



## Complete Summary

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### GUIDELINE TITLE

Clinical challenges of perimenopause: consensus opinion of The North American Menopause Society.

### BIBLIOGRAPHIC SOURCE(S)

Clinical challenges of perimenopause: consensus opinion of The North American Menopause Society. Menopause 2000 Jan-Feb;7(1):5-13. [68 references]

## COMPLETE SUMMARY CONTENT

- SCOPE
- METHODOLOGY - including Rating Scheme and Cost Analysis
- RECOMMENDATIONS
- EVIDENCE SUPPORTING THE RECOMMENDATIONS
- BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
- QUALIFYING STATEMENTS
- IMPLEMENTATION OF THE GUIDELINE
- INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
- IDENTIFYING INFORMATION AND AVAILABILITY

## SCOPE

### DISEASE/CONDITION(S)

Perimenopause

### GUIDELINE CATEGORY

Counseling  
Diagnosis  
Evaluation  
Management  
Prevention  
Screening  
Treatment

### CLINICAL SPECIALTY

Endocrinology  
Internal Medicine  
Obstetrics and Gynecology

## INTENDED USERS

Advanced Practice Nurses  
Allied Health Personnel  
Health Care Providers  
Health Plans  
Managed Care Organizations  
Nurses  
Physician Assistants  
Physicians

## GUIDELINE OBJECTIVE(S)

To maintain or improve the perimenopausal woman's health and quality of life through preventive care, lifestyle modification, early diagnosis of disease or increased risk for disease, and interventions when appropriate.

## TARGET POPULATION

Perimenopausal women in North America

## INTERVENTIONS AND PRACTICES CONSIDERED

### Screening/Diagnosis

1. Assessment of acute perimenopausal symptoms (vasomotor symptoms, sleep disturbances, genitourinary effects)
2. Laboratory testing of serum and hormonal levels (estrogen, follicle-stimulating hormone levels, inhibin levels, estradiol, luteinizing hormone levels)
3. Assessment for and evaluation of abnormal uterine bleeding (history and physical examination plus one or more of the following procedures: endometrial biopsy, office aspiration curettage, dilation and curettage, saline sonohysterography, hysteroscopy, or transvaginal ultrasound)
4. Assessment for and evaluation of amenorrhea (pregnancy testing; follicle-stimulating hormone levels; presence of excessive dieting or exercising)
5. Screening for thyroid dysfunction (thyroid-stimulating hormone level assay)
6. Assessment for and evaluation of symptoms of premenstrual syndrome (age of onset, timing of symptoms)
7. Annual health examination for the perimenopausal woman, to include the following:
  - Complete medical and personal histories (especially for cardiovascular disease, osteoporosis, cancer, health status, diet/nutritional assessment, and physical activity)
  - Complete physical examination, including breast, pelvic, and rectovaginal examinations as well as standard measurements (e.g., weight, height, blood pressure)
  - Laboratory testing, such as standard blood/urine screens, Papanicolaou test, stool guaiac, mammography, serum cholesterol levels, thyroid testing, and when indicated, screens for sexually transmitted diseases
  - Appropriate testing for specific chronic conditions

- Counseling regarding health changes related to menopause, including acute symptoms (e.g., hot flashes, sleep disturbances), sexuality (e.g., contraceptive options, high-risk sexual behaviors, sexual function), hygiene (e.g., dental care), psychosocial concerns (e.g., family relationships, job/work satisfaction), cardiovascular and osteoporosis risk factors (e.g., hypertension, obesity), health/risk behaviors (e.g., smoking, exercise, proper diet, nutrition), and treatment options, both nonprescription and prescription
- Encouraging the patient to keep a personal health maintenance schedule

## Management

1. Lifestyle modifications for perimenopausal women
  - Smoking cessation
  - Physical exercise
  - Proper diet and nutrition
  - Weight maintenance
  - Stress reduction
2. Management of vasomotor symptoms
  - Behavioral changes (such as moderate exercise, avoidance of hot-flash triggers, paced respiration)
  - Alternative therapies (such as botanicals, acupuncture, massage, meditation, and some soy products)
  - Estrogen or hormone replacement therapy
3. Management of sleep disturbances
  - Measures to improve the woman's sleep routine (such as keeping a regular sleep schedule; keeping the bedroom cool; and avoiding ingesting alcohol, caffeine, or spicy food before bedtime)
  - Estrogen or hormone replacement therapy
  - Considerations for treatment of depression-related insomnia
4. General counseling
  - Changes in sexual function
  - Psychological effects: what to expect; relaxation and stress management techniques; screening for clinical depression
  - Risk factors and preventive therapy for osteoporosis, cardiovascular disease, and genitourinary problems

## MAJOR OUTCOMES CONSIDERED

- Differential diagnosis of perimenopause, abnormal uterine bleeding, amenorrhea, thyroid abnormalities, and premenstrual syndrome
- Relief of vasomotor symptoms and sleep disturbances

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
 Hand-searches of Published Literature (Secondary Sources)  
 Searches of Electronic Databases

#### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The developer searched the medical literature using the database MEDLINE, as well as performed hand searches of the primary and secondary published literature.

