

MENOPAUSE UPDATES 2026

2026

What changed, what matters, and what can be done Monday

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Evidence current through September 13, 2026

TODAY'S PURPOSE

Learning objectives

- Describe the FDA hormone therapy labeling changes that now shape 2026 conversations
- Compare hormone therapy with the expanding nonhormone options for vasomotor symptoms
- Recognize genitourinary syndrome, bone loss, sexual concerns, and cardiovascular risk earlier
- Use a nursing workflow that improves assessment, education, safety monitoring, and referral

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AUDIENCE POLL

Opening case: “I want my life back”

52 years old

8–10 hot flashes daily
Wakes 3 times nightly
New vaginal dryness
Mother had breast cancer at 72

Which concern would you
address first?

- Sleep and vasomotor symptoms
- Breast cancer fear
- Genitourinary symptoms
- Cardiometabolic and bone risk

Keep your answer. We will revisit the case.

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The 2026 practice-changing headlines

- FDA-approved label revisions removed several boxed-warning statements from many menopausal hormone therapy products
- Elinzanetant joined fezolinetant as an FDA-approved neurokinin-targeted option for moderate to severe vasomotor symptoms
- Flibanserin eligibility expanded to women younger than 65 with acquired, generalized hypoactive sexual desire disorder
- The 2025 AUA/SUFU/AUGS GSM guideline now informs multidisciplinary practice
- Access, misinformation, and inconsistent symptom screening remain major clinical gaps

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Hormone therapy labeling: what changed in 2026

REMOVED OR REVISED

- Prominent language that generalized cardiovascular disease, breast cancer, and probable dementia risk across all users
- “Lowest dose for the shortest duration” framing

REMAINS CLINICALLY ESSENTIAL

- Individual assessment by age, time since menopause, route, formulation, dose, uterus status, and comorbidities
- Endometrial cancer warning for systemic estrogen without adequate progestogen in a patient with a uterus
- VTE, stroke, and other product-specific risks and contraindications

Label change improves accuracy. It does not make hormone therapy risk-free.

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Hormone Therapy

- Most effective treatment for bothersome vasomotor symptoms
- Prevents bone loss and fracture while used
- Improves genitourinary symptoms, although local vaginal therapy often targets GSM more directly
- Healthy symptomatic patients younger than 60 or within 10 years of menopause generally have a favorable benefit-risk profile
- Do not prescribe systemic hormone therapy solely to prevent coronary disease or dementia

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The prescription depends on the patient

Uterus?

Systemic estrogen requires endometrial protection unless a specific exception applies

Route?

Transdermal estradiol avoids first-pass hepatic effects and may suit patients with metabolic or thrombotic risk factors

Goal?

Treat the symptom burden. Reassess benefit, adverse effects, bleeding, and changing health risks

Age alone does not mandate discontinuation.

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Contraindications and red flags

- Unexplained vaginal bleeding needs evaluation before systemic therapy
- Known or suspected estrogen-sensitive malignancy requires oncology-informed decision-making
- Prior coronary disease, stroke, myocardial infarction, or venous thromboembolism changes the risk discussion
- Active liver disease may preclude systemic therapy and affects nonhormone drug choice
- New chest pain, focal neurologic symptoms, jaundice, or heavy bleeding needs urgent evaluation

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New nonhormone option: elinzanetant

NK1/NK3 receptor antagonist

- FDA approved October 24, 2025 for moderate to severe vasomotor symptoms due to menopause
- Taken at bedtime as two capsules, with dose adjustment for certain interacting medicines
- Adds another targeted choice when hormone therapy is unsuitable or unwanted
- Review the current prescribing information for contraindications, interactions, and adverse effects

Nursing focus

- Medication reconciliation
- Daytime somnolence and fall risk counseling
- Response and tolerability follow-up
- Clear expectations: symptom reduction, not cure

Fezolinetant: liver safety remains central

- FDA-approved nonhormone NK3 antagonist for moderate to severe vasomotor symptoms
- FDA added a boxed warning after rare but serious liver injury reports
- Obtain baseline hepatic laboratory tests and follow the current label monitoring schedule
- Teach patients to stop the drug and seek care for fatigue, nausea, pruritus, jaundice, dark urine, or right upper abdominal pain
- Check interactions and avoid casual “set it and forget it” refills

Evidence-based nonhormone choices

MEDICATIONS

- SSRIs and SNRIs
- Gabapentin
- Oxybutynin
- Fezolinetant
- Elinzanetant

BEHAVIORAL

- Clinical hypnosis
- Cognitive behavioral therapy
- Weight loss when appropriate

USE CAUTION

- Supplements with uncertain purity or efficacy
- Compounded “bioidentical” products when an approved option exists
- Testosterone pellets

Match choice to symptoms, comorbidities, interactions, cost, and patient preference.

