PREKURE CLINIC

THE PREKURE CLINIC APPROACH · MENOPAUSE

Menopause: lifestyle and hormone therapy

It's not just your age.

Menopause is a normal life stage, but for many women its symptoms are long-lasting and disruptive. PREKURE supports lifestyle care and menopausal hormone therapy (MHT) used together and chosen after an individual risk check. Long-term use is guided by an ongoing indication and a yearly review rather than an arbitrary time limit.

Professor Grant Schofield and Dr Jenni Hurling

The PREKURE Clinic · Lifestyle medicine · Metabolic medicine · Behavioural medicine · Clinically reviewed November 2026

PART 1

The PREKURE Clinic approach at a glance

Symptoms and impact. Every woman goes through menopause, and about three in four have symptoms (British Menopause Society survey). Symptoms often begin in perimenopause, the years before periods stop, so falling and fluctuating hormones can cause symptoms while women are still having periods, and MHT can help then too. About a quarter of women under 55 who are past menopause have moderate to severe hot flushes, and for many they last 7 years or more. Symptoms vary widely and can affect almost any part of the body: hot flushes and night sweats; brain fog; mood changes; vaginal dryness and more urinary infections; joint and muscle aches; tiredness and weight gain around the middle; poor sleep; and dry skin or thinning hair. They push some women out of work. In

a New Zealand survey, 28% of women with symptoms quit, changed jobs or cut their hours. Depression is 2 to 4 times more likely around the transition, especially in women who have had it before. Brain fog is common but usually settles after the transition (Gravelsins, Science 2026). Frequent flushes are linked to a higher risk of heart disease later, and menopause before 45 to higher heart disease and death rates. Bone loss also speeds up, and about 1 in 3 women over 50 will have a fracture caused by osteoporosis.

Hormone therapy. The main hormonal change in perimenopause and menopause is a fall in the oestrogen made by the ovaries, and in perimenopause levels also swing up and down. This drives most symptoms, which is why replacing oestrogen with menopausal hormone therapy (MHT) works. In women who still have a uterus, oestrogen on its own thickens the lining of the womb (endometrium) and raises the risk of endometrial cancer. We prescribe a progestogen alongside it to keep the lining thin and protect against that risk. MHT is the most effective treatment for hot flushes and night sweats, cutting them by about 75% compared with placebo, and it protects bone density while it is taken. Its risks depend on the type of MHT, the route, the woman's age and how long it is used. Oestrogen through the skin (patch or gel) does not detectably raise the risk of clots. Tablets do. Much of the fear about MHT dates from 2002, when the Women's Health Initiative trial tested one older type (horse oestrogen tablets with a progestogen called MPA) in women averaging 63, and its results were applied to all MHT. Type, route and age at starting all change the risks (Gravelsins, Science 2026).

How big the breast cancer risk is. Combined oestrogen and progestogen raises breast cancer risk slightly, and more the longer it is used. For women aged 50 to 59, combined MHT adds about 4 cases per 1,000 women over 5 years, on a background of about 23. By comparison, drinking two or more UK units of alcohol a day (16 g, about 1.5 NZ standard drinks) adds about 5, a BMI over 30 is linked to about 24 more, and 2.5 hours of moderate exercise a week is linked to about 7 fewer (Women's Health Concern, British Menopause Society). With micronised progesterone (Utrogestan), the progestogen we prefer, a large French study found little or no increase in the first 5 years, as did UK data for the similar progestogen dydrogesterone, although those data show a small increase with longer use. These are observational studies, so the difference between progestogens is not yet certain. Some extra risk continues for 10 years or more

after stopping, so the lifetime total is higher than the figure for the years of use (Part 2). For women who have had a hysterectomy and take oestrogen alone, any change is small. The largest trial found slightly fewer breast cancers, while observational studies found slightly more.

