

# The menopause consultation



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## Background

The menopausal transition is a time of hormonal chaos. Many women will present to their general practitioner (GP) seeking help and advice. It is important to have an empathetic and structured approach to assessing women experiencing menopause symptoms as these consultations can be complex and multi-faceted.

## Objective

The aim of this paper is to summarise key components of a menopause consultation. This includes assessment of the impact of menopausal hormonal changes, as well as of broader midlife health conditions and risks.

## Discussion

GPs play an important part in the provision of solid, evidence-based information for women at this midlife transition point. Symptom management and support should be provided within the broader context of a psychosocial framework. Consideration needs to be given to the changes in future health risk that occur at the menopause transition, most notably in cardiovascular and bone health. Menopause consults are a great opportunity to strengthen the GP-patient relationship, to guide women on the right path for healthy ageing, and to provide good longitudinal primary care.

Menopause is currently attracting extensive attention – commentary in social media, influencers, magazine articles, health supplements, books and podcasts abound. This spotlight on menopause has further empowered women to seek out support for their symptoms. Interest in menopause hormone therapy (MHT) is high, and many women are presenting to their general practitioners (GPs) seeking prescriptions. Public opinion, both in the lay and medical communities, has swung over the decades. Following the publication of the Women's Health Initiative in 2002, there was significant fear around using MHT. Since then, it has been established that MHT started within the first 10 years of menopause has robust safety data and significantly improves quality of life in symptomatic women.<sup>1</sup> The pendulum now seems to have swung to public confidence that MHT should be freely taken. It is important that GPs can access up-to-date and evidence-based information to guide women regarding diagnosis and management.

Menopause and its associated health implications is a complex transition with many facets. It can have significant implications on women's work, relationships and personal lives.<sup>2,3</sup>

The following outline of the 'menopause consultation' is likely to occur over a number of sessions in real-life practice. It is useful to set this expectation early on and have a plan for future consults. Women will often present at

the end of their tether with an extensive list of symptoms. This can be overwhelming for the GP in a standard-length consult! It is crucial that women feel heard and understood so allow plenty of time to just sit and actively listen.

## Aim

This article aims to be a comprehensive guide on assessing women experiencing menopause symptoms. It will summarise the common symptoms and signs and outline important points to cover. It will briefly touch on management, although a detailed appraisal of pharmacological options is beyond the scope of this article. Menopause also heralds a change in risk for future disease for women, with increasing cardiovascular risk, increased bone loss, and adverse metabolic changes. A good menopause consult should also be an opportunity to address preventive health strategies and set the groundwork for healthy ageing in the future (Table 1).

## The menopause consultation

The first step in the menopause consult is to gain trust, using the skills needed in any complex GP consultation. It is essential to allow the woman time and space to express the concerns that are of most importance to her.

Approximately 75% of women will experience symptoms due to menopausal hormone changes and about 25% of women have symptoms impacting severely

**Table 1. A suggested structure for the menopause consultation****Set expectations early and plan for a series of consultations if needed**

<b>Menstrual pattern</b>	<ul style="list-style-type: none"> <li>Establish whether perimenopause/menopause is the likely cause of symptoms</li> <li>In women with regular cycles consider possibility of PMDD</li> <li>In women with regular cycles, no vasomotor symptoms and non-cyclical symptoms consider other causes</li> </ul>			
<b>Symptom discussion</b>	<ul style="list-style-type: none"> <li>Vasomotor symptoms</li> <li>Sleep disturbance</li> </ul>	<ul style="list-style-type: none"> <li>Mood disturbance</li> <li>Cognitive change</li> </ul>	<ul style="list-style-type: none"> <li>Libido and sexual function</li> <li>Genitourinary symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Other common symptoms (eg joints, skin, MSK, headache/migraine)</li> </ul>
<b>Current or prior treatments</b>	<ul style="list-style-type: none"> <li>Any complementary therapies, herbal supplements, prior MHT or non-hormonal options?</li> <li>Any prior problems or side effects with hormonal contraception?</li> </ul>			
<b>General health</b>	<ul style="list-style-type: none"> <li>Cardiovascular health – absolute cardiovascular risk assessment if appropriate</li> <li>Bone health – risk factors for osteoporosis</li> <li>Dementia risk – consider CogDrisk (Box 3)</li> <li>Diet – nutritional advice if required</li> </ul>		<ul style="list-style-type: none"> <li>Exercise and lifestyle – discuss recommendations if appropriate</li> <li>Alcohol and smoking</li> <li>Home and work life</li> <li>Contraception needs</li> </ul>	
<b>PMH/DH</b>	<ul style="list-style-type: none"> <li>Review any relevant past medical history such as breast cancer, thromboembolic disease, migraines with aura, heart or vascular disease and diabetes</li> <li>Consider if there are any medications that might influence treatment choices</li> </ul>			
<b>Examination</b>	<ul style="list-style-type: none"> <li>Blood pressure</li> <li>Consider if it is appropriate to check height/weight/waist circumference within a HAES framework</li> <li>Vulvovaginal exam if required</li> </ul>			