GSM is chronic and often missed

- Ask directly about dryness, burning, irritation, dyspareunia, urinary urgency, dysuria, and recurrent urinary tract infection
- Patients may not connect urinary or sexual symptoms with menopause
- Symptoms usually persist or worsen without treatment, unlike many vasomotor symptoms
- First-line options include moisturizers and lubricants. Low-dose vaginal estrogen, vaginal DHEA, and oral ospemifene are evidence-based prescription options
- Low-dose vaginal estrogen has minimal systemic absorption and usually does not require a progestogen

Recurrent UTI: menopause belongs in the history

Clinical pattern	Practice implication
• Recurrent culture-confirmed infections • Urgency, dysuria, and irritation between infections • Vaginal dryness or dyspareunia	• Assess for GSM • Avoid repeated empiric antibiotics without culture when feasible • Discuss local low-dose vaginal estrogen for appropriate peri- and postmenopausal patients • Coordinate with primary care, gynecology, urology, and oncology as needed

Sexual health update: flibanserin

- FDA expanded the indication in December 2025 to include women younger than 65 with acquired, generalized hypoactive sexual desire disorder
- Diagnosis requires distress and exclusion of another medical condition, medication effect, relationship problem, or psychiatric condition as the primary cause
- Counsel about hypotension, syncope, central nervous system depression, alcohol timing, and drug interactions using the current label
- Treat coexisting GSM, pain, sleep disturbance, mood symptoms, and relationship factors

Bone health begins before the first fracture

Case finding	Nursing interventions
• Age and menopausal stage • Prior fragility fracture • Family history and low body weight • Glucocorticoids, rheumatoid arthritis, smoking, alcohol, falls	• DXA and FRAX follow-through • Progressive resistance and impact exercise as appropriate • Protein, calcium, vitamin D, and fall prevention counseling • Medication adherence and dental planning

A normal mammogram does not close the menopause visit. Bone and muscle need equal attention.

Dr. Michael McClung: prevent bone loss early

The prevention window	Prevention and maintenance
• Bone loss accelerates during late perimenopause and the early postmenopausal years • Risk assessment should begin before a fragility fracture or an osteoporosis-range T-score appears • Consider earlier DXA when clinical risk factors, premature menopause, rapid change, or secondary causes are present	• Address resistance and impact exercise, adequate protein, calcium, vitamin D, smoking, alcohol, and fall risk • Menopausal hormone therapy prevents bone loss and fracture in appropriate symptomatic candidates • Use fracture probability and the full clinical picture to guide bone-specific medication and follow-up

McClung’s central message: identify risk during the menopause transition and preserve bone before irreversible loss.

Osteoporosis and fragility fracture: 2022 definitions

Osteoporosis can be diagnosed by

- DXA T-score of -2.5 or lower at the femoral neck, total hip, lumbar spine, or 33% radius
- A hip or vertebral fracture, regardless of bone mineral density
- A proximal humerus, pelvis, or distal forearm fracture in a patient with osteopenia

Fragility fracture

- A fracture caused by low-energy trauma, typically a fall from standing height or less
- Common sites include the hip, vertebrae, distal forearm, proximal humerus, and pelvis
- A fracture after age 50 should trigger evaluation for osteoporosis and secondary causes
- The first fragility fracture is a warning “heart attack” for future fractures

A T-score alone does not define the whole disease. Fracture history and clinical risk can establish high-risk osteoporosis.

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Musculoskeletal syndrome of menopause

A connected clinical pattern

- Musculoskeletal pain and arthralgia
- Loss of lean muscle mass and strength
- Loss of bone density and higher fracture risk
- Tendon and ligament injury, adhesive capsulitis, and cartilage changes

Why we need to recognize it

- The review estimates that more than 70% experience musculoskeletal symptoms and 25% experience disability during the transition
- Ask about new pain, weakness, falls, function, exercise tolerance, and activity avoidance
- Support progressive resistance training, weight-bearing or impact activity when safe, adequate protein, and timely physical therapy or medical evaluation

New musculoskeletal symptoms deserve assessment. Menopause may contribute, but it does not exclude another diagnosis.

