# Troubleshooting menopause hormone therapy

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**Background**
Public interest in menopause hormone therapy (MHT) is currently high, and more women are presenting to general practitioners (GPs) interested in starting medication. MHT can be complex to prescribe, and regimens will commonly need adjusting. Although there are increasing resources available to GPs around MHT prescribing, there is less available guidance in managing difficulties when they arise.

**Objective**
The aim of this paper is to summarise the key components to follow-up consultations for women starting on MHT and to provide some practical guidance to troubleshooting problems.

**Discussion**
Given the wide range of MHT products available, finding the right option for each woman can be both a challenge and an opportunity. The variety of formulations and delivery methods allows greater ability for GPs to adjust regimens and individualise. Initial difficulties when starting MHT are common and for some women it might take a few months to stabilise therapy. Most women will be able to find a regimen that suits them if proper care is given to exploring the balance between symptom control, side effects and bleeding patterns.

**INTEREST IN MENOPAUSE HORMONE THERAPY** (MHT) has grown in recent years among both clinicians and the public.[1] The 2002 Women's Health Initiative study previously generated widespread concern about the safety of MHT, however subsequent evidence has established its robust safety profile.[2] MHT is now considered the first-line therapy for managing bothersome menopausal symptoms in women without contraindications to exogenous hormones.[3] With more women empowered to seek treatment, demand for MHT is increasing. This highlights the need for general practitioners (GPs) to be well-informed in managing associated issues if they arise.

## Aim

Prescribing MHT can be complex given the wide range of available products, combinations, routes of administration and the need to be tailored to a woman's menopausal status. There is no one-size-fits-all approach, and many women require adjustments to their regimen after initiation. Some might experience inadequate symptom control, while others develop intolerable side effects. Bleeding issues are also common in both perimenopausal and menopausal women. This article explores common concerns that might arise during early MHT reviews and aims to support GPs in making medication adjustments.

## Menopause hormone therapy follow-up consultations

It is generally recommended to review women starting on MHT within 6–12 weeks, depending on the severity of their initial symptoms and the presence of any factors that might predict potential complications.

Early follow-up is advised for women with severe mood disturbances who might require additional psychological support or mood-specific pharmacological interventions such as selective serotonin reuptake inhibitors (SSRIs). Similarly, women with a history of adverse reactions to hormonal contraceptives should be reviewed early, as they might be at increased risk of experiencing difficulties with MHT.

It might take up to 3 months to achieve maximal therapeutic effect, making a 12-week review appropriate for most patients. Key components of the follow-up consultation should include an evaluation of any side effects, a review of bleeding patterns and an assessment of symptom control.

## Troubleshooting side effects

### Mastalgia

Mastalgia is a common side effect when initiating MHT and typically resolves within a few weeks. It can be related to the oestrogen or progestogen component.[4]

The initial management should involve reducing the oestrogen dose, followed by reassessment after several weeks. If symptoms persist despite oestrogen reduction, switching to a different progestogen might help. Anti-androgenic progestogens such as drospirenone are associated with lower rates of breast pain.[5] Tibolone is another MHT option with a lower incidence of mastalgia.[6]

In some cases, there is no straightforward solution, and the oestrogen dose required for symptom relief might exceed the dose a woman can tolerate because of mastalgia. In such instances, non-hormonal menopause treatments might be considered. Supportive measures such as well-fitting sports-style bras and topical nonsteroidal anti-inflammatory drugs (NSAIDS) can provide symptomatic relief. For women who require MHT but continue to have problematic mastalgia, referral to a breast specialist might be appropriate. Low-dose tamoxifen has been used effectively in selected cases.[7]

### Headaches/worsening migraine

Both menstrual and non-menstrual migraines can be problematic during the perimenopause. Poor sleep and fatigue can initiate migraine as well as menopausal hormonal shifts. Fluctuations in oestrogen are the usual trigger for hormonal migraine.[8] It is not uncommon when starting MHT for the sudden increase in oestrogen to act as a migraine trigger. For most women this will settle fairly quickly if they stay on their MHT. Starting on a low oestrogen dose can also prevent this – and then titrating up slowly as needed. Estradiol patches are the most flexible in this regard because of their stable blood levels, wider dose range and the ability to cut patches to further alter doses. Transdermal estradiol is preferable in women with a history of migraine, and mandatory in migraine with aura because of the increased stroke risk.