Breast cancer: how MHT compares with everyday factors

Extra or fewer cases per 1,000 women aged 50 to 59 over 5 years, against a background of about 23



Source: Women's Health Concern and the British Menopause Society, based on NICE 2015. These figures count cases while MHT is taken; some extra risk continues for 10 years or more after stopping (see Part 2).

MHT and length of life. For women who start MHT in their 50s or within 10 years of menopause, MHT does not shorten life and may lengthen it slightly. In trials of early starters, deaths from any cause were about 30% lower (Cochrane 2015, moderate-quality evidence). In the Women's Health Initiative, women aged 50 to 59 had about 5 fewer deaths per 1,000 over 5 years (Manson, JAMA 2013). Over 5 years, about 17 or 18 in every 1,000 women in their 50s die from any cause. On that scale, by our arithmetic from published relative risks, smoking adds roughly 30 deaths per 1,000 and a BMI of 30 to 35 about 8, while early MHT and 150 minutes of moderate activity a week each mean about 5 fewer. In years of life, smoking costs women at least 10 years (Pirie, Lancet 2013), a BMI of 30 to 35 costs 2 to 4 years (Prospective Studies Collaboration, Lancet 2009), drinking more than 35 NZ standard drinks a week (350 g of alcohol) costs 4 to 5 years (Wood, Lancet 2018), and 150 minutes of brisk walking a week adds about 3.4 years (Moore, PLoS Med 2012). No reliable years-of-life estimate exists for MHT.

Deaths from any cause: how early MHT compares

Extra or fewer deaths per 1,000 women aged 50 to 59 over 5 years, against a background of about 17 or 18



Our arithmetic: published relative risks (smoking 2.76, Pirie 2013; BMI 30 to 35, 1.45, Global BMI Mortality Collaboration 2016; early MHT 0.70, Cochrane 2015, matching about 5 fewer per 1,000 in women aged 50 to 59 in the Women's Health Initiative; activity 0.69, Arem 2015) applied to the death rate of women aged 50 to 59 in the Women's Health Initiative placebo groups. Observational for smoking, weight and activity; moderate-quality trial evidence for MHT. Figures are approximate.

Heart and other effects. Started after 60 or more than 10 years after menopause, MHT raises the risk of stroke and clots and does not protect the heart. Started earlier, it does not appear to raise heart disease risk and may lower it. However, clot risk still rises with tablets and stroke risk is not reduced. Both risks are lowest with patches or gel. MHT also lowers the risk of type 2 diabetes. Possible effects on bowel cancer and dementia are uncertain, and MHT is not used to prevent either.

Lifestyle and behavioural care. CBT and clinical hypnosis reduce how much flushes bother women, and weight loss helps some. Exercise does not reduce flushes. Strength and impact training improves bone density, reducing the risk of osteoporosis. Activity also protects heart, mood and sleep. Lifestyle care helps less than MHT for flushes and more for long-term health, which is why we use both.

How long. Current guidance sets no arbitrary limit. Use should match an ongoing indication, be reviewed every year, and come with clear information that breast cancer risk rises with duration and that some extra risk lasts 10 years or more after stopping (Collaborative Group, Lancet 2019). MHT is not for primary prevention of heart disease or dementia.

Our stance

1. Menopause is a life stage, not a disease, but symptoms that affect quality of life warrant effective treatment.
2. Lifestyle care and hormone therapy work together rather than as alternatives.
3. MHT is first-line for bothersome hot flushes and night sweats in most women under 60 or within 10 years of menopause, after an individual risk check.
4. We prefer oestradiol through the skin, with a progestogen for every woman who has a uterus.
5. Long-term use is reasonable when there is an ongoing reason and a yearly review, and women are told how breast cancer and cardiovascular risks change with age and time.
6. We do not use MHT to prevent heart disease or dementia, or testosterone for mood or energy.
7. Every woman gets lifestyle support for bone, muscle, heart, sleep and mood, with or without MHT.

