebowski RT; Stefanick ML; et al, *JAMA* 2013

### WHI: Results
#### MI Risk

<table>
<thead>
<tr>
<th>Age</th>
<th>CEE + MPA HR (95% CI)</th>
<th>CEE HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 yr</td>
<td>1.25</td>
<td>0.60</td>
</tr>
<tr>
<td>60-69 yr</td>
<td>0.99</td>
<td>1.03</td>
</tr>
<tr>
<td>70-79 yr</td>
<td>1.34</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Source: Manson JE; Chlebowski RT; Stefanick ML; et al, *JAMA* 2013
### WHI: Results: Colorectal Cancer

<table>
<thead>
<tr>
<th>Age</th>
<th>HR (95% CI) CEE + MPA</th>
<th>HR (95% CI) CEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 yr</td>
<td>1.05</td>
<td>0.76</td>
</tr>
<tr>
<td>60-69 yr</td>
<td>0.81</td>
<td>1.04</td>
</tr>
<tr>
<td>70-79 yr</td>
<td>0.67</td>
<td>1.61</td>
</tr>
</tbody>
</table>

Source: Manson JE; Chlebowski RT; Stefanick ML; et al, JAMA 2013

### WHI: Results: Hip Fracture

<table>
<thead>
<tr>
<th>Age</th>
<th>HR (95% CI) CEE + MPA</th>
<th>HR (95% CI) CEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 yr</td>
<td>0.57</td>
<td>0.88</td>
</tr>
<tr>
<td>60-69 yr</td>
<td>0.94</td>
<td>0.95</td>
</tr>
<tr>
<td>70-79 yr</td>
<td>0.77</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Source: Manson JE; Chlebowski RT; Stefanick ML; et al, JAMA 2013

### WHI: Results: All-cause Mortality

<table>
<thead>
<tr>
<th>Age</th>
<th>HR (95% CI) CEE + MPA</th>
<th>HR (95% CI) CEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 yr</td>
<td>0.88</td>
<td>0.78</td>
</tr>
<tr>
<td>60-69 yr</td>
<td>0.99</td>
<td>1.02</td>
</tr>
<tr>
<td>70-79 yr</td>
<td>1.04</td>
<td>1.06</td>
</tr>
</tbody>
</table>

Source: Manson JE; Chlebowski RT; Stefanick ML; et al, JAMA 2013
Other Outcomes

- Both groups had significantly lower incidence of Type II DM
- Health-related QOL had significant benefits for:
  - Physical functioning
  - Bodily pain
  - General health
- Age 50-59 CEE alone: 40 fewer adverse events/10,000 person years
- Age 70-79 CEE + P: 34 excess adverse events/10,000 person years

The Timing Hypothesis: Age Matters

- Explains the apparent discordance between observational studies and RCT outcomes of postmenopausal HT.

ELITE: Early Vs Late Intervention Trial with Estradiol

- 643 women, ~50% within 6 years of menopause
- Mean age was 55 years in “young” group
- 1 mg PO 17 beta-estradiol +/- cyclical micronized progesterone
- Outcome measure was C-IMT measured by ultrasound
ELITE: Conclusions

- ELITE supports the timing hypothesis whereby women who start HT within 6 years of menopause show a significant slowing of subclinical carotid artery atherosclerosis whereas women who are >10 years postmenopausal when starting HT show no difference from placebo.
- ELITE supports the concept that HT reduces early atherosclerosis but not established lesions.
- ELITE results are consistent with the majority of the literature that shows that women who are young and/or in close proximity to menopause when starting HT have reduced coronary heart disease and overall mortality.
- ELITE adverse events show no difference between treatment groups.