A stable continuous progestogen dose is generally advisable for women with menstrual migraine. The cyclical regimens typically used in perimenopause can sometimes trigger migraine in susceptible women. However continuous progestogen dosing in perimenopausal women will often cause bothersome bleeding disturbances. A 52 mg levonorgestrel intra-uterine device (IUD, Mirena) is one way of providing a continuous dosing pattern for perimenopausal women. The drospirenone-only contraceptive pill (Slinda) is widely used off label for this purpose too. As it suppresses ovulation, it can be extremely useful in managing menstrual migraine in the perimenopause while acting as the endometrial protection arm of MHT, and providing contraception if needed.[9,10]

Citalopram/escitalopram, serotonin and norepinephrine reuptake inhibitors (SNRIs), and gabapentin can be used as both migraine prophylaxis and for management of vasomotor menopause symptoms in women that cannot tolerate MHT.[11]

Non-migrainous headaches are also reasonably common when first starting MHT – often as a side effect of the progestogen component. If this does not settle, then it might be worth considering a switch of progestogen type.

### Fluid retention

Fluid retention can occur when first starting MHT. As with most side effects, it will usually settle on its own after a few weeks. If it does not resolve, then a switch to a progestogen with anti-mineralocorticoid properties such as drospirenone can help.[5] If this does not change symptoms then reducing the overall oestrogen dose might improve matters. Fluid retention can be a particular problem with tibolone, so a change of MHT type might be in order if this is an issue.

### Mood disturbance

Mood disturbance can be a particularly challenging side effect to manage. It can be predicted to be a problem if women have had prior mood issues on hormonal contraception, and is more common in women with pre-menstrual dysphoric disorder.[12] It is a well-recognised side effect of the progestogen component of MHT and can be severe for some women.[13–15] If it is unclear whether it is the progestogen component that is triggering symptoms, then a short trial of oestrogen-only MHT for a couple of weeks can be useful. If mood disturbance resolves with cessation of a progestogen, then this confirms that the progestogen is the culprit and another type can be tried.

Trialling different progestogens is key to the management. Micronised progesterone is probably the least likely to trigger mood disturbance[16] although any progestogen can be a problem. An IUD offers a lower systemic dose of progestogen and is a good choice for many women. For women that cannot tolerate oral micronised progesterone, there is the option to trial a switch to vaginal use of the same capsule. This is off label for endometrial protection in Australia but is commonly used this way. There are limited data on the most appropriate dosing for vaginal usage, and the conservative approach would be to use the same dose as that used orally.[17–19]

Some of the combined oral contraceptive pills (COCPs) can also be used in lieu of MHT in women with no contraindications. COCPs containing natural oestrogens such as estradiol or estetrol are the most suitable for use for menopausal symptoms.[20,21] Standard COCPs with their wider range of progestogens can be used, but the synthetic ethinylestradiol might be less efficacious for vasomotor symptoms and have a less favourable metabolic profile.[21]

Women that have been unable to tolerate any of the standard MHT progestogens will benefit from a referral to a specialist menopause service for consideration of the more unusual off-label progestogen choices. A hysterectomy might be considered as the definitive solution for progestin sensitivity in women who require MHT but are unable to tolerate any form of progestogen.

## Troubleshooting bleeding problems

Women that are within 12 months of their last menstrual period at the initiation of MHT should receive a sequential cyclical regimen for at least the first 12 months, whereas post-menopausal women can use a continuous regimen. Cyclical regimens typically result in a predictable withdrawal bleed after the scheduled cessation of the progestogen component. Women receiving continuous regimens should not have any bleeding beyond the initial 6-month adjustment period.

