

VASOMOTOR SYMPTOMS AS A VITAL SIGN

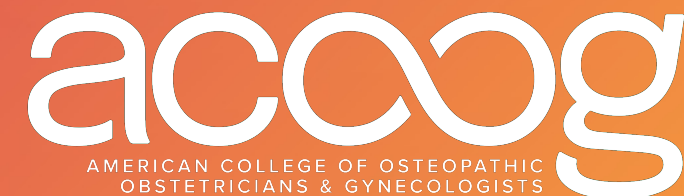
Building the Treatment Algorithm

Module 2: From Complaint to Prescription

Carolyn Moyers, DO, MS, FACOG, MSCP, IF

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Turning a symptom into a plan

- Module 1 made VMS a whole-health signal. Module 2 is the path from complaint to prescription.
- Hormone therapy remains the most effective treatment for VMS and prevents bone loss and fracture. [1]
- Nonhormonal options serve women who can't or prefer not to use it — and the menu just got better. [2]

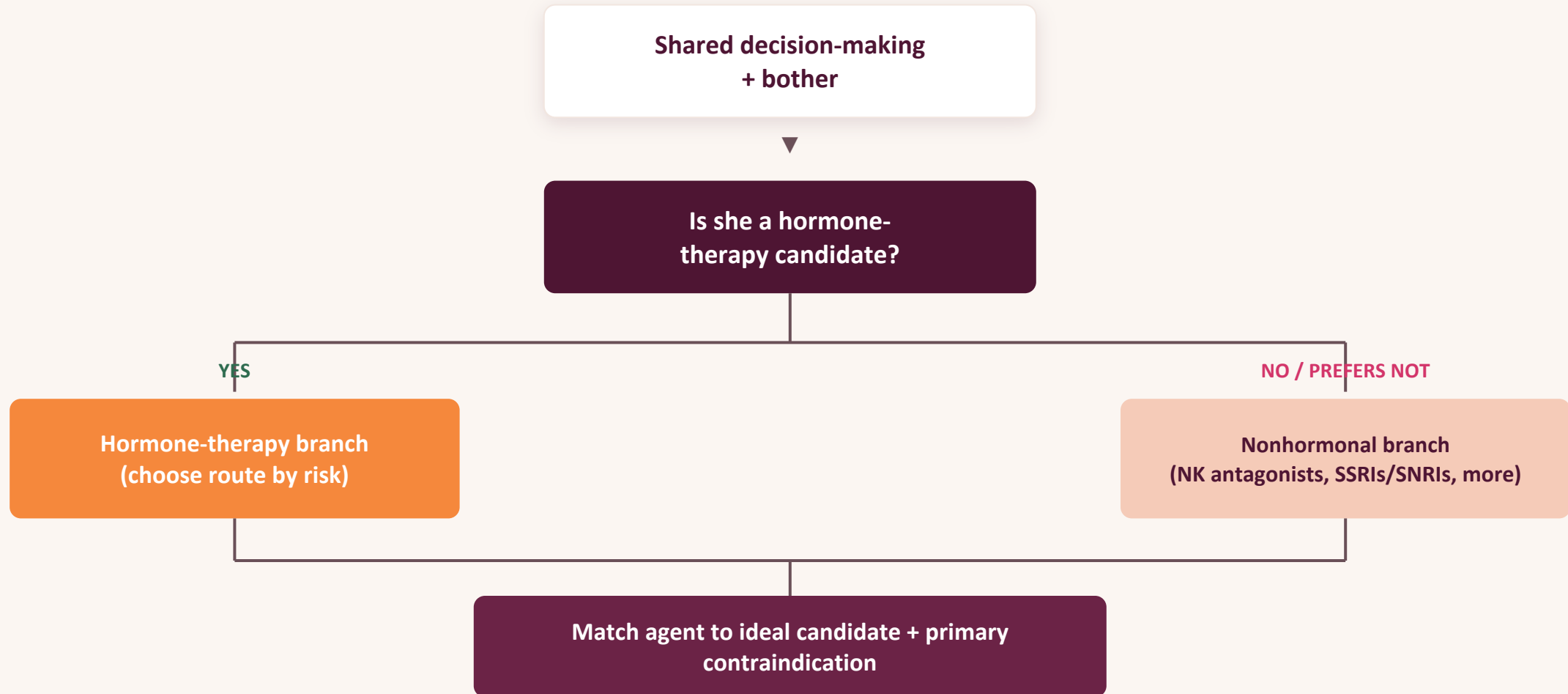
2022 HT Position Statement

- The hormone-therapy branch: candidacy, timing, route. [1]

2023 Nonhormone Statement

- The nonhormonal branch: what works, what doesn't. [2]

One question sends you down one of two branches



Where is she in the window?