**Assess priorities – what is bothering the woman most?****Assess the patient's expectations – what are they hoping for out of the consultation?**

<b>Investigations</b>	<ul style="list-style-type: none"> <li>Standard bloods such as renal function, lipids and HbA1c if due. Consider full blood count, iron studies, TSH</li> <li>Consider pelvic ultrasound if menorrhagia or dysfunctional uterine bleeding</li> <li>Hormonal testing is mainly not required unless premature ovarian insufficiency is suspected</li> </ul>			
<b>Screening</b>	<ul style="list-style-type: none"> <li>Cervical screening test 5 yearly</li> <li>Mammogram 2 yearly. Consider risk assessment tool if risk factors for breast cancer, especially if there is a strong family history (Box 4)</li> <li>FOBT 2 yearly – now starting at age 45 years</li> </ul>		<ul style="list-style-type: none"> <li>Lung cancer screening 2 yearly if appropriate</li> <li>AUSDRISK if any risk factors for diabetes</li> <li>Consider DEXA if appropriate depending on medical history and risk factors</li> </ul>	
<b>Management discussion</b>	<ul style="list-style-type: none"> <li>Provide information about the menopausal transition and likely pattern of changes</li> <li>Lifestyle advice</li> <li>Psychosocial support if needed</li> <li>Contraception needs</li> </ul>		<ul style="list-style-type: none"> <li>Pharmacological management: <ul style="list-style-type: none"> <li>– MHT</li> <li>– Non-hormonal options</li> <li>– Vaginal oestrogen</li> </ul> </li> </ul>	
<b>Consider whether MBS health assessments and/or plans would optimise care</b>	<ul style="list-style-type: none"> <li>45–49 year old health assessment</li> <li>40–49 year old with high risk of T2DM health assessment</li> <li>Healthy heart assessment</li> <li>Menopause health assessment</li> </ul>		<ul style="list-style-type: none"> <li>GPCCMP with associated allied health referrals (ie pelvic floor physiotherapist, exercise physiologist, dietitian)</li> <li>Mental healthcare plan with associated psychology referral</li> </ul>	
<b>Set up future review appointments</b>	<ul style="list-style-type: none"> <li>Women experiencing menopause symptoms should be reviewed at least annually for a general health check</li> </ul>		<ul style="list-style-type: none"> <li>A review within 3 months of starting MHT or non-hormonal medications is useful to touch base and troubleshoot any issues or concerns</li> </ul>	

AUSDRISK, Australian type 2 diabetes risk assessment tool; CogDrisk, Cognitive Health and Dementia Risk Assessment; DEXA, dual X-ray absorptiometry; FOBT, faecal occult blood test; GPCCMP, General Practitioner chronic condition management plan; HAES, Health At Every Size; HbA1c, haemoglobin A1c; MBS, Medicare Benefits Schedule; MHT, menopausal hormone therapy; MSK, musculoskeletal system; PMDD, premenstrual dysphoric disorder; PMH/DH, past medical history/drug history; T2DM, type 2 diabetes mellitus; TSH, thyroid-stimulating hormone.

on their lives.<sup>2</sup> Women are often leading busy and overburdened lives, and some symptoms they attribute to menopause can have other root causes. Teasing out which symptoms are due to menopausal hormone changes requires a knowledge of menopausal symptomatology to provide appropriate management advice.

### Menstrual cycle

Changes in the menstrual cycle are the hallmark of the menopausal transition. This is a time of hormonal chaos and might precede the final menstrual period by several years. Cycles might become longer, shorter, or more variable. Menstrual loss might change and become heavier, lighter, longer or shorter. Abnormal bleeding, such as menorrhagia, post-coital, or intermenstrual bleeding should be investigated as usual. In women with oligomenorrhoea or amenorrhoea aged under 40 years, premature ovarian insufficiency (POI) should be considered. The article by Vincent et al<sup>4</sup> discusses POI diagnosis and management. Box 1 provides menopause definitions and statistics.