Bleeding problems are common during the initiation of MHT, particularly as more women are starting treatment earlier in the perimenopausal transition. Breakthrough bleeding is a normal occurrence with both cyclical and continuous regimens during the first 6 months of use and typically resolves over time. However, bleeding that is particularly heavy, frequent, or otherwise concerning should be investigated, even within this initial period.

Many progestogens used in MHT are not highly effective at suppressing endogenous menstrual bleeding. This is especially true

for micronised progesterone, one of the most commonly prescribed progestogens.[22] Women who begin MHT early in the perimenopause are therefore more likely to have persistent breakthrough bleeding on their cyclical regimen when using micronised progesterone. In such cases, increasing the dose or switching to a more potent progestogen (eg norethisterone, drospirenone, or a 52 mg levonorgestrel-releasing IUD) often leads to improved bleeding control. For women who wish to continue micronised progesterone because of its beneficial effects on sleep or mood and they do not want a levonorgestrel-releasing intrauterine device, the addition of 1.25 mg (one-quarter tablet) of norethisterone on the cyclical progesterone days can be a helpful strategy. The cyclical dose of micronised progesterone can instead be increased to 300 mg; however, its use at this dose is often limited by side effects.

Women on cyclical MHT that continue to bleed outside of the scheduled withdrawal bleed, or have excessively heavy bleeds despite adjusting their progestogen, should be investigated with a pelvic exam, a transvaginal pelvic ultrasound, and potentially a cervical co-test depending on bleeding pattern. An ultrasound timed after bleeding with an endometrial thickness of ≥5 mm is considered abnormal in perimenopause and should be referred to a gynaecologist for further assessment.[23]

Traditional guidance has suggested transitioning to continuous MHT regimens after 12 months of therapy. However, with the shift towards earlier initiation of MHT in the perimenopause, this timeline might need to be extended. If a woman continues to have bleeding after switching to continuous MHT then she should revert to cyclical therapy for at least a further 6–12 months.

Women on continuous MHT should not bleed at all once they are established on therapy. Any level of bleeding should be investigated with a pelvic exam, cervical co-test, and transvaginal pelvic ultrasound. If the endometrial thickness is >4 mm then they should be promptly referred to a gynaecologist.[23,24] If they are having problematic bleeding, then the progestogen dose can be increased in the interim.

Women with an endometrial thickness of <4 mm can just continue their MHT as long as there is no further bleeding and no evidence of vaginal or cervical pathology.[23,24] Any further bleeding requires a gynaecology referral regardless of the endometrial thickness.[23,24]

In post menopause women with a thin endometrium on transvaginal ultrasound (<4 mm), bleeding might be a result of excessive endometrium atrophy.[25,26] This might reflect post-menopausal changes as well as the effects of exogenous progestogen. In women with recurrent bleeding, a thin endometrium and atrophic findings on histology, a slight reduction in progestogen dose or increase in oestrogen dose might reduce risk of further bleeding.[27]

## Troubleshooting poor symptom control

If menopausal symptoms persist after the initial 3 months of therapy, it is important to assess both the nature of ongoing symptoms and the degree of improvement achieved. Many women will need an increase in oestrogen and hence usually an increase in progestogen coverage.

There is a wide interpersonal variability of blood levels from both transdermal and oral oestrogen and the tissue effect of any given level of oestrogen can vary wildly, with no set 'level' providing symptomatic relief.[28] There is therefore limited clinical value in routinely checking serum oestradiol levels.[28,29] In women that are still symptomatic at the highest licenced doses (generally 100 mcg patch or equivalent), then a blood level might be useful to assess for potential absorption issues. For women receiving high-dose MHT with serum oestradiol levels below approximately 300 pmol/L and ongoing menopausal symptoms, a trial of dose escalation or an alternative delivery method might be appropriate.[29] Conversely, in women with oestradiol levels exceeding 500–600 pmol/L, it is prudent to re-evaluate the underlying causes of persistent symptoms.[29] There has been a strong move towards MHT in recent years, fuelled in part by social media trends.[30,31] There is often public perception that all symptoms can be attributed to menopause, when the reality is that fatigue, brain fog and mood disturbance are often multifactorial and hence might not improve with MHT.

