HEALTH BY HEATHER HIRSCH

THE MENOPAUSE GUIDEBOOK

Get answers, get support, & get your life back!

HEATHER HIRSCH MD, MS, NCMP

THE MENOPAUSE WORKBOOK

THIS WORKBOOK PROUDLY BELONGS TO:

DATE:

I ABOUT THE AUTHOR

Dr. Heather Hirsch MD, MS, NCMP is an American Board Certified Internist and North American Menopause Society (NAMS) member. She is the author of *Unlocking Your Menopause: Personalized Treatments, the Last Word on Hormones, and Remedies that Work* (on-sale wherever books are sold).

II UNDERSTAND YOUR BODY & HORMONES

We are going to learn about perimenopause and menopause in order to best prepare you to talk to your doctor about your struggles and symptoms. Several worksheets and letters are included here to help you and your doctor navigate your menopause journey well.

III JOURNAL YOUR SYMPTOMS

You will learn how to track your symptoms. Doing so will help you to define your health priorities and goals, which you will use to inform your doctor. This way, he/she can be best prepared to help you answer questions and manage your symptoms.

IV LEARN ABOUT MENOPAUSE

As you go through this Workbook, you will learn about the menopause transition. With me as your guide, you will be better prepared to advocate for the care you feel you need and deserve.

V SEEK HELP

This workbook is intended to help you learn what you need during your menopause transition. Many types of resources are mentioned throughout - from online support groups to worksheets. You will be provided with various options to promote your overall well-being and live your best life.

VI RESOURCES

At the end of this workbook you will find a list of my recommended resources.

Why is midlife and menopause so hard to understand?

The question of the century

Midlife women's health care may be the most undeserved area of women's health. Too often, women feel embarrassed, dismissed, or silly for bringing their menopause concerns to their doctor.

As time constraints continue to pressure health-care providers, it is surely in your best interest to be brave, prepared, and concise in what you need from your provider.

Not only that, but **health-care provider education around the issues that women face at midlife and in menopause is sparse and inconsistent.**

Therefore, by staying proactive and getting your education from credible sources, you are going to have the best chance at living your best quality of life.

Another reason I created this workbook was to help educate your physician.

In doing so, you are directly helping to change the narrative for midlife women's health and raise awareness. At the same time, my sincere hope for you is that you become extremely satisfied and symptom free during your menopause transition. The idea that women's health means pregnancy and post-partum is completely outdated and wrong.

A woman's life does not end there. In fact, midlife is often intensely more cumbersome and challenging.

Many women face health challenges in midlife.

At the same time that they find themselves at the peak of their careers, working double time in the office while raising children, or juggling caring for step-children, pets, and a spouse or partner.

And let's not forget care-giving for one's parents - a job that most often falls on the daughter or daughter-in-law.

From the boardroom and clients, to driving your children to college interviews, to fighting for a drifting marriage, it is no surprising that when you add hormonal and health changes into the mix, **the menopause transition is an alarming shock to many women.**

An widening gap exists in midlife women's health care due to a lack of evidence-based, consistent, and accurate messages for women surrounding the midlife and menopause transition.

My wish is that this workbook goes some way towards filling that gap for you.

Workbooks give you the opportunity to discover and uncover.

This should be helpful when developing your health goals.

What's Perimenopause?

Tell me **exactly** what is going on with me.

THE AVERAGE AGE OF PERIMENOPAUSE VARIES, BUT IS GENERALLY FROM AGE 47. FOR SOME WOMEN THE TRANSITION INTO MENOPAUSE LASTS MANY YEARS, WHILE FOR OTHERS IT MAY BE SHORTER, LIMITING THE SYMPTOMS.

Perimenopause can last from 1–10 years.

What happens to my body when perimenopause starts?

This is the beginning of your menopause transition.

In perimenopause, the ovaries begin to decline in the production of oocytes (or an egg cell) every month, and therefore in the secretion of estrogen.