- <60 or within 10 yrs of menopause onset, no contraindications → favorable benefit-risk for bothersome VMS + bone protection. [1]
- Beyond 60 or >10 yrs out → less favorable: greater absolute risks of CHD, stroke, VTE, dementia. [1]
- Risk-stratify by age and time since menopause; individualize; reevaluate. [1]
- Early menopause / POI: higher risk from estrogen deficiency — treat at least to the average age of menopause. [1]

<60 / <10 yrs

the window where benefits outweigh risks [1]

***The counseling isn't “good or bad” —
it's “where is she in the window, and
what's her risk profile?”***

Transdermal lowers risk — default to it when in doubt

- Transdermal routes and lower doses may decrease VTE and stroke risk — they avoid hepatic first-pass. [1]
- Favor transdermal with: VTE risk factors, diabetes, hypertension, hypertriglyceridemia, gallbladder disease.
- Transdermal preferable when libido is a concern — minimal SHBG effect preserves free testosterone. [1]
- Add a progestogen for endometrial protection if she has a uterus.

MYTH TO RETIRE

Migraine — even with aura — is not a contraindication to low-dose menopausal HT.

That's a combined-oral-contraceptive rule from old high-dose data. Continuous transdermal estradiol is preferred and considered safe in these patients.. [11]

Ideal candidate and primary contraindications

Ideal candidate	Primary contraindications
<i>*Estrogen-sensitive cancer is nuanced — depends on pathology, stage, grade, and treatment; a shared decision with oncology, not a blanket “never.”</i> <60 or within 10 yrs of FMP; bothersome moderate-to-severe VMS; also wants bone protection; no contraindications.	Estrogen-sensitive cancer (breast, endometrial)*; active or prior VTE; active liver disease; unexplained vaginal bleeding; prior MI or stroke; known thrombophilia.

What works — and what doesn't

Recommended

- SSRIs / SNRIs (Level I)
- Gabapentin (Level I)
- Fezolinetant — NK3 antagonist (Level I)
- CBT and clinical hypnosis (Level I)
- Oxybutynin (Level I–II)

Not recommended

- Supplements & herbal remedies
- Soy foods, soy extracts, equol
- Paced respiration; cooling techniques
- Clonidine; pregabalin
- ... the rest of the supplement aisle

The evidence-based / not-evidence-based line your patients most need drawn for them. [2]

NK receptor antagonists — pays off the KNDy mechanism

They block neurokinin B at KNDy-neuron receptors, restoring thermoregulation — nonhormonal and targeted (the Module 1 mechanism). [2]

Fezolinetant (NK3)

- First hormone-free approval (2023); effective for moderate-to-severe VMS. [3]
- Boxed warning (2024) for serious liver injury — check LFTs before and during early therapy. [4]

Elinzanetant (NK1/NK3)

- Approved 2025; dual antagonist. [5]
- NK1 action also improves menopause-related sleep; comparatively favorable liver profile. [5]

Ideal candidate: HT-contraindicated (e.g., breast cancer survivor) or HT-averse. Watch: hepatic monitoring, especially with fezolinetant.

One prescription, two problems

- Level I for VMS — and they treat comorbid mood and anxiety at the same time. [2]
- Low-dose paroxetine (7.5 mg) is the only FDA-approved agent in this class for VMS; venlafaxine, desvenlafaxine, escitalopram are effective off-label. [2, 6]
- Counsel on sexual side effects and weight — loops back to Module 1's sexual-health screening.

MEMORIZE THIS TRAP

Never pair paroxetine with tamoxifen.

Paroxetine is a strong CYP2D6 inhibitor — it blunts tamoxifen's active metabolite.

Gabapentin and oxybutynin

Gabapentin (~300 mg qhs, titrate)

- Level I; especially useful for nocturnal VMS and sleep. [2]
- Watch sedation and dizziness; adjust for renal function.