WHO???
What we’ve learned since the WHI

- Symptomatic, recently menopausal women
  - < 60 yo
  - Less than 10 years since menopause

The Who: Special Populations

- Premature/Early menopause - HT is recommended until at least the median age of menopause (52 yr)
- Extended use - the recommendation using Beers criteria to routinely discontinue systemic HT after age 65 is not supported by data.
- Family history of breast cancer - Observational data suggests that HT does not alter the risk for breast cancer in women with a family history.
- BRCA-positive women without breast cancer - For those that have undergone oophorectomy, benefits of estrogen to decrease health risks caused by premature loss of estrogen need to be considered.
Menopausal Hormone Therapy: The Why

- Approved indications
  - First line therapy to treat vasomotor symptoms (VMS)
  - May be considered as a first line therapy for prevention of bone loss and fracture in postmenopausal women at elevated risk
  - Women with hypoestrogenism caused by POI, hypogonadism, or premature surgical menopause
  - Genitourinary Syndrome of Menopause (GSM)

Vasomotor Symptoms

- Hot flashes - reported by approximately ~75% of menopausal women
- Risk factors include:
  - Higher body mass index
  - Lower income and education
  - Tobacco use
  - Race
  - Night sweats
- ET with or without progestogen is the most effective treatment of menopause-related vasomotor symptoms

Bone Health

- 1 in 2 postmenopausal women will have an osteoporosis related fracture in their lifetime
- Direct medical care costs of osteoporotic fractures total $17 billion/yr in U.S.
- HT reduced the risk for fracture in postmenopausal women in the WHI

HT and Bone Health

- Systemic estrogen products (estrogen plus progestogen [EPT] for women with a uterus or ET for women without a uterus) are government approved in the United States for prevention, but not treatment, of postmenopausal osteoporosis.

- Extended use of HT is an option for women at high risk of osteoporotic fracture when alternate therapies aren’t appropriate

- Benefits of HT on bone mass dissipate quickly after discontinuation

Source: Management of osteoporosis in postmenopausal women. 2010 position statement of The North American Menopause Society

Premature Menopause

- Age < 40
- Due to POI or premature surgical menopause
- Benefits outweigh risks in almost all cases

Mayo Clinic Oophorectomy Study

- Surgical menopause at age 45 or younger without hormone replacement shows increased risk for:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis &amp; Bone Fx</td>
<td>50%</td>
</tr>
<tr>
<td>Stroke</td>
<td>62%</td>
</tr>
<tr>
<td>CHD</td>
<td>33%</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>60%</td>
</tr>
<tr>
<td>All-cause mortality</td>
<td>28%</td>
</tr>
</tbody>
</table>

Hormone Replacement In Women With Premature Menopause

- Women with oophorectomy at age 45 or younger need higher dose of estrogen replacement therapy.
- Treatment should be continued until at least age of natural menopause (~52).
- Best results are seen in women who start at time of menopause and continue for 10 years or longer.
- Must use progesterone in women with uterus.

Genitourinary Syndrome of Menopause (GSM)

- Formerly referred to as vaginal or vulvovaginal atrophy (VVA).
- A collection of signs & symptoms resulting from the loss of E.
- Involves changes to the labia minora/majora, vestibule/introitus, clitoris, vagina, urethra and bladder.

Table 1. Clinical Manifestations and Complications of GSM

<table>
<thead>
<tr>
<th>Genital symptoms</th>
<th>Sensual symptoms</th>
<th>Urinary symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryness</td>
<td>Lack of lubrication</td>
<td>Urgency</td>
</tr>
<tr>
<td>Burning</td>
<td>Discomfort or pain (dyspareunia)</td>
<td>Painful or difficult urination</td>
</tr>
<tr>
<td>Itching</td>
<td>Impearedfunction</td>
<td>Recurrent urinary tract infections</td>
</tr>
</tbody>
</table>

Note: Women may present with some or all of the signs and symptoms, which vary from bothersome and should not be home assessed for by another diagnosis. Source: Reference 1, 3.
Therapeutic Goals

- Alleviate symptoms of GSM
- Preserve sexual function
- Preferred rx therapy is low-dose vaginal estrogen therapy or Ospemifene (Osphena)
Vaginal ET: Effectiveness

- Typically provides greater benefit than non-hormonal interventions
- Preferred mode of delivery when vaginal symptoms are the only complaint
- Shown in clinical trials to be more effective than systemic oral ET
- May also reduce risk of urinary urgency and recurrent urinary tract infections