Perimenopause is the time from when this process begins up until when it ends at menopause, which is defined by having no vaginal bleeding for one full year.

The average length of perimenopause is about four years; however, for some women this time period can be as long as ten years. For others, perimenopause can be as short as a few months.

Since the body is not used to wide swings in estrogen levels, a woman may begin to experience traditional symptoms of menopause, such as hot flashes, night sweats, and vaginal dryness. NOTE - it is not 'menopause' if one has not gone a full twelve months without bleeding.

In most women going perimenopause, periods become erratic and irregular due to the wide fluctuations in hormone levels, which are not as constant and steady as when the ovaries were younger and worked more reliably.

Take time to learn about yourself

Because this part is super important

Introduction to perimenopause and early menopause

Perimenopause and early menopause can be a confusing and frustrating time for many women. It spans the time period when the ovarian reserve begins its fluctuating decline in the secretion of estrogen, up until the time when the ovaries no longer release any eggs (the primary source of estradiol, the main form of estrogen in a woman's body), resulting ultimately in the last menstrual period and entry into menopause.

Perimenopause is thus often referred to as the "transition period." Menopause, by contrast, is defined retrospectively when there has been no bleeding in one year.

For some women, perimenopause is the most concerning and difficult time, as hormones level swing from high to low during this period, and this can cause erratic bleeding patterns that are new and worrisome. It may also mean the beginning of hot flashes, night sweats, difficulty sleeping, changes in libido, vaginal dryness, and emotional liability.

Many women don't realize perimenopause can be considered separately from menopause, and there are options to help women get through this difficult period.

Just a note

A woman's life is guided by her reproductive cycle – but that does not mean her life has to be controlled by it.

Out of all the transitions the female body goes through, menopause may be the most important.

START JOURNALING NOW!

Journaling can tell you a lot about your body

WHY JOURNAL?

Each menopause transition is different. No two women experience menopause in the same way. Each woman brings a different and unique past medical history to the table. In addition, women have different goals and health priorities depending on their external environment and the demands placed upon them. Let's discover what's important to you.

WHEN SHOULD I START?

Start right now. It's never to early or too late to start. There is no one-size-fits-all. Whether menopause was five years ago (or more), or you think you may be in perimenopause, now is the right time to start. Take time now to reflect on how you got to this point, bathe in gratitude that you are taking time out to learn more about yourself, and treat yourself with the respect and care you deserve.

WHY IT IS IMPORTANT?

Journaling is going to give you and your health-care provider the best information to get you to where you want to go. It is the best way to ensure that treatment of your symptoms aligns with your health and lifestyle goals. Tracking can be tedious, but it is key in receiving the help that your body needs during this important time in your life. Take back your life by knowing what you need!

WHAT CAN I EXPECT?

Journaling is by far the best way to understand exactly what it is that you need. By tracking which symptoms bother you the most, and when they bother you the most, you and your doctor are going to be better prepared to tackle them head on - and treat the things that matter most to you.

HOW LONG WILL THIS TAKE?

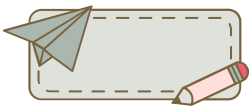
That really depends on how long it takes to get to your end goal: which should be to live your best life. Some women find that once they get into the habit of journaling, they continue long past feeling their best. It will be different for each person.

WHAT ARE MY OTHER OPTIONS?

You can use phone a app or an online version of journaling. As this is a workbook, I want to move you away from "remembering" to actually writing. So use whatever method works best for you.

TAKE IT A STEP FURTHER

Get involved. Stay updated and educated. Join a support group. Talk to your doctor. This journal is merely the place to get started on your journey. Learning about what you need first and seeking help is going to improve your life in so many ways. This workbook also contains many resources, where you can join others in the movement to make menopause matter!



YOUR MENOPAUSE JOURNAL

A QUICK GUIDE ON HOW TO STRUCTURE YOUR JOURNAL

I recommend getting a brand new colorful journal that you can handwrite in. But you can also use an app on your phone.