MHT is extremely effective at treating vasomotor symptoms, so treatment failure in this instance should prompt investigation for secondary causes.

On those rare occasions where serum oestradiol testing is warranted, then this should be performed roughly 24 hours after an estradiol patch change, or around 4–5 hours after estradiol gel application. It is important to make sure that the patient does not apply any gel on the arm undergoing venesection in the preceding 24 hours to avoid false high readings. Interpretation of serum oestradiol levels in women taking oral MHT is confounded by metabolites generated through first-pass hepatic metabolism and is therefore generally of limited value.

For women that appear to be poor absorbers of transdermal MHT, then the first step should be to assess their technique. Estradiol 0.06% gel (Estrogel) should be applied over a wide surface area, whereas estradiol 0.1% gel (Sandrena) should be applied over an area no bigger than the size of the hand palm. Skin products can block the absorption of both the gels and patches, with moisturising products, including shower gels and soaps, being common culprits.

Oral oestrogen products are best avoided in women that might have gut malabsorption issues such as Crohn's disease or gastric bypass surgery. Glucagon-like peptide-1 (GLP-1) agonist use for weight loss or diabetes can reduce the absorption of oral medications because of delayed gastric emptying. This effect appears to be more marked with tirzepatide in particular, and this might affect the efficacy of both oral contraceptives and MHT.[32] There have been concerns about the potential for inadequate endometrial protection when using transdermal oestrogen combined with oral progestogen in women using GLP-1 agonists. For women using micronised progesterone or other non-combined oral progestogens, expert consensus suggests that the dose should be doubled for the first 4 weeks after any dose increase of the GLP-1 agonist.[33]

## Troubleshooting product supply issues

MHT product supply issues have continued to plague Australia over the last few years, and it is very common to have women presenting to the GP needing an urgent change of MHT type. This can be challenging for GPs

not familiar with MHT prescribing as there are a myriad of products and combinations. The Australian Menopause Society has an excellent equivalency table to provide guidance here (Box 2). The Therapeutic Goods Administration (TGA) shortages database can also be useful and lists any TGA-approved unregistered products that have been imported to improve supply (Box 2). General principles to consider:

- **Can the patient have oral MHT?** If they have a history of migraine with aura, cardiovascular disease, or are at risk for venous thromboembolism (VTE) (including having a BMI over 30) then they should have transdermal oestrogen only.[34] Tibolone is the only oral therapy that does not carry VTE risk, although it does slightly increase risk of stroke, especially in women aged over 60 years, and so is best avoided in women with migraine with aura or cardiovascular disease.[35,36]
- **Is the dose of oestrogen comparable?** Check the equivalency table (Box 2). Generally, 2 mg oral estradiol = 50 mcg estradiol patch = 2 pumps of estradiol 0.06% gel = 1 sachet of estradiol 0.1% gel.
- **Does the progestogen need changing?** If the patient has a separate progestogen to their oestrogen, then this will not need changing as long as the dose equivalence stays the same. If the patient is changing from a combination product, then they will need a new progestogen too.