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Muscle is a menopause health outcome

- Ask about strength, falls, stair climbing, chair rise, activity decline, and unintentional weight change
- Preserve lean mass during weight loss, including GLP-1 therapy, with adequate protein and resistance training
- Exercise plans should include progressive resistance, balance work, and weight-bearing activity
- Refer when pain, frailty, neurologic symptoms, severe deconditioning, or fall risk limits safe exercise

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Cardiovascular risk accelerates at midlife

- Menopause visits create an opportunity to identify hypertension, dyslipidemia, diabetes, tobacco use, sleep apnea, and inactivity
- Premature menopause and adverse pregnancy outcomes may refine lifetime cardiovascular risk
- Hormone therapy treats symptoms. It does not replace statins, antihypertensives, diabetes care, or smoking cessation
- Coordinate risk reduction with primary care and cardiology when indicated

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Mood, sleep, cognition: validate and triage

Common contributors

- Vasomotor symptoms and fragmented sleep
- Depression, anxiety, grief, caregiving burden
- Sleep apnea, restless legs, thyroid disease, anemia
- Medication and substance effects

Urgent escalation

- Suicidal thoughts or inability to function
- Acute confusion or focal neurologic findings
- Mania, psychosis, or severe insomnia
- Safety concerns at home

“Brain fog” deserves assessment, not dismissal.

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Menopause care after cancer

- Clarify cancer type, receptor status, current therapy, recurrence risk, and the symptom that needs treatment
- Use nonhormone strategies first when systemic estrogen poses concern
- For persistent GSM, shared decision-making may include low-dose vaginal estrogen after nonprescription measures fail
- In patients taking aromatase inhibitors, involve oncology before vaginal estrogen
- Document the discussion and maintain surveillance appropriate to the cancer history

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Suggested screening questions

1. Cycle change or bleeding?
2. Hot flashes or night sweats?
3. Sleep and mood?
4. Vaginal, urinary, or sexual symptoms?
5. Fractures, falls, strength, or exercise?

6. Medication goals and biggest fear?

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Shared decision-making in plain language

- 1** Name the symptom and its effect on daily life
- 2** Compare realistic benefits, risks, and uncertainties for this patient
- 3** Choose a trial with a monitoring and follow-up plan
- 4** Revisit the decision as symptoms and health risks change

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Myth check

TRUE OR FALSE?

- All hormone therapy carries the same risk
- A uterus always requires progestogen with any vaginal estrogen
- Menopause hormone testing confirms the diagnosis in most women over 45
- GSM improves spontaneously with time
- Age 65 automatically means hormone therapy must stop

Answers: False • False • False • False • False

Case revisited: a coordinated plan

- Assess bleeding history, cardiovascular and VTE risks, migraine, liver disease, cancer history, medications, and patient priorities
- Explain that a maternal breast cancer diagnosis at 72 does not automatically exclude hormone therapy
- Discuss systemic hormone therapy and evidence-based nonhormone options for vasomotor symptoms
- Treat GSM directly and arrange follow-up
- Screen bone, cardiometabolic, mood, sleep, and sexual health needs
- Set a time-limited follow-up to assess benefit, adverse effects, bleeding, adherence, and questions

A practical follow-up schedule

START	Document baseline symptoms, blood pressure, relevant risks, medications, and safety labs
6–12 WEEKS	Review response, adverse effects, bleeding, adherence, interactions, and dose
ONGOING	Reassess goals and evolving risks. Continue age-appropriate preventive care

Earlier review when symptoms, bleeding, laboratory results, or safety concerns require it.

Resources worth bookmarking

- The Menopause Society: position statements, MenoNotes, clinician education, and certified practitioner directory
- FDA Drugs@FDA and Drug Safety Communications: current labels, approvals, and warnings
- ACOG: clinical guidance on menopause and GSM after estrogen-dependent breast cancer
- AUA/SUFU/AUGS: 2025 guideline on genitourinary syndrome of menopause
- USPSTF: osteoporosis screening recommendation

Use the live label and current guideline when prescribing or teaching.

Five take-home messages

- 2026 hormone therapy labeling is more individualized, while contraindications and monitoring still matter
- Neurokinin-targeted drugs expand nonhormone choices and bring new safety counseling needs
- GSM, recurrent UTI, sexual concerns, bone loss, and muscle decline deserve active screening
- Nurses improve care through direct questions, medication safety, clear education, and planned follow-up
- Credible resources protect patients from both undertreatment and misinformation

Questions and discussion

What will you change in your next menopause conversation?

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