Don't overthink it - Just get started!

PERIODS/BLEEDING/SPOTTING

It is important to note when you get your periods (if you are still having periods). If you no longer get periods, then note any spotting or bleeding that you see. This can be from intercourse or a new medication, such as hormone therapy. It is important to track any bleeding/spotting and to tell your doctor about it.

SYMPTOMS

Write down any symptoms that are bothering you. This can include (but is not limited to) hot flashes, mood swings, night sweats, dizziness, low libido, or painful intercourse. Note, too, if you are experiencing what you feel is an atypical hormonally related symptom.

SLEEP

Track how many hours of sleep you are getting a night and how many times you wake up during the night. If sleep is a big concern, then also note what time you go to bed, what time you fall asleep, and what time you wake up. Note also how you feel upon waking up.

EXERCISE

Note briefly the days that you exercised.
What kind of exercise you did (for example, running, yoga). How long you exercised for. How you felt before and after.

TREATMENTS

Note the start date of any new treatment. This could be an over-the-counter supplement, or a medication prescribed by a doctor.
Write down the dose you are taking and what time of day you take this supplement or medication.

CALMING ACTIVITIES OR HOBBIES

Jot down any time you spend in new or existing calming activities, such as reading, meditation, gratitude, music, or art. Note how any of these activities make you feel. Notice if the activity has any effect on your most bothersome symptoms.

What's the difference between Perimenopause & Menopause?

Let's make this easy

The difference between perimenopause and menopause is that in perimenopause the ovarian tissue is still releasing some estrogen, but not as much as before entering this ‘transition period.'

One can be sure that they are in menopause when one has experienced a full twelve months without any bleeding, are over the age of 50, and have common menopausal symptoms. Other signs are a high level of follicle stimulating hormone (FSH) and a low estrogen level, particularly in a woman over the age of 51. At that point the ovarian reserve has mostly run out, and one is now approaching menopause.

It is often easier to make the diagnosis looking backwards, which can make the ‘here and now’ very frustrating for women.

A way to tell if one is in perimenopause is to make a menstrual calendar.

If there is consistent bleeding in any kind of pattern without a 12 month break, a women is likely still in perimenopause.

However, if a woman has had an endometrial ablation, or is on continuous hormonal contraception or has a Mirena IUD, menstrual patterns cannot be used.

In addition, some women may have polycystic ovarian syndrome (PCOS) and do not ovulate regularly. Such women may mistakenly think that their irregular periods are due to perimenopause.

Another important difference is that women can still become pregnant during perimenopause!

The body does incredible things, and even though the levels of estrogen and progesterone are declining, pregnancy is still possible. Contraception during this time is therefore important to avoid unplanned pregnancies; hormonal contraception can also help with erratic bleeding.

HOW DO I KNOW IF I AM IN PERIMENOPAUSE?

It's not as easy as it seems.

Perimenopause is often a clinical diagnosis, one that is best made by reviewing your gynecologic history and current symptoms.

Blood work can be drawn, but these values are often unhelpful, as hormone levels can swing from high to low and therefore do not tell the full picture.

A history of symptoms along with basic blood work is therefore the most helpful in determining a woman's status.

If a woman has had a hysterectomy or endometrial ablation but still has ovaries, she may experience hot flashes, night sweats, or vaginal dryness, and lab work is used as a marker because the menstrual history cannot be used.

HOW DO I KNOW IF I AM IN MENOPAUSE?

It's also not as easy as it seems.

Traditionally, menopause is defined as having gone 12 consecutive months without a period. At the same time, your lab work should show an elevated FSH level that is greater than 35 on two separate occasions. Your estradiol level would be very low, and would range from 0–20. I recommend only checking these two labs and making the diagnosis of menopause after one year of no bleeding, plus an elevated FSH. However many women do not follow the textbook.