**Box 1. Progestogen menopause hormone therapy choices, including natural oestrogen contraceptive pills**

| | |
|---|---|
| Micronised progesterone | 'Prometrium'<br>In the combined products 'Bijuva' and 'Estrogel Pro' |
| Dydrogesterone | In the combined product 'Femoston' |
| Norethisterone | 'Primolut'<br>In the combined products 'Estalis', 'Kliovance' and 'Kliogest' |
| Levonorgesterol | 'Mirena' intra-uterine device |
| Drospirenone | 'Slinda'<br>In the combined product 'Angeliq'<br>In the combined contraceptive pill 'Nextstellis' |
| Medoxyprogesterone acetate | 'Provera'<br>'Ralovera' |
| Nomegesterol | In the combined contraceptive pill 'Zoely' |
| Tibolone | 'Livial' |

**Box 2. Resources for menopause hormone therapy**

**Australian Menopause Society guide to MHT/HRT doses:** https://menopause.org.au/hp/information-sheets/ams-guide-to-mht-hrt-doses

**Australian Menopause Society resources for health professionals:** https://menopause.org.au/hp

**Monash University's Practitioner's toolkit for managing menopause:** www.monash.edu/__data/assets/pdf_file/0011/3476072/menopause-toolkit-update.pdf

**European Menopause and Andropause Society information sheets:** https://emas-online.org/guidelines-and-education

**Cancer Council Australia guidelines on management of peri and post-menopausal bleeding:** www.canceraustralia.gov.au/sites/default/files/migrated-files/publications/abnormal-vaginal-bleeding-pre-peri-and-post-menopausal-women-diagnostic-guide-general-practitioners/pdf/ncgc_a3_menopause_chart_june_2012_final.pdf

**Therapeutic Goods Administration shortages database:** https://apps.tga.gov.au/prod/MSI/search

HRT, hormone replacement therapy; MHT, menopause hormone therapy.

## Conclusion

MHT remains the first-line treatment for women experiencing troublesome menopause symptoms. Symptom control, side effect profiles and bleeding patterns are key elements to cover during an MHT review. Most issues can be resolved by careful assessment of current MHT use and then appropriate regimen alterations. The vast majority of women experiencing problems with their MHT will be able to be well managed by their usual GP, while referral to a specialist menopause service remains appropriate for more complex cases.

## Key points

- MHT remains the first-line treatment for managing menopausal symptoms that are affecting quality of life.
- Key components of the follow-up consultation should include an evaluation of any side effects, a review of bleeding patterns, and an assessment of symptom control.
- Persistent symptoms, even after dose adjustments, should prompt a re-evaluation of the primary cause of symptoms.
- MHT must be individualised – there is no one-size-fits-all approach.
- Most women can find a regimen that achieves effective symptom relief without ongoing side effects or problematic bleeding.