PART 2 · THE EVIDENCE

Why menopause symptoms matter

Menopause symptoms affect quality of life, mental health and work for years, and the transition marks a shift in long-term heart and bone risk. The heart and fracture findings are observational.

Measure	Finding	Source
Heart disease and hot flushes	Frequent flushes linked to 51% higher later cardiovascular events, and persistent frequent flushes to 77% higher	Thurston, J Am Heart Assoc 2021

Measure	Finding	Source
Early menopause	Menopause before 40 linked to 55% higher cardiovascular risk; before 45 to 50% higher coronary heart disease and 12% higher death rates	Zhu, Lancet Public Health 2019; Muka, JAMA Cardiol 2016
Bone	About 1 in 3 women over 50 will have an osteoporotic fracture; up to 1 in 5 die in the year after a hip fracture	International Osteoporosis Foundation
WHAT TREATMENT CHANGES		
Symptoms	MHT cuts hot flushes by about 75% compared with placebo	Cochrane 2004
Bone	MHT reduces fractures while taken; strength and impact training raises spine bone density	Cochrane 2017; LIFTMOR 2018

Menopause is also a useful moment to check blood pressure, lipids, glucose and bone health, because risks rise in the years that follow.

Menopause and who it affects

Symptoms are common, often last for years, and affect work and mental health as well as comfort.

Measure	Finding	Source
How long hot flushes and night sweats last	Median 7.4 years overall; 4.5 years after the final period; over 11.8 years if they start before periods stop	SWAN, JAMA Intern Med 2015
Moderate to severe flushes	28.5% of postmenopausal women under 55; 15.1% at 55 to 59; 6.5% at 60 to 65 (Australia)	Gartoulla, Menopause 2015
Vaginal and urinary symptoms (genitourinary syndrome)	27 to 84% of postmenopausal women	Menopause Society 2020

Measure	Finding	Source
Depression	Major depressive episodes 2 to 4 times more likely around the transition	Bromberger, Psychol Med 2011
Work impact in New Zealand	28% of women with symptoms quit, changed jobs or cut hours; only 22% told their GP about the effect on work	NZIER 2023

In the NZIER survey (an online panel, not a random sample), Māori women reported more fatigue (74% against 60%) and brain fog (67% against 56%), and were more often offered sleeping pills or antidepressants (42% against 29%). That points to unequal care as well as unequal symptoms.

Placebo matters in this field. In hot flush trials, placebo groups improved by about 58%. Personal stories of a remedy that "worked for me" are weak evidence on their own.

Lifestyle and behavioural approaches

Behavioural treatments reduce how much symptoms bother women, and exercise builds long-term health, but none matches MHT for cutting the number of hot flushes.

Approach	What it does	Evidence
CBT for menopause	Cut the problem rating of flushes and night sweats by about 2 points on a 10-point scale at 6 weeks. Self-help CBT worked almost as well. NICE recommends it, including alongside MHT	Moderate (MENOS 2, Menopause 2012; NICE NG23)
Clinical hypnosis	Flushes fell 74% against 17% with a control (187 women)	Moderate, one main trial (Elkins, Menopause 2013)
Weight loss	Women who lost weight were more than twice as likely to improve; losing 10% or more of body weight raised the chance of symptoms disappearing	Moderate (Huang, Arch Intern Med 2010; Kroenke, Menopause 2012)

Approach	What it does	Evidence
Exercise	No effect on hot flushes	Low quality (Cochrane 2014)
Heavy resistance and impact training	Spine bone density rose 2.9% against a 1.2% fall in controls over 8 months, safely	Moderate (LIFTMOR, J Bone Miner Res 2018)
Low-fat vegan diet with soybeans	Moderate to severe flushes fell 88% against 34%	Low: small, unblinded, no independent replication (Barnard, Menopause 2023)
Phytoestrogens and herbal products	Red clover no effect; weak signal for higher-dose genistein; product quality uncertain	Low (Cochrane 2013)
Stopping smoking	Smokers are 1.6 times as likely to have moderate to severe flushes	Observational

The case for lifestyle care in menopause is strongest for long-term health, including bone, muscle, heart, metabolic health, sleep and mood over the decades ahead. Strength training, protein, alcohol reduction, sleep and weight management belong in every woman's plan.