### Vasomotor symptoms

Vasomotor symptoms (VMS) are the symptoms most specifically associated with the menopause transition. They are usually described as ‘hot flushes’ but might also be experienced as a general sensation of the ‘thermostat being set higher’. It is important to establish the impact that they are having on work and personal life. In a recent Australian

study, almost 40% of women who are perimenopausal had untreated and potentially debilitating vasomotor symptoms.<sup>5</sup>

### Sleep disturbance

Adverse changes in sleep quantity and quality are common complaints. Sleep problems are often related to VMS, but development of restless leg syndrome and sleep apnoea are also common. Insomnia might also be caused or exacerbated by anxiety or depression. Adverse changes to sleep invariably contribute to a decrease in general wellbeing and can worsen any co-existing mood disturbances.

### Mood changes

Anxiety, irritability, lability of mood, and depression might occur because of, or be exacerbated by, hormonal changes.

The causation of mood changes in women with regular menstrual cycles, especially without vasomotor symptoms, might be unrelated to menopause. On eliciting a careful history, these women may have premenstrual dysphoria disorder (PMDD), rather than what they perceive as perimenopause.

There has been an increase in younger women presenting with regular cycles and ‘peri-menopausal’ symptoms, seeking MHT; the influence of social media seems to be at play here.<sup>6,7</sup> These women often have no VMS and symptoms predominantly clustered around mental health, fatigue and brain fog. Spending time unpicking these often reveals

plenty of life stressors with women juggling multiple roles with children, work and relationships. In the absence of a diagnosed cyclical mood disorder, there is no evidence for MHT in women who are premenopausal.

### Cognitive changes

Difficulty concentrating and memory changes associated with menopause are described by up to 60% of women,<sup>8</sup> often using the term ‘brain fog’. It is thought to be transient and not related to subsequent development of dementia.<sup>9</sup> Sleep issues, VMS, and mood disturbance can affect cognition, and this often improves with menopause treatment.

### Genitourinary symptoms

Genitourinary syndrome of the menopause (GSM) due to oestrogen deficiency is extremely common, and the incidence continues to rise with increasing age. Urinary urgency and frequency, incontinence, and recurrent urinary tract infections are common. Women might experience vulval discomfort, dryness, itch, and dyspareunia.

Typical features of GSM that might be seen on examination include pale mucosa of the vulva and vagina, atrophy of the labia minora, urethral caruncle, loss of vaginal rugosity, and petechiae on the vaginal walls.

Unrelated to GSM, dermatoses such as lichen sclerosus, eczema, and irritant dermatitis from urine are common findings that might also cause vulval discomfort.

### Sex and relationships

It is important to ask about sex rather than waiting for it to be brought up. Be mindful to use a trauma-informed approach and to not make assumptions around sexual orientation, gender-identity and sexual practices.

Women often complain of loss of libido. In most cases this is multifactorial – dyspareunia, relationship issues, general health, poor sleep, medications, changing body shape and self-image, as well as hormonal changes can all contribute. Management will often depend on the underlying factors.

Testosterone therapy is licensed in Australia for hypoactive sexual desire disorder in women who are post-menopausal, namely low libido causing distress where there is no other clear cause. Despite public perception, there is no current evidence that it improves mood, muscle strength or vitality.<sup>10</sup>

## Box 1. Menopause definitions and statistics

### Menopause definitions

Menopause	12 months after the final menstrual period
Perimenopause	Onset of menstrual changes and menopausal symptoms that precede menopause
Irregular menses	More than 7 days variability in cycle length
Early menopause	Menopause occurring between age 40 and 45 years
Premature menopause/premature ovarian insufficiency	Loss of ovarian function in women aged under 40 years

### Menopause statistics

Normal spread of menopause age	45–55 years, with average of 51 years in Australia <sup>21</sup>
Average length of troublesome symptoms	7–8 years <sup>22</sup>
Percentage of women with vasomotor symptoms persisting over 10 years	10% <sup>23</sup>

Most women in the menopausal transition will still require contraception, although many women assume that they are no longer fertile. There is a helpful article on managing contraception in late-reproductive aged women by Emerson et al.<sup>11</sup>