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## References

*References are available online only.*

## References


1. Velentzis LS, Egger S, Banks E, Canfell K. Menopausal hormone therapy: Characterising users in an Australian national cross-sectional study. PLoS One 2021;16(8):e0253725. doi: 10.1371/journal.pone.0253725.
2. Madsen TE, Sobel T, Negash S, et al. A review of hormone and non-hormonal therapy options for the treatment of menopause. Int J Womens Health 2023;15:825–36. doi: 10.2147/IJWH.S379808.
3. Panay N, Ang SB, Cheshire R, Goldstein SR, Maki P, Nappi RE; International Menopause Society Board. Menopause and MHT in 2024: Addressing the key controversies – an International Menopause Society White Paper. Climacteric 2024;27(5):441–57. doi: 10.1080/13697137.2024.2394950.
4. Crandall CJ, Markovic D, Huang MH, Greendale GA. Predictors of breast discomfort among women initiating menopausal hormone therapy. Menopause 2010;17(3):462–70. doi: 10.1097/gme.0b013e3181c29e68.
5. Foidart JM. Added benefits of drospirenone for compliance. Climacteric 2005;8(Suppl 3):28–34. doi: 10.1080/13697130500330309.
6. Palomba S, Di Carlo C, Morelli M, et al. Effect of tibolone on breast symptoms resulting from postmenopausal hormone replacement therapy. Maturitas 2003;45(4):267–73. doi: 10.1016/S0378-5122(03)00153-1.
7. Sinha MK, Barman A, Sahu S, Jha AK, Asharaf AA. Tamoxifen in mastalgia: A meta-analysis. J Obstet Gynaecol Can 2022;44(10):1084–94. doi: 10.1016/j.jogc.2022.06.006.
8. Reddy N, Desai MN, Schoenbrunner A, Schneeberger S, Janis JE. The complex relationship between estrogen and migraines: A scoping review. Syst Rev 2021;10(1):72. doi: 10.1186/s13643-021-01618-4.
9. Archer DF, Thorneycroft IH, Foegh M, et al. Long-term safety of drospirenone-estradiol for hormone therapy: A randomized, double-blind, multicenter trial. Menopause 2005;12(6):716–27. doi: 10.1097/01.gme.0000177318.24005.b1.
10. Stute P, Walker LJ, Eicher A, et al. Progestogens for endometrial protection in combined menopausal hormone therapy: A systematic review. Best Pract Res Clin Endocrinol Metab 2024;38(1):101815. doi: 10.1016/j.beem.2023.101815.
11. Waliszewska-Prosół M, Grandi G, Ornello R, et al. Menopause, perimenopause, and migraine: Understanding the intersections and implications for treatment. Neurol Ther 2025;14(3):665–80. doi: 10.1007/s40120-025-00720-2.
12. Björn I, Bäckström T, Lalos A, Sundström-Poromaa I. Adverse mood effects during postmenopausal hormone treatment in relation to personality traits. Climacteric 2006;9(4):290–97. doi: 10.1080/13697130600865766.
13. Sundström-Poromaa I, Comasco E, Sumner R, Luders E. Progesterone – Friend or foe? Front Neuroendocrinol 2020;59:100856. doi: 10.1016/j.yfrne.2020.100856.
14. Schindler AE, Campagnoli C, Druckmann R, et al. Classification and pharmacology of progestins. Maturitas 2008;61(1-2):171–80. doi: 10.1016/j.maturitas.2008.11.013.
15. Panay N, Studd J. Progestogen intolerance and compliance with hormone replacement therapy in menopausal women. Hum Reprod Update 1997;3(2):159–71. doi: 10.1093/humupd/3.2.159.
16. Bencker C, Gschwandtner L, Nayman S, et al. Progestagens and progesterone receptor modulation: Effects on the brain, mood, stress, and cognition in females. Front Neuroendocrinol 2025;76:101160. doi: 10.1016/j.yfrne.2024.101160.
17. Stute P, Neulen J, Wildt L. The impact of micronized progesterone on the endometrium: A systematic review. Climacteric 2016;19(4):316–28. doi: 10.1080/13697137.2016.1187123.
18. Sriprasert I, Mert M, Mack WJ, Hodis HN, Shoupe D. Use of oral estradiol plus vaginal progesterone in healthy postmenopausal women. Maturitas 2021;154:13–19. doi: 10.1016/j.maturitas.2021.09.002.
19. Di Carlo C, Tommaselli GA, Gargano V, Savoia F, Bifulco G, Nappi C. Transdermal estradiol and oral or vaginal natural progesterone: Bleeding patterns. Climacteric 2010;13(5):442–46. doi: 10.3109/13697137.2010.490605.