Another helpful tool is to journal any changes happening in your life. Are you having hot flashes, night sweats, changes in mood (such as anxiety, depression, or irritability)? Symptoms with periods may be a sign of perimenopause. The more you journal, the better you will be able to help take control of your menopause transition.

3 THINGS THAT HELP YOU DETERMINE WHEN PERIMENOPAUSE BECOMES MENOPAUSE

- No periods in 12 months
- Elevation in FSH > 35 on two separate occasions, with low estradiol level (between 0–20)
- Classic symptoms such as hot flashes, night sweats, mood changes, vaginal dryness, painful intercourse, and others (continue reading!)

WHAT ARE THE MAJOR SYMPTOMS OF PERIMENOPAUSE AND EARLY MENOPAUSE?

ERRATIC BLEEDING

Periods can become irregular as ovarian reserves begin to decline. Periods can become both shorter or longer in frequency, and can be heavy with clots on occasion as hormone levels start to swing in adjustment to the lower than usual levels of estrogen and progesterone circulating in the body.

Some women may have very heavy bleeding that requires evaluation with an ultrasound or perhaps with an office-based endometrial biopsy, as it is important to rule out other causes of erratic bleeding – such as hormonal problems, infections, pre-cancerous lesions, or even endometrial cancer. Structural problems, such as fibroids and polyps, are one of the common causes of heavy bleeding during perimenopause. It is therefore important to seek advice from a medical provider if one's periods are heavy.

Loss of progesterone from the corpus luteum during perimenopause, which normally acts to protect the lining of the uterus (also called the endometrium) from excess build up, can further increase the amount of bleeding. Bleeding disorders should also be considered if no hormonal or anatomic reason for bleeding can be identified.

HOT FLASHES

One may start to experience hot flashes when the body's circulating level of estrogen fluctuates. As hormone levels swing, women may also experience night flashes and trouble sleeping, or a sensation of rapid heart rate or chills.

LOWER LIBIDO

After menopause, a woman is no longer capable of conception. The drive to conceive, also known as your libido, may thus start to decline during the transition as your hormone levels decrease.

VAGINAL DRYNESS

One of the most concentrated areas of estrogen receptors is in the lower one-third of the vagina. As hormone levels start to decline, one may start to experience vaginal dryness, which often translates into painful intercourse. This may trigger vaginismus, a condition in which there is an involuntary tightness or muscular spasm of the vaginal muscles when attempting vaginal intercourse.

MOOD CHANGES

Some women experience mood changes due to the wide swing in hormone levels, and the stress that these new symptoms can have on one's the mental, physical, and emotional life - termed emotional liability. Emotional changes may also stem from a decline in sleep quality.

Women predisposed to hormone-associated mood issues, such as post-partum depression, premenstrual syndrome, or premenstrual dysphoric disorder, should be aware that a prolonged perimenopause increases their risk of depressive symptoms.

WHAT TREATMENT OPTIONS ARE AVAILABLE FOR PERIMENOPAUSE?

Fortunately, there are treatment options.

What one qualifies for depends on a thorough medical history and determination of a woman's most bothersome symptoms.

A clinician will need to assess a woman's bleeding history to determine what workup and treatment options would be best. If bleeding is very heavy or associated with new clots, one may need an evaluation of their bleeding with further blood work, an up-to-date pap smear, an ultrasound, or, possibly, an endometrial biopsy.

In some cases low dose hormonal contraception – with either the pill, the patch, or the vaginal ring – are good options, as these stabilize hormone levels and control bleeding in healthy non-smokers who qualify for treatment.

Natazia, which contains bio-idential estradiol, is a hormonal contraceptive agent that is FDA approved to help treat abnormal uterine bleeding. Natazia also functions as contraception for the perimenopausal woman who does not desire pregnancy.

If one cannot take systemic hormones or chooses not to, a progestin IUD can stop bleeding and provide protection to the uterus with local progesterone if needed. This also functions as contraception.