### Other menopausal symptoms

Other common symptoms include dry skin, formication (sensation of crawling skin), headaches, worsening menstrual migraines and general loss of vitality. Musculoskeletal complaints and joint pains are also very common in this period; these can be caused by both menopause and general ageing.<sup>12</sup>

Many women gain weight and accumulate more abdominal fat during the menopausal transition. This is related to a combination of reduced metabolic rate as part of ageing, hormonal changes, and lifestyle factors. Changes in lifestyle such as reduced exercise and poor diet are often consequences of other menopausal symptoms. Strategies for weight loss are important, but so is concentrating on overall health and disease prevention rather than absolute weight.

### Pre-existing conditions and family history

Medical conditions, family medical history and medications (prescribed and non-prescribed) might influence management decisions. Particularly pertinent history should include migraine, venous thromboembolism, epilepsy, cardiovascular disease, diabetes, osteoporosis, and breast or other cancers.

### Overall health

#### Cardiovascular health

Cardiovascular disease risk starts to climb as women lose the protective effect of oestrogen on the vascular system.<sup>13</sup> An absolute cardiovascular risk assessment, in line with the Australian Heart Foundation guidelines, is important for managing cardiovascular disease risk, but also might influence their suitability for MHT. A coronary artery calcium score might be useful to further stratify risk in some women, especially in those with female-specific risk factors (Box 2) that are not captured in standard risk assessment.

### Box 2. Female-related cardiovascular risk factors<sup>24</sup>

- Hypertensive diseases of pregnancy, including pre-eclampsia and eclampsia
- Preterm delivery
- Gestational diabetes
- Polycystic ovarian syndrome
- Premature ovarian insufficiency and early menopause
- Breast cancer
- Certain breast cancer treatments – certain chemotherapies, left-sided breast irradiation
- Autoimmune disease – higher prevalence in women
- Depression – higher prevalence in women

### Bone health

Around 40 to 60% of Australian women will sustain a fragility fracture within their lifetime.<sup>14</sup> Bone loss accelerates with the loss of oestrogen at around the time of menopause and is a major future health concern. Women lose an average of 10% of their bone mass in the first 5 years after menopause, and thereafter the loss continues at a rate of about 1% per year.<sup>15</sup> The menopause consult is an opportunity to talk about calcium intake, vitamin D, lowering alcohol consumption, and increasing exercise. Weight bearing exercise and activities for balance are key in maintaining bone and muscle health into older age. For women with existing risk factors, it might be appropriate to order a bone density scan.

MHT prevents bone loss and significantly reduces fracture risk.<sup>16</sup> It is a treatment option in managing osteoporosis in this cohort. It also should be strongly considered in women who are osteopenic within a decade of menopause.<sup>17</sup>

### Other general health

Women have a higher lifetime risk of dementia. Consider recommending an online cognitive health and dementia risk assessment (CogDrisk) for managing lifestyle factors (Box 3).

Lifestyle is the key for risk reduction in almost every disease of old age. Although it can be difficult for many women experiencing menopause symptoms to exercise, GPs play a vital part in encouraging this. The same holds true for nutritional advice, smoking cessation and advice on alcohol consumption.

A general examination including appearance, weight, height, waist circumference and blood pressure should

be performed if they have not been recorded recently. Usual screening bloods such as renal function, cholesterol profile and glycated haemoglobin can be ordered if due, as well as iron studies, liver function test and thyroid-stimulating hormone test if indicated. Make sure that cervical screening tests, mammograms, bowel screening and, potentially, lung cancer screening, are up to date. Breast density is now reported on most screening mammograms. Menopause consults are a good opportunity to discuss the implications, especially in women considering MHT. Assess the familial risk of breast cancer and consider a risk assessment tool score in women with risk factors for breast cancer (Box 4). The combination of breast density, familial risk, and risk assessment score can then be used to guide shared decision making on additional screening imaging tests (Box 4).

### Investigations

There is no need for hormonal testing in the typical woman who is peri-menopausal and aged 45 years or older. Even in a woman with a hysterectomy or an intrauterine device, measurement of follicle-stimulating hormone (FSH) is rarely indicated unless there is some doubt around the diagnosis. FSH levels and other investigations are crucial, however, when investigating amenorrhoea or oligomenorrhoea in a woman aged under 40 years to rule out the possibility of POI (Box 4).