Vaginal ET: Safety

- Presumed lower risk than commonly used doses of systemic ET
- Serum estrogen levels reported with use are within postmenopausal range

Vaginal ET: Adverse Effects

- Vulvovaginal candidiasis, uterine bleeding, mastalgia and nausea have been reported, may be dose related
- Data for women at high risk for VTE are lacking
- Insufficient data to recommend annual endometrial surveillance in asymptomatic women
- Closer surveillance may be required if a woman is
  - Using a higher dose of vaginal ET
  - At high risk for endometrial cancer
  - Having symptoms such as spotting or breakthrough bleeding
Vaginal ET: Length of therapy

- Improvement in symptoms typically occurs within a few weeks of starting treatment
- Vaginal ET may be continued as long as distressful symptoms remain

Treatment Options

- Vaginal ET
  - U.S. FDA-approved vaginal ET products for GSM
  - Estradiol vaginal cream 0.01% (Estrace) - 2 to 4 g applied daily for 1 to 2 weeks, then 1 g applied 1 to 3 times per week for maintenance therapy
  - Conjugated estrogen vaginal cream 0.625 mg/g (Premarin) - 0.5 to 2 g applied 1 to 3 times per week
  - Estradiol vaginal ring (Estriq) - 2 mg released at 7.5 mcg/day over 3 months
  - Estradiol hemihydrate vaginal tablet (Vagifem) - 10 mg applied once daily for 2 weeks, then twice weekly
  - Estradiol succinate vaginal ring (Femring)
  - Prasterone vaginal insert (Intrarosa) - FDA approved to treat moderate to severe pain during sexual intercourse (dyspareunia)
  - Debrisoquine (Depillex) - 60 mg per day taken orally with food
  - All effective at recommended dose
  - Choice depends on clinical experience and patient preference

Vaginal ET and Breast Cancer

- Symptoms of VVA are common among women with breast cancer, especially those on endocrine treatments or aromatase inhibitors
- For women with a non-hormone-dependent cancer, VVA management is similar to that for women without cancer
- In February 2016 ACOG released a safety endorsement for use of localized ET in women who have had a breast cancer diagnosis
- For women with a hormone-dependent cancer, VVA management depends on each woman’s preference in consultation with her oncologist
Menopausal Hormone Therapy: The What & Where

- HT options vary in type of estrogen/progestogen, dosage, route of administration and cost
- Risks/benefits vary
- ET with or without progestogen is most effective treatment of menopause related VMS
- Almost all systemic HT products are approved for VMS relief

(NAMS position statement. Menopause 2012.)

Bioidentical Hormone Therapy

- Consists of hormones chemically identical or very similar to those made in the body
- Available from two sources: 1) FDA-approved and tested; 2) unapproved and untested from compounding pharmacies
- Started as a marketing term and often used to refer to compounded formulations
- Many well-tested, government-approved HT products contain bioidentical hormones
- Compounded preparations and salivary hormone testing not recommended
- Compounded HT not tested for efficacy, safety, batch standardization, or purity
- Some compounders make unsubstantiated claims about safety and effectiveness
- Compounded HT should include patient information

(NAMS. Menopause 2012;19:257-71)

Progestogen Indication

- Unopposed systemic ET in postmenopausal women with an intact uterus is associated with increased endometrial cancer risk related to dose and duration of use
- Primary menopause-related indication for progestogen use is endometrial protection from systemic ET
- Progestogen generally not indicated with low-dose local ET for vaginal atrophy
- Most commonly prescribed progestogen is micronized progesterone (Premarin) 100 mg po qhs used continuously with E
- Other P regimens include use of MPA, cyclical dosing, intrauterine and vaginal routes

(NAMS position statement. Menopause 2012.)
HT & Venous Thromboembolism: Oral vs Transdermal Estrogen

- Oral HT increases the risk of VTE in postmenopausal women
- Absolute risk is age dependent
- VTE risk with either EPT or ET is rare in women before age 60
- VTE risk emerges soon after HT initiation (1-2 y) and decreases over time
- Other risk factors: obesity, immobilization, fracture, prothrombotic mutations
- Possible lower VTE risk with transdermal and lower oral HT doses however no RCT evidence