Hormone therapy: benefits, harms and how long to use it

MHT works well for symptoms and bone. Its main risks are breast cancer with combined therapy (rising with duration), and clots and stroke with oral oestrogen. Absolute risks are lower in women in their 50s than the trial averages below, which include women up to 79.

Out of 1,000 women	Change with MHT	Time	Source
Hot flush frequency	About 75% fewer than placebo (placebo itself cut flushes by about 58%)	3 months to 3 years	Cochrane 2004
Any fracture (combined MHT)	111 fall to 79 to 96	5.6 years	Cochrane 2017

Out of 1,000 women	Change with MHT	Time	Source
Hip fracture	About 2.5 to 3 fewer	5 years	WHI (2002; 2004)
Type 2 diabetes (combined MHT)	About 7 fewer	5.6 years	Margolis, Diabetologia 2004
Breast cancer, oestrogen plus daily progestogen, 5 years from age 50	20 more (on a background of 63)	Ages 50 to 69	Collaborative Group, Lancet 2019
Same, 10 years of use	About 40 more	Ages 50 to 69	Same
Breast cancer, oestrogen plus intermittent progestogen, 5 years	14 more	Ages 50 to 69	Same
Breast cancer, oestradiol plus micronised progesterone or dydrogesterone	No clear increase with under 5 years of use; small increase with longer dydrogesterone use (observational)	Under 5 years	Fournier, Breast Cancer Res Treat 2008; Vinogradova, BMJ 2020
Breast cancer, oestrogen only, 5 years (observational)	5 more	Ages 50 to 69	Same
Breast cancer, oestrogen only, randomised trial (women after hysterectomy)	Fewer: breast cancer hazard ratio 0.78, breast cancer deaths 0.60	About 7 years of use, 20 years of follow-up	WHI; Chlebowski, JAMA 2020
Blood clots, oral MHT	About 2.5 more at 40 to 54; 7.5 more at 55 to 64	5 years	Vinogradova, BMJ 2019

Out of 1,000 women	Change with MHT	Time	Source
Blood clots, patch or gel	No detectable increase	5 years	Same
Stroke	About 4 more (combined) and 6 more (oestrogen only); low-dose patches showed no clear increase	5 years, ages 50 to 79	WHI; Renoux, BMJ 2010
Death from any cause, women aged 50 to 59 at the start	About 5 fewer (hazard ratio about 0.7 in both trials, not statistically significant on its own); across all ages, no change in deaths over 18 years	5 to 7 years of use	WHI; Manson, JAMA 2013 and 2017
Heart disease and death, started within 10 years of menopause	Deaths 30% lower and coronary heart disease 48% lower (moderate-quality evidence); stroke not reduced; clots 74% higher	Trial durations	Cochrane 2015
Heart disease and stroke, started more than 10 years after menopause	No effect on deaths or heart disease; stroke 21% higher; clots about twice as common	Trial durations	Cochrane 2015
Dementia, combined MHT started at 65 or over	About 9 more	4 years	WHIMS, JAMA 2003
Dementia, combined MHT started earlier	Uncertain: a Danish registry study linked combined MHT to 24% more dementia, even when started at 55 or younger; observational, so confounding is possible	Up to 18 years	Pourhadi, BMJ 2023

Out of 1,000 women	Change with MHT	Time	Source
Bowel cancer (combined MHT)	Fewer diagnosed (hazard ratio 0.72), but found at a later stage, with no fewer deaths; authors found no meaningful benefit	5.6 years of use, with long-term follow-up	WHI; Simon, J Clin Oncol 2012
Gallbladder disease (combined MHT)	27 rise to 38 to 60	5.6 years	Cochrane 2017