### Management

The key to management is understanding the many things women are often juggling – work, children, personal relationships, ageing parents, as well as their connection with their changing bodies and menopausal symptoms. GPs are ideally placed to provide

### Box 3. Menopause resources for women

<b>Australasian Menopause Society (AMS)</b>	<ul style="list-style-type: none"> <li>Evidence-based information around menopause and includes many printable factsheets for women. They also provide some video information in Asian languages, <a href="https://menopause.org.au">https://menopause.org.au</a></li> </ul>
<b>Jean Hailes for Women's Health</b>	<ul style="list-style-type: none"> <li>National organisation providing articles, videos, podcasts and factsheets. They also provide translated factsheets and videos in many languages, and resources specifically aimed at First Nations women, <a href="http://www.jeanhailes.org.au">www.jeanhailes.org.au</a></li> <li>Symptom checklist, <a href="http://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist">www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist</a></li> </ul>
<b>Beyond Blue</b>	<ul style="list-style-type: none"> <li>National mental health organisation, <a href="http://www.beyondblue.org.au/mental-health/womens-mental-health/perimenopause-menopause-mental-health">www.beyondblue.org.au/mental-health/womens-mental-health/perimenopause-menopause-mental-health</a></li> </ul>
<b>Healthy Bones Australia</b>	<ul style="list-style-type: none"> <li>National organisation providing information around bone health and osteoporosis, <a href="http://healthybonesaustralia.org.au">http://healthybonesaustralia.org.au</a></li> </ul>
<b>Where did my libido go?</b>	<ul style="list-style-type: none"> <li>Book by Dr Rosie King, ISBN: 9781864711561, 2010</li> </ul> <p><i>Note: There is also useful information for women regarding libido on both the AMS and Jean Hailes websites.</i></p>
<b>Sleep Foundation Australia</b>	<ul style="list-style-type: none"> <li><a href="http://www.sleephealthfoundation.org.au">www.sleephealthfoundation.org.au</a></li> </ul>
<b>CogDrisk</b>	<ul style="list-style-type: none"> <li>Cognitive health and dementia risk assessment, <a href="https://cogdrisk.neura.edu.au">https://cogdrisk.neura.edu.au</a></li> </ul>

### Box 4. Menopause resources for general practitioners

<b>Australasian Menopause Society</b>	<ul style="list-style-type: none"> <li>Guide to equivalent doses of menopause hormone therapy, <a href="https://menopause.org.au/hp/information-sheets/ams-guide-to-mht-hrt-doses">https://menopause.org.au/hp/information-sheets/ams-guide-to-mht-hrt-doses</a></li> <li>elearning platform, <a href="https://elearning.menopause.org.au">https://elearning.menopause.org.au</a></li> </ul>
<b>Jean Hailes for Women's Health</b>	<ul style="list-style-type: none"> <li>Online course in managing menopause, <a href="http://www.jeanhailes.org.au/health-professionals/elearning-modules/managing-menopause">www.jeanhailes.org.au/health-professionals/elearning-modules/managing-menopause</a></li> </ul>
<b>Monash University</b>	<ul style="list-style-type: none"> <li>Practitioner's toolkit for managing menopause, <a href="http://www.monash.edu/_data/assets/pdf_file/0011/3476072/menopause-toolkit-update.pdf">www.monash.edu/_data/assets/pdf_file/0011/3476072/menopause-toolkit-update.pdf</a></li> </ul>
<b>Peter Mac</b>	<ul style="list-style-type: none"> <li>Breast cancer risk assessment tool, <a href="https://iprevent.net.au">https://iprevent.net.au</a></li> </ul>
<b>Tyrer-Cuzick Risk Calculator</b>	<ul style="list-style-type: none"> <li>Breast cancer risk assessment tool, <a href="https://magview.com/ibis-risk-calculator">https://magview.com/ibis-risk-calculator</a></li> </ul>
<b>BreastScreen Australia</b>	<ul style="list-style-type: none"> <li>Breast Density GP Guidance, <a href="http://www.health.gov.au/sites/default/files/2025-11/breast-density-gp-guidance.pdf">www.health.gov.au/sites/default/files/2025-11/breast-density-gp-guidance.pdf</a></li> </ul>
<b>The Royal Australian College of General Practitioners (RACGP)</b>	<ul style="list-style-type: none"> <li>Guidelines for preventive activities in general practice (the <i>Red Book</i>) - Risk of breast cancer, <a href="http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/preventive-activities-in-general-practice/cancer/breast-cancer">www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/preventive-activities-in-general-practice/cancer/breast-cancer</a></li> </ul>
<b>Healthy Bones Australia and RACGP</b>	<ul style="list-style-type: none"> <li>Guidelines on management of osteoporosis, <a href="https://healthybonesaustralia.org.au/wp-content/uploads/2024/03/hba-racgp-guidelines-2024.pdf">https://healthybonesaustralia.org.au/wp-content/uploads/2024/03/hba-racgp-guidelines-2024.pdf</a></li> </ul>
<b>European Society of Human Reproduction and Embryology (ESHRE)</b>	<ul style="list-style-type: none"> <li>Guidelines on premature ovarian insufficiency, <a href="http://www.eshre.eu/Guidelines-and-Legal/Guidelines/Premature-ovarian-insufficiency">www.eshre.eu/Guidelines-and-Legal/Guidelines/Premature-ovarian-insufficiency</a></li> </ul>