Oral vs Transdermal: ESTHER Study

A case-control study that compared oral estrogen to transdermal ET and the risk of VTE in postmenopausal women aged 45-70

<table>
<thead>
<tr>
<th>HT</th>
<th>OR (95% CI) for VTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral ET</td>
<td>4.2</td>
</tr>
<tr>
<td>Transdermal ET</td>
<td>0.9</td>
</tr>
</tbody>
</table>


VTE Risks

- Oral ET exerts a pro-thrombotic effect through hepatic induction of substances increasing the risk of VTE
- Transdermal ET bypasses the liver and has no effect in increasing these substances.
- Transdermal ET may have beneficial effects on pro-inflammatory markers including CRP, prothrombin activation peptide and antithrombin activity. It may also suppress effect on tissue plasminogen activator antigen and plasminogen activator inhibitor activity

Source: ACOG Committee Opinion. Number 556, April 2013
KEEPS Study
The Kronos Early Estrogen Prevention Study

- Mean age – 52.7 (within 3 yrs of FMP)
- Trial duration of 48 months (published in 2012)
- Multi-center double-blinded placebo-controlled RCT
- Treatment Arms:
  - Oral conjugated equine estrogen (o-CEE) 0.45mg/d (lower does than WHI)
  - Transdermal Estradiol (t-E2) 0.06 mg/d patch
  - Placebo
  - Active arms received cyclical micronized P 200 mg/d X 12 d/month or placebo P

Direction of Changes in CV Risk Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>o-CEE</th>
<th>t-E2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic BP</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
<tr>
<td>Diastolic BP</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td>Favorable</td>
<td>Neutral</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td>Neutral</td>
<td>Favorable</td>
</tr>
<tr>
<td>Fasting Glucose</td>
<td>Neutral</td>
<td>Favorable</td>
</tr>
</tbody>
</table>

Direction of Change in Other Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>o-CEE</th>
<th>t-E2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Favorable</td>
<td>Neutral</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Favorable</td>
<td>Favorable</td>
</tr>
<tr>
<td>Sexual Pain</td>
<td>Neutral</td>
<td>Favorable</td>
</tr>
<tr>
<td>Desire</td>
<td>Neutral</td>
<td>Favorable</td>
</tr>
<tr>
<td>Arousal</td>
<td>Neutral</td>
<td>Favorable</td>
</tr>
<tr>
<td>Orgasm</td>
<td>Adverse</td>
<td>Favorable</td>
</tr>
<tr>
<td>Cognition</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
</tbody>
</table>
Oral vs Transdermal: Clinical Pearls

- Due to possibility of lower risk for VTE and sexual dysfunction we tend to use transdermal E as first line in most cases
- VTE risk is RARE in women < 60 and within 10 years of menopause...oral E is an acceptable choice when benefits outweigh risks, i.e. cost, absorption issues, etc
- Individualize therapy based on patient risk factors and preference