PERIMENOPAUSE TREATMENT

CONTINUED...

Some women actually have very high levels of estrogen and need oral progesterone to help balance their hormones. A history and lab work helps to make this decision.

Other methods to stop erratic ovulation include Depo-Provera. These injections also function as hormonal contraception, without added estrogen.

With heavy bleeding, clots, or a history of fibroids, further definitive methods after a medical evaluation could include a more invasive endometrial ablation, or a procedure called a uterine fibroid embolization (UFE).

Invasive procedures, such as a myomectomy or a hysterectomy, are also options if all other medical treatments fail.

Non-hormonal options are available and include nonsteroidal anti-inflammatory drugs, or Lysteda – a prescription tranexamic acid approved for heavy bleeding in a woman not using hormonal contraception.

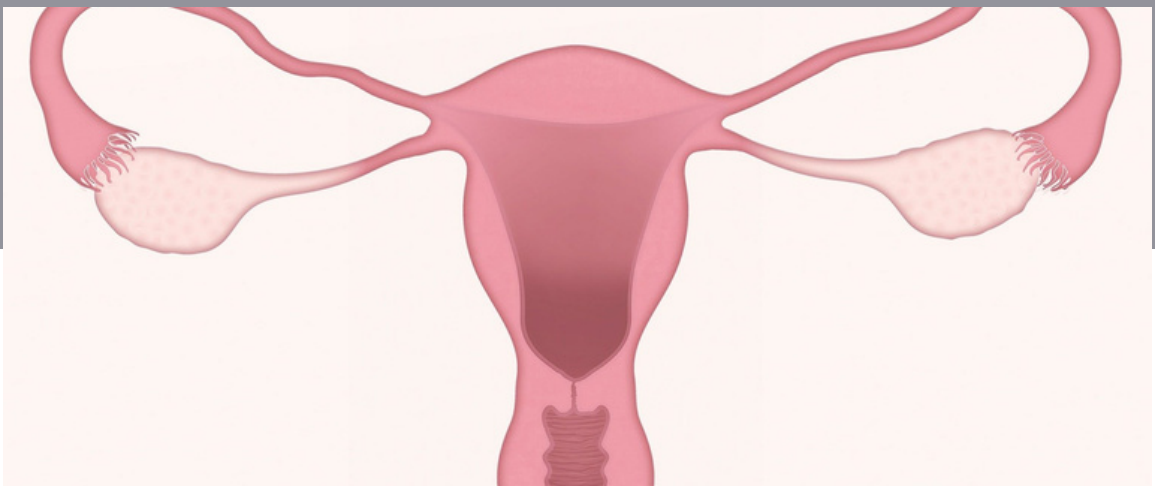
A 100 mg dose of oral thiamin B1 can be taken to help reduce painful cramping.

A low dose serotonin reuptake inhibitor called Brisdelle (or paroxetine 7.5 mg) has been FDA approved as a non-hormonal treatment for bothersome hot flashes for women not taking hormones.

There is no one-size-fits-all for either perimenopause or menopause. My advice is to work with your doctor to determine what is best for YOU.

Be sure to journal your symptoms.

Things to journal include periods/bleeding, hot flashes, sleep quality/quantity, mood, exercise and general food intake.



What treatment options are available for menopause?

There are numerous safe and effective FDA-approved treatments

There are numerous types and kinds of treatment for menopause, many of which I have listed in the Cheat-Sheet to your Doctor. You can jump to that section to see the different FDA-approved options one can try.

One of the most commonly asked questions is: "What are bioidentical hormones and are they safer?" Let me explain.

The term "BIOIDENTICAL" is actually just a slang term. It means the form of estrogen used in the product is estradiol. The good news is that there are plenty of FDA-approved estradiol products, if that is important to you. Premarin, a conjugated estrogen, is just as effective and safe in my opinion, but using the product depends on your personal preferences.