20. Panay N, Simoncini T, Taziaux M, et al. Estetrol for the treatment of moderate to severe vasomotor symptoms in postmenopausal women: The design of the E4COMFORT I and II trials. Maturitas 2026;204:108781. doi: 10.1016/j.maturitas.2025.108781.
21. Fidecicchi T, Ardito M, Giudetti M, Luisi S, Simoncini T. Hormonal contraception and menopausal transition: A short review. GREM Gynecol Reprod Endocrinol Metab 2024;5(2). doi: 10.53260/grem.245026.
22. de Medeiros SF, Yamamoto MM, Barbosa JS. Abnormal bleeding during menopause hormone therapy: Insights for clinical management. Clin Med Insights Womens Health 2013;6:13–24. doi: 10.4137/CMWH.S10483.
23. Australian Government, Cancer Australia. Abnormal vaginal bleeding in pre-, peri- and post-menopausal women: A diagnostic guide for general practitioners and gynaecologists. Cancer Australia, 2011. Available at www.canceraustralia.gov.au/sites/default/files/migrated-files/publications/abnormal-vaginal-bleeding-pre-peri-and-post-menopausal-women-diagnostic-guide-general-practitioners/pdf/ncgc_a3_menopause_chart_june_2012_final.pdf [Accessed 21 December 2025].
24. Carugno J. Clinical management of vaginal bleeding in postmenopausal women. Climacteric 2020;23(4):343–49. doi: 10.1080/13697137.2020.1739642.
25. Ferenczy A. Pathophysiology of endometrial bleeding. Maturitas 2003;45(1):1–14. doi: 10.1016/S0378-5122(03)00068-9.
26. Sung S, Carlson K, Abramovitz A. Postmenopausal bleeding. StatPearls Publishing, 2025. Available at www.ncbi.nlm.nih.gov/books/NBK562188 [Accessed 21 December 2025].
27. Australasian Menopause Society. Bleeding – Perimenopausal, postmenopausal and breakthrough bleeding on MHT/HRT. Australasian Menopause Society, [date unknown]. Available at https://hub.menopause.org.au/Play?pId=f34327c6-e7c5-421e-87c4-4ae6f5201db3 [Accessed 21 December 2025].
28. Davis SR, Baber R, Briggs P, et al. Letters to the Editor. Menopause 2025;32(7):665–67. doi: 10.1097/GME.0000000000002581.
29. British Menopause Society. Measurement of serum estradiol in the menopause transition: BMS tool for clinicians. British Menopause Society, 2025. Available at https://thebms.org.uk/wp-content/uploads/2025/11/24-NEW-BMS-ToolsforClinicians-Measurement-of-serum-estradiol-JULY2025-C.pdf [Accessed 29 October 2025].
30. Baber R. Marketing the menopause. Climacteric 2023;26(3):171–72. doi: 10.1080/13697137.2023.2196885.
31. Thomas SL, Hickey M. The hot flush gold rush: How women feel about being flooded with menopause marketing. The Conversation Australia + NZ, 2026. Available at https://theconversation.com/the-hot-flush-gold-rush-how-women-feel-about-being-flooded-with-menopause-marketing-269810 [Accessed 7 February 2026].
32. Skelley JW, Swearengin K, York AL, Glover LH. The impact of tirzepatide and glucagon-like peptide 1 receptor agonists on oral hormonal contraception. J Am Pharm Assoc (2003) 2024;64(1):204–11.e4. doi: 10.1016/j.japh.2023.10.037.
33. British Menopause Society. Use of incretin-based therapies in women using hormone replacement therapy (HRT): Tool for clinicians. British Menopause Society, 2025. Available at https://thebms.org.uk/wp-content/uploads/2025/05/23-BMS-TfC-Use-of-incretin-based-therapies-APRIL2025-E.pdf [Accessed 25 October 2025].
34. Hicks A, Robson D, Tellis B, Smith S, Dunkley S, Baber R. Safety of menopause hormone therapy in postmenopausal women at higher risk of venous thromboembolism: A systematic review. Climacteric 2025;28(5):497–509. doi: 10.1080/13697137.2025.2503874.
35. Cummings SR, Ettinger B, Delmas PD, et al. LIFT Trial Investigators. The effects of tibolone in older postmenopausal women. N Engl J Med 2008;359(7):697–708. doi: 10.1056/NEJMoa0800743.
36. Canonico M, Plu-Bureau G, Scarabin PY. Progestogens and venous thromboembolism among postmenopausal women using hormone therapy. Maturitas 2011;70(4):354–60. doi: 10.1016/j.maturitas.2011.10.002.


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