Oxybutynin (2.5–5 mg BID or ER)

- Level I–II; effective but anticholinergic. [2]
- Counsel on dry mouth, constipation, and the long-term cognitive/dementia signal with cumulative use.

Drawing the line on unproven supplements

- The 2023 statement does not recommend supplements and herbal remedies — black cohosh, soy foods and extracts, the metabolite equol — nor paced respiration or cooling techniques. [2]
- The objective in action: differentiate FDA-approved and evidence-based therapies from popular but unproven ones.
- Counsel honestly — acknowledge the appeal, then redirect to something that works.

The respect-plus-redirect

“I understand why you'd try that — here's what the evidence actually supports.”

Fill the grid before the reveal

Building the Treatment Algorithm · Module 2

Matched: class → candidate → contraindication → mood

Class (starting dose)	Ideal candidate	Primary contraindication	Mental-health consideration
Systemic HT — transdermal/oral (lowest effective dose)	<60 / within 10 yrs FMP; wants bone protection	Estrogen-sensitive cancer; VTE; active liver disease; unexplained bleeding	Perimenopausal window: may improve depressive symptoms [1]
NK antagonist — fezolinetant (NK3) / elinzanetant (NK1/3)	HT-contraindicated (e.g., breast Ca) or HT-averse	Hepatic impairment; fezolinetant needs LFT monitoring (boxed warning)	Neutral for mood; elinzanetant also improves sleep [3,4,5]
SSRI/SNRI — paroxetine 7.5 mg; venlafaxine 37.5–75 mg	VMS with comorbid mood or anxiety	Paroxetine + tamoxifen (CYP2D6)	Dual-purpose: treats mood; watch sexual side effects [2,6]
Gabapentin — ~300 mg qhs, titrate	Nocturnal VMS; sleep disruption	Sedation/dizziness; renal dosing	May aid sleep and anxiety; sedation [2]
Oxybutynin — 2.5–5 mg BID / ER	HT-averse; limited options	Anticholinergic; cognitive/dementia signal	Caution if cognitive concerns [2]
Supplements / herbals (black cohosh, soy, equol)	— (not recommended)	Insufficient evidence of benefit	No proven benefit [2]

What's your next step?

THE PATIENT

48-year-old, perimenopausal · estrogen-receptor-positive breast cancer, on tamoxifen · 9 moderate-to-severe hot flashes daily · disrupted sleep · not a hormone-therapy candidate.

- A** Low-dose paroxetine
- B** An NK receptor antagonist (fezolinetant or elinzanetant)
- C** Systemic transdermal estrogen therapy
- D** A soy isoflavone supplement

Don't forget GSM — chronic, progressive, undertreated

- GSM (vaginal dryness, dyspareunia, urgency, recurrent UTIs) doesn't resolve with time the way VMS can — yet it's badly undertreated.
- First-line when it's the main issue and OTC moisturizers aren't enough: low-dose vaginal estrogen — minimal systemic absorption, generally no progestogen needed. [1, 10]
- Alternatives: vaginal DHEA (prasterone) and oral ospemifene (a SERM) — both FDA-approved for dyspareunia. [1, 10]
- Its own session, really — but I can't treat the whole woman and skip a chronic, fixable problem.

Three options

Low-dose vaginal estrogen

Vaginal DHEA (prasterone)

Oral ospemifene (SERM)

And don't forget desire — HSDD and testosterone

- Both position statements are essentially silent on testosterone — a real gap in a whole-health framework.
- The 2019 Global Consensus Statement (ISSWSH + 10 societies) supports testosterone for postmenopausal HSDD — its only evidence-based indication — at physiologic doses. [7, 8]
- No FDA-approved female testosterone product: prescribe off-label at ~1/10th the male dose, target the premenopausal range, monitor. [7, 8]
- FDA-approved for premenopausal HSDD: flibanserin (daily) and bremelanotide (on-demand). [9]
- Its own lecture too — but VMS care can't ignore desire, which clusters with mood and metabolic health (Module 1).

Rational, whole-person prescribing

Tenet 4 — Rational treatment

A rational, individualized plan that weighs her whole risk profile — vascular, oncologic, hepatic, affective — rather than reflexively reaching for one therapy.

Tenet 2 — Self-regulation

The NK-antagonist class works by restoring the body's own thermoregulatory balance at the KNDy neuron — correcting a dysregulated set point rather than overriding it.

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Numbered to the in-slide citations

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