You want to make sure that any post-menopausal hormone therapy that you are prescribed is FDA approved and can be bought commercially (meaning at your local pharmacy). This will be much safer than non-FDA approved, compounded medications or pellet injections. Unregulated hormones are simply that, UNREGULATED. They are often promoted as being "safer," but that is simply not true.

Importantly, if you have an intact uterus you MUST take a progesterone combination for a minimum of 12 days of the month. If you do not have a uterus (you had it surgically removed) you DO NOT need to take a progesterone with your estrogen replacement.

No two women will experience menopause in the same way.

Each patient has a unique gynecologic, medical and surgical history.

Each woman has different health goals and priorities.

It's impossible to prescribe a "one-size-fits-all" approach to menopause.

Your Journal will be the key to understanding how to treat you best, helping your doctor to target the symptoms that matter the most to you.

Make sure you know the most common myths around hormone therapy so you can inform your health-care providers and health team.

PAST YOU

GRAB A PEN AND TAKE NOTES

Your first period:

Date of your last period:

Number of lifetime pregnancies:

Breastfeeding history:

Prior use of birth control and length of time used:

Pregnancy complications:

Current/Past Medical Conditions:

Surgeries: List any

Current medications: List any

CURRENT YOU

Reflect on what you are doing today

SLEEP
Average hours per night:

EXERCISE
Average minutes per week:

DIET
My diet comprises:

PERIODS
Frequency:
Length:

MOOD
Most day I feel:

SEX
My libido is:

I would like to have sex:

The top three things I would like to fix (in order of importance) are:

1.

2.

3.

(eg. 1. Constant fatigue 2. Irregular periods 3. My mid-belly weight gain)

A LETTER TO MY DOCTOR

From Heather Hirsch MD, MS, NCMP

From one doctor to another, thank you for taking your patient's menopause and midlife concerns seriously. If you are reading this, it is because your patient wants to talk to you about perimenopause or menopause, and I am writing this note directly to you to encourage you to become updated on menopause best practices.

Your patient likely found me via my website or through social media. Did you know that millions of women across the globe are forming support groups because they are so frustrated with the care they are currently receiving? My personal worry is that women are buying unregulated, unsafe non-FDA approved hormones when their own doctor discourages FDA-approved hormone therapy options.

As a North American Menopause Society (NAMS) certified physician, we know that the benefits of FDA-approved hormone therapy, started when a woman is less than ten years from menopause, outweigh the risks.

I would like to encourage you to re-train yourself on the use of FDA-approved hormone therapy by visiting my website www.heatherhirschmd.com, where I offer my course "The Complete Guide to Menopause" – which has helped many physicians, NPs and PAs. I also encourage you to learn about the safety of prescribing hormone therapy by reading the latest research articles and 2017 NAMS position statement listed below:

JoAnn V. Pinkerton. Hormone Therapy for Postmenopausal Women. NEJM. Jan 20th, 2020. 382:446-455. North American Menopause Society Position Statement, 2017.

The Meno-Pro mobile app is a great tool for clinicians to chose FDA-approved hormone therapy, and I have provided a list as well.

Finally, if you are still uncomfortable providing counseling on menopause, please help your patient find a NAMS doctor on www.menopause.org.

Heather Hirsch MD, MS, NCMPs

TO MY DOCTOR

I need help with menopause

Date:
My doctor:

Date of last period:
Other doctors:

OVERVIEW

MY TOP MENOPAUSE SYMPTOMS
I have listed my top three symptoms and how long they have been bothering me:

THE SCOPE
How much it's affecting my quality of life:

MY CIRCLE
Examples of it affecting those close to me:

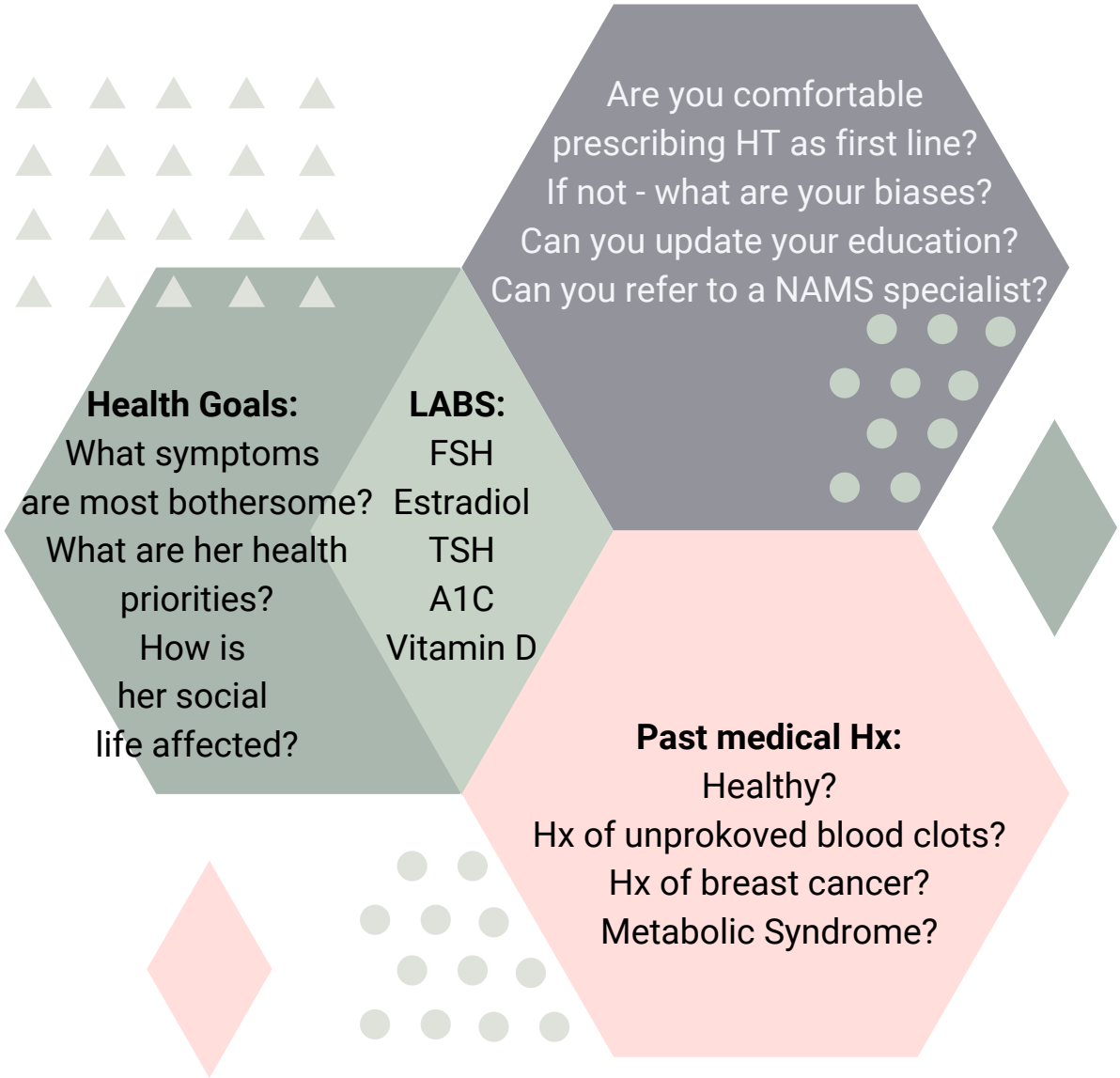
NARRATIVE
Here are some examples of how this is affecting my life:

ANALYSIS
Here is what I have tried in the past:

INSIGHTS
Here is what I am thinking of trying:

DECISION TREE

A woman should be viewed as a whole



INDIVIDUALIZATION IS KEY

What are the risks of NOT treating with HT if the woman has no known contraindications?