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>AVAILABLE DOSAGES</th>
<th>BIODEIDENTICAL</th>
<th>COST*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estrace</td>
<td>0.5, 1.0, 2.0 (per day)</td>
<td>Yes</td>
<td>$131</td>
</tr>
<tr>
<td>Menest</td>
<td>0.3, 0.625, 1.25 (per day)</td>
<td>No</td>
<td>$48</td>
</tr>
<tr>
<td>Premarin</td>
<td>0.3, 0.45, 0.625, 0.9, 1.25 (per day)</td>
<td>No</td>
<td>$143</td>
</tr>
<tr>
<td>Transdermal patch (estradiol)</td>
<td></td>
<td>Yes</td>
<td>$90</td>
</tr>
<tr>
<td>Climara</td>
<td>0.025, 0.0375, 0.05, 0.06, 0.075, 0.1 (once per week)</td>
<td>Yes</td>
<td>$50</td>
</tr>
<tr>
<td>Minivelle</td>
<td>0.025, 0.0375, 0.05, 0.075, 0.1 (twice per week)</td>
<td>Yes</td>
<td>$137</td>
</tr>
<tr>
<td>Vivelle Dot</td>
<td>0.025, 0.0375, 0.05, 0.075, 0.1 (twice per week)</td>
<td>Yes</td>
<td>$84</td>
</tr>
<tr>
<td>Transdermal gel (estradiol)</td>
<td></td>
<td>Yes</td>
<td>$118</td>
</tr>
<tr>
<td>Divigel</td>
<td>0.25, 0.5, 1.0 (per day)</td>
<td>Yes</td>
<td>$118</td>
</tr>
<tr>
<td>Elestrin</td>
<td>0.52 (per day; adjust dosage based on response)</td>
<td>Yes</td>
<td>$109</td>
</tr>
<tr>
<td>Estrogel</td>
<td>0.75 (per day)</td>
<td>Yes</td>
<td>$126</td>
</tr>
<tr>
<td>Transdermal spray (estradiol)</td>
<td></td>
<td>Yes</td>
<td>$118</td>
</tr>
<tr>
<td>Evamist</td>
<td>1.53 per spray (start with 1 spray per day, adjust up to 3 sprays per day based on response)</td>
<td>Yes</td>
<td>$118</td>
</tr>
<tr>
<td>Vaginal (estradiol)</td>
<td>Femring</td>
<td>Yes</td>
<td>$355</td>
</tr>
</tbody>
</table>

*— Estimated retail price of one month's treatment based on information obtained at http://www.goodrx.com (accessed June 13, 2016)
**DUAVEE**
(Bazedoxifene 20 mg + CE 0.45 mg)

- Pairs an estrogen with a SERM
- Indicated for the treatment of moderate to severe vasomotor symptoms **in women with a uterus**
- Indicated for the prevention of postmenopausal osteoporosis
- Oral, daily
- **No need for Progesterone/progestin use**

**HT & Breast Cancer**

- **Diagnosis** of breast cancer increases with **EPT** use beyond 3-5 years
- Unclear whether EPT risk differs between continuous and sequential progestogen
- EPT and to a lesser extent ET increase breast cell proliferation, breast pain, and mammographic density
- Breast cancer diagnosis dissipated 3 years post EPT cessation
- Women starting EPT shortly after menopause experience increased breast cancer risk, but those with a gap time greater than 5 years do not


**HT & Breast Cancer (cont’d)**

- ET arm of WHI showed **no increased** cancer risk after mean 7.1 years on study
- ET and EPT use in breast cancer survivors may increase recurrence risk and decision to use should be shared between patient, oncologist and PCP

Key Points

- Vasomotor symptoms affect up to 75% of women
- HT is an acceptable option for treating moderate to severe menopausal symptoms in relatively young (up to age 59 or within 10 years of menopause) and healthy women
- Individualization and shared decision making are key
- For women with vaginal symptoms only, the preferred therapy is low-dose vaginal estrogen therapy or Osphena
- A progestogen is not necessary with use of low-dose vaginal ET
- Women with a uterus need to take a progestogen along with systemic estrogen to prevent uterine cancer
- Women s/p hysterectomy can use unopposed estrogen

Key Points

- Both systemic E and E+P increase the risk of VTE, although the risk of blood clots and strokes is rare (<1/1000) in the 50-59 year-old age group
- The risk of VTE appears to be significantly lower with transdermal E
- The Timing Hypothesis - women who are young and/or in close proximity to menopause when starting HT have reduced coronary heart disease and overall mortality is reduced by 30%
- Systemic E (with or without P) is government approved in the United States for prevention of postmenopausal osteoporosis
- In recently menopausal women, diagnosis of breast cancer increases with EPT (but not ET) use beyond 3-5 years although the risk decreases after discontinuation
- In patients with premature menopause (age < 40) the benefits of HT almost always outweigh the risks

Menopause Resources

- The North American Menopause Society
  - www.menopause.org
- Find a NAMS certified menopause practitioner (NCMP)
- American College of Obstetricians and Gynecologists
Thank You