Other points. About half the extra breast cancers appear after stopping, and the risk lasts at least 10 years. We prefer micronised progesterone because of the observational data in the table, although NICE treats the difference between progestogens as uncertain. Women with a uterus need a progestogen, because oestrogen alone raises endometrial cancer risk sharply with time. A hormonal coil (Mirena) is another way to protect the womb lining. It is approved in New Zealand for this for 5 years, provides contraception and suits women with heavy or irregular bleeding. Much less progestogen reaches the bloodstream than with tablets, but its effect on breast cancer risk when used with MHT is not established, and some observational studies suggest a small increase (Medsafe data sheet; Zürcher, Arch Gynecol Obstet 2023). In the Women's Health Initiative, MHT did not change death rates overall over 18 years (Manson, JAMA 2017). Vaginal oestrogen relieves dryness and urinary symptoms with no breast cancer excess seen. Testosterone helps only distressing low sexual desire, not energy or mood (Global Consensus 2019).

How long to use it. NICE (updated April 2026) says to discuss duration at the start and at every review, review at 3 months and then yearly, and not to offer MHT to prevent heart disease. The Menopause Society (2022) says MHT does not need to be stopped routinely at 60 or 65 if there is a documented reason and regular review (Menopause 2022). The British Menopause Society and bpacnz reject arbitrary time limits. Tapering and stopping abruptly give the same long-term result. In November 2025 the US FDA removed most boxed warnings from MHT labels. The absolute risk numbers above have not changed.

Our view. Long-term use is reasonable when there is an ongoing reason, oestrogen is given through the skin where possible, and the woman understands

that breast cancer risk with combined MHT keeps rising with time. "Probably OK indefinitely" goes further than the evidence.

Non-hormonal options, New Zealand access and cost

Non-hormonal medicines help women who cannot or prefer not to use MHT, although they help less than MHT does. Most MHT products are fully funded in New Zealand, but supply has been unreliable.

Option	Fewer hot flushes per day than placebo	Notes	Source
Elinzanetant	About 3.2	Newer; NZ approval not confirmed	OASIS 1 and 2, JAMA 2024
Fezolinetant	About 2.4 to 2.6	Rare serious liver injury: liver tests needed; NZ approval not confirmed	SKYLIGHT 1, Lancet 2023; FDA warning 2024
Gabapentin	About 2	Older, lower-quality trials	Nelson, JAMA 2006
Venlafaxine	About 1.8	In the same trial, low-dose oestradiol cut flushes by about 2.3 a day	Joffe, JAMA Intern Med 2014
SSRIs and SNRIs	About 1.1	NICE: not first-line for flushes alone	Nelson, JAMA 2006
Clonidine	About 1	Not recommended by the Menopause Society	Nelson, JAMA 2006

For comparison, MHT cuts flushes by about 75%.

Funding in New Zealand (Pharmac Schedule, November 2026). Fully funded: Estrogel, oestradiol patches (two brands), Progynova tablets, Utrogestan (micronised progesterone), Mirena and Ovestin vaginal oestriol. Estrofem tablets carry a part-charge of about $7 per pack. Progesterone has been funded for any use since December 2022 (Pharmac).

Supply. A global oestradiol patch shortage led Pharmac to fund a second brand from December 2025, and progesterone was dispensed one month at a time from

May 2026 (1News). Check current Pharmac notices before relying on a product.

What to avoid. Compounded "bioidentical" hormone creams and pellets are not regulated for dose or purity and are not recommended. Testosterone pellets and injections are also not recommended for women.

Equity. GP fees and prescription charges are a barrier for some women, and Māori women were more often offered sleeping pills or antidepressants (above). The PREKURE Clinic assessment asks directly about menopause in women aged 40 to 60.

Weighing it up: the PREKURE Clinic approach

Whether MHT is right is a personal decision that depends on symptoms, age, time since menopause, personal and family history, and what matters most to each woman.