a 'port in the storm' and coordinate support and evidence-based treatments.

Exploration around the woman's expectations can be a useful insight – maybe they cannot 'do it all'! Can they share the load, rationalise and prioritise what is important in their lives? Some women might benefit from psychology input through a mental health care plan.

It is important to reflect on the potential burden of our lifestyle recommendations, and the reality of a woman who is already struggling with menopause symptoms. It is worth considering deferring many of these discussions to later review consults when they are hopefully better placed to be able to act on recommendations.

Women might also benefit from other multidisciplinary team input if needed, such as dietitians, exercise physiologists and pelvic floor physiotherapists. Although menopause itself would generally not be eligible for a GP chronic condition management plan (GPCCMP), many of the conditions that come alongside it would be appropriately managed under a plan with associated allied health referrals.

MHT is the first-line pharmacological treatment in symptomatic women that have no contraindications.<sup>18</sup> MHT is extremely effective at managing the plethora of menopausal symptoms. It has robust safety data for women beginning MHT within 10 years of their menopause. There is a separate article in this edition by Magraith et al<sup>19</sup> addressing the specifics of prescribing.

Vaginal oestrogen is appropriate for women with GSM. This can usually be used even in women with contraindications to systemic MHT, such as most breast cancer scenarios. It can, and often should, be continued indefinitely.

There are a range of non-hormonal pharmacological options for managing symptoms in women that cannot have or do not want hormonal treatment. The article by Farrell et al<sup>20</sup> in this edition details these treatments. There are also several complementary therapies that might be of benefit for some women. The Australasian Menopause Society has an excellent 'traffic light' handout for women considering these, guiding what has evidence of benefit and/or harm.

The conclusion of a menopause consultation should include the expectation of future consults, needed for reviewing symptoms,

checking on effectiveness of any treatments and maintaining any preventive health strategies.

## Conclusion

A consultation around menopause requires accurate assessment of the symptoms associated with menopausal hormone changes. A relationship of trust will facilitate teasing out which symptoms have a hormonal causation. In addition, the consultation should include assessment and advice regarding the health conditions that are so relevant for midlife women, in particular cardiovascular disease and osteoporosis. In reality, this 'consultation' will likely take several visits to cover all these aspects.

MHT is the first-line treatment where drug therapy is appropriate for menopausal symptoms. It can also be used to treat osteoporosis in this age group. In the current media frenzy for MHT, a balanced, nuanced approach is often required.

The menopause consult is both a consultation regarding the hormonal chaos of menopause, and also its impact in the following years. It also represents a key opportunity to strengthen the longitudinal relationship between the patient and their GP, supporting future management and the development of ongoing preventive health strategies.

## Key points

- The menopause transition is complex and might need several appointments as well as an empathetic ear.
- Assess which symptoms are actually due to menopausal hormone changes.
- A menopause consult is an important opportunity to assess general midlife health and preventive health strategies, especially for cardiovascular and bone health.
- Consider utilising available Medicare Benefits Schedule (MBS) item numbers to optimise care: 45–49-year-old health assessment (HA); 40–49-year-old with risk of type 2 diabetes mellitus (T2DM) HA, healthy heart HA, menopause HA, GPCCMP with allied health referrals, and mental health care plans.
- MHT is a first line treatment for menopausal symptoms that are affecting quality of life and can be used for prevention and management of osteoporosis.

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