MEDICATIONS*

If a women has an intact uterus, she needs to take a progesterone with systemic estrogen.
If she does not have an intake uterus, there is no need for a progestin.
*Suggestions but not exhaustive list

Combined oral combinations: Good for mood-based symptoms, hair thinning, and those without metabolic syndrome.

- Premarin - start at 0.625/2.5 mg
- Mimvey - Lo
- Mimvey
- Activella
- Bijuvia

Separate estrogen and progesterone (add progesterone 100-200 mg daily with a separate estrogen to any oral or transdermal estrogen alone)

- Estradiol 0.5 mg twice daily (can go up to 1 mg twice daily) + Progesterone 100-200 mg nightly or days 1-12 of the month.
- Covaryx (estrogen + oral testosterone) + Progesterone 100-200 mg nightly or days 1-12 of the month.

Combined estrogen/progesterone patches: Good for those who forget to take medication or have metabolic syndrome.

- Combipatch
- Climara-Pro

Estrogen alone patches: Need to take progesterone if has intact uterus.

- Vivelle
- Climara (not Climara Pro)

FDA-approved transdermal estrogen therapy: Need to take progesterone if has intact uterus.

- Evamist
- Elestin

What are the local vaginal estrogen options? (NO NEED TO TAKE A PROGESTERONE WITH THESE AS THEY ARE ONLY LOCALLY EFFECTIVE)

Some women use only a vaginal estrogen for painful intercourse, and some use it in conjunction with a systemic estrogen if the vaginal tissue needs extra treatment. Options include:

- Vagifem
- Estrace vaginal cream
- Premarin vaginal cream
- Imvexxy vaginal suppository
- Prasterone suppository (DHEA)

COMMON QUESTIONS/SIDE EFFECTS

Use this **CHEAT-SHEET with your doctor** to help answer the most commonly asked questions after starting hormone therapy

I am bleeding on the new hormones that were prescribed to me. Why? Is this a problem?

This can be common, especially if you are recently into menopause. It can also be normal even if it has been years since your last period. This is because the uterine lining is being stimulated by the hormones you are taking. Often, it can mean the estrogen dose is too high, or the progesterone dose is too low. If bleeding is light, jot it down on a calendar. If bleeding is heavy, then stop the hormones and call your doctor. Try restarting at half the dose.

Why is my hormone therapy not helping?

Please give your medications at least 8-12 weeks, as it can take up to three months to see full effects. When you return to see your doctor he/she may change your dose. It might mean that the dose is too low or that the route is inappropriate for you. Please be patient, because finding the right medication type can sometimes take a few trials.

Why am I having side effects from nightly progesterone?

Sometimes progesterone can make women feel sleepy or irritated. If this is you, please let your doctor know.
This is uncommon but can be a side effect in a small percentage of women. Sometimes women do better on a topical progesterone or with the IUD.

Why am I noticing a change in my mood?

This can be normal for a short period of time. If it is truly affecting your life, please feel free to stop the medication and call your doctor's office. It can be helpful to journal your symptoms, and when they started in relation to the medications. At your next appointment your doctor might ask if there is any underlying mental health concern that may need to be addressed separately.

My estrogen level came back high and I am on postmenopausal hormone therapy. Is this normal?

The goal dose for most women on hormone replacement is around 50–100. If it is very high, this means we can likely try to decrease your dose and you will still feel just as well as you do currently.
Your doctor can check an estradiol level.

Why am I having trouble sleeping?

Here are some good sleep hygiene tips.

- Go to bed and wake up at the same time every day.
- Have a night-time routine. Keep the room cold and dark. Use white noise.
- Use the bed for sleep and sex only!
- Do not watch TV in your bed and remove the TV from the bedroom.
- Try adding 250-500 mg of magnesium oxide at bedtime and/or 10 mg of melatonin.
- Try a meditation app or bedtime app that you enjoy.