Situation	Balance of benefit and risk
Under 60 or within 10 years of menopause, bothersome symptoms	Usually favourable, especially with oestradiol through the skin
Menopause before 45, including after surgery	Hormone therapy usually recommended until at least about 51, the average age of menopause, unless there is a reason not to
Starting over 60 or more than 10 years after menopause	More caution: higher clot, stroke and dementia risks; individual decision
Past breast cancer, clots, stroke or active liver disease	Usually non-hormonal options; specialist advice
No symptoms, wanting to prevent disease	Not recommended for heart disease or dementia prevention
Vaginal dryness or urinary symptoms only	Vaginal oestrogen is effective with very low risk

Questions to ask: How much are my symptoms affecting my life? What is my own breast, clot and heart risk? Which type and route suit me? How will we decide each year whether to continue? What can I do alongside MHT for bone, heart and sleep?

What the PREKURE Clinic does

1. **Medical assessment** with a lifestyle-medicine-trained doctor: symptoms, personal and family history, reproductive history (past depression, severe premenstrual symptoms, pregnancy complications, and the age and type of menopause), blood pressure, and a breast, clot and cardiovascular risk check.
2. **MHT where suitable,** with oestradiol through the skin preferred and a progestogen (micronised progesterone or a Mirena coil) for women with a uterus, prescribed directly or in partnership with the woman's GP.
3. **A matched PREKURE health coach** for strength and impact training, protein, alcohol, sleep, weight and CBT-based tools for flushes and sleep.
4. **Support at work and home,** including how to talk to employers.
5. **Review at 3 months, then yearly,** reassessing reason, dose, route and risk.
6. **Outcome tracking** of symptoms, sleep, strength and wellbeing.

What PREKURE will not claim: that MHT is risk-free or right for everyone; that it prevents heart disease or dementia; that compounded or "bioidentical" products are safer; that testosterone improves energy or mood; that genetic tests can choose the right MHT; or that lifestyle alone will control severe flushes for most women.

PREKURE™ CLINIC

Lifestyle medicine · Metabolic medicine · Behavioural medicine. Online, anywhere in New Zealand.

This page is general information based on published evidence as at November 2026. It is not personal medical advice. Talk with your doctor or a PREKURE Doctor about what is right for you.

© PREKURE 2026

Selected references

Figures were checked against primary sources on 30 October 2026. "Per 1,000" figures are our arithmetic from published rates. Not yet confirmed: Medsafe approval status of fezolinetant and elinzanetant, and current GP and prescription costs.

Symptoms and burden

- Avis NE et al. SWAN symptom duration. JAMA Intern Med 2015. doi:10.1001/jamainternmed.2014.8063
- Gartoulla P et al. Moderate to severe symptoms. Menopause 2015. doi:10.1097/gme.0000000000000383
- NZIER. The silent transition: menopause in NZ workplaces. 2023. Report

Hormone therapy

- Collaborative Group on Hormonal Factors in Breast Cancer. Lancet 2019. doi:10.1016/S0140-6736(19)31709-X
- Vinogradova Y et al. MHT and blood clots. BMJ 2019. doi:10.1136/bmj.k4810; breast cancer, BMJ 2020. doi:10.1136/bmj.m3873
- Marjoribanks J et al. Long-term MHT. Cochrane 2017. doi:10.1002/14651858.CD004143.pub5
- Manson JE et al. WHI 18-year mortality. JAMA 2017. doi:10.1001/jama.2017.11217; WHI overview, JAMA 2013. doi:10.1001/jama.2013.278040
- Renoux C et al. Transdermal oestrogen and stroke. BMJ 2010. doi:10.1136/bmj.c2519
- Davis SR et al. Global Consensus on testosterone for women. J Clin Endocrinol Metab 2019. doi:10.1210/jc.2019-01603
- The Menopause Society. Hormone therapy position statement. Menopause 2022. doi:10.1097/gme.0000000000002028
- NICE NG23, Menopause (updated 2026). Recommendations
- bpacnz. Menopausal hormone therapy, 2019. PDF
- ESHRE, ASRM, CRE-WHiRL and IMS Guideline Group on POI. Premature ovarian insufficiency guideline. Hum Reprod Open 2024. doi:10.1093/hropen/hoae065
- Gravelsins LL et al. Reframing menopause and menopause hormone therapy as opportunities for healthy aging. Science 2026. doi:10.1126/science.aeg5004
- Medsafe. Mirena data sheet (endometrial protection during oestrogen replacement therapy). Data sheet
- Zürcher A et al. Influence of the levonorgestrel-releasing intrauterine system on the risk of breast cancer: a systematic review. Arch Gynecol Obstet 2023. doi:10.1007/s00404-022-06640-y

Breast cancer, heart and other outcomes (added after clinical review)

- Women's Health Concern (British Menopause Society). Understanding the risks of breast cancer. 2017. PDF
- Chlebowski RT et al. WHI breast cancer incidence and mortality, long-term follow-up. JAMA 2020. doi:10.1001/jama.2020.9482
- Fournier A et al. E3N cohort: breast cancer risk by type of HRT. Breast Cancer Res Treat 2008. doi:10.1007/s10549-007-9523-x
- Boardman HMP et al. Hormone therapy for preventing cardiovascular disease. Cochrane 2015. doi:10.1002/14651858.CD002229.pub4

- Pourhadi N et al. MHT and dementia, Danish nested case-control study. BMJ 2023. doi:10.1136/bmj-2022-072770
- Simon MS et al. Oestrogen plus progestin and colorectal cancer, WHI. J Clin Oncol 2012. doi:10.1200/JCO.2012.42.7732
- British Menopause Society. National survey infographic. 2017. PDF

Living longer: deaths and years of life

- Manson JE et al. WHI intervention and post-stopping phases. JAMA 2013. doi:10.1001/jama.2013.278040
- Pirie K et al. Smoking and stopping: one million women in the UK. Lancet 2013. doi:10.1016/S0140-6736(12)61720-6
- Prospective Studies Collaboration. BMI and mortality in 900,000 adults. Lancet 2009. doi:10.1016/S0140-6736(09)60318-4
- Global BMI Mortality Collaboration. BMI and all-cause mortality. Lancet 2016. doi:10.1016/S0140-6736(16)30175-1
- Wood AM et al. Risk thresholds for alcohol consumption. Lancet 2018. doi:10.1016/S0140-6736(18)30134-X
- Arem H et al. Leisure-time physical activity and mortality. JAMA Intern Med 2015. doi:10.1001/jamainternmed.2015.0533
- Moore SC et al. Physical activity and life expectancy. PLoS Med 2012. doi:10.1371/journal.pmed.1001335

Non-hormonal and lifestyle

- Lederman S et al. SKYLIGHT 1 (fezolinetant). Lancet 2023. doi:10.1016/S0140-6736(23)00085-5
- Pinkerton JV et al. OASIS 1 and 2 (elinzanetant). JAMA 2024. doi:10.1001/jama.2024.14618
- Ayers B et al. MENOS 2 (CBT). Menopause 2012. doi:10.1097/gme.0b013e31823fe835
- Elkins GR et al. Clinical hypnosis. Menopause 2013. doi:10.1097/gme.0b013e31826ce3ed
- Daley A et al. Exercise for vasomotor symptoms. Cochrane 2014. doi:10.1002/14651858.CD006108.pub4
- Watson SL et al. LIFTMOR. J Bone Miner Res 2018. doi:10.1002/jbmr.3284
- Huang AJ et al. Weight loss and hot flushes. Arch Intern Med 2010. doi:10.1001/archinternmed.2010.162

New Zealand

- Pharmac: progesterone access decision 2022; Schedule Online