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

#### METHODS USED TO ANALYZE THE EVIDENCE

Review

#### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

#### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

#### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The North American Menopause Society (NAMS) held a closed conference of experts in the field to review the current literature, share clinical experience, and make recommendations about how to help women achieve optimal health throughout perimenopause. The proceedings of the conference were used to assist the NAMS Board of Trustees in developing this consensus opinion of the Society.

#### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

#### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

#### METHOD OF GUIDELINE VALIDATION

Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This Consensus Opinion was reviewed by the Board of Trustees of The North American Menopause Society.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Summarized by the National Guideline Clearinghouse (NGC)

#### Diagnosis

Menstrual cycle changes that occur in perimenopause are usually marked by elevated follicle-stimulating hormone levels and decreased levels of inhibin, whereas levels of estradiol and luteinizing hormone remain normal or may be elevated. However, follicle-stimulating hormone levels can fluctuate from month to month and from woman to woman during perimenopause, which limits their utility as a predictor. Moreover, finding elevated follicle-stimulating hormone levels does not predict when menopause will start. Oral contraceptive use lowers follicle-stimulating hormone levels, and women may need to stop taking them temporarily (and use a nonhormonal form of birth control) before follicle-stimulating hormone levels can be measured to help substantiate a presumptive diagnosis of menopause.

Estradiol levels usually remain in the normal range until follicular growth and development cease. However, estrogen levels have been reported to increase occasionally before menopause. Fluctuations of estrogen can become extreme during perimenopause, with occasional elevations to levels similar to those seen during early pregnancy, followed by prolonged low levels. For these reasons, laboratory tests (e.g., blood estradiol, estrone, follicle-stimulating hormone) are of limited value in confirming perimenopause.

Many clinicians regard the appearance of menstrual cycle irregularity in a previously regularly menstruating woman as confirmation of perimenopause. Menstrual cycle patterns, however, differ widely during perimenopause.

Because any menstrual pattern is possible, the perimenopausal woman is not totally protected from an unplanned pregnancy until amenorrhea greater than 1 year occurs or consistently elevated levels of follicle-stimulating hormone (greater than 30 MIU/mL) can be demonstrated. Sexually active women should be made aware of the possibility of pregnancy; contraception may be needed until menopause is confirmed.

Confirmation of perimenopause usually relies on the woman's medical history and the symptoms that she experiences (e.g., irregular menses, hot flashes), as well as ruling out other causes for those changes. However, the physical symptoms that occur and the pattern of menstrual cycles during perimenopause differ markedly from woman to woman. Thus, clinicians should not assume that

irregular menstrual cycles or bleeding indicates the onset of perimenopause without ruling out other causes, including local uterine pathology, pregnancy, and thyroid abnormalities.

#### Abnormal uterine bleeding

Prolonged intervals of amenorrhea are common among perimenopausal women, and no therapy is usually needed if the woman ovulates periodically. Abnormal uterine bleeding is a more serious concern and requires further investigation. Women who bleed fewer than nine times each year and have no menses warrant evaluation as well.

An evaluation of abnormal uterine bleeding should include a history and physical examination plus one or more of the following procedures: endometrial biopsy, office aspiration curettage, dilation and curettage, saline sonohysterography, hysteroscopy, or transvaginal ultrasound. As with all invasive procedures, the potential benefits and risks need to be discussed with the patient.

Medical treatment is preferable for anovulatory (i.e., dysfunctional) uterine bleeding. The following therapies have been reported to be efficacious in treating abnormal uterine bleeding:

- Progestogen (progestin/progesterone) therapy
- Low-dose oral contraceptives
- Danazol
- A progesterone-releasing intrauterine device

In addition, nonsteroidal anti-inflammatory drugs reduce heavy menstrual bleeding (i.e., menorrhagia) in ovulating patients.

#### Amenorrhea

Amenorrhea should not be ascribed automatically to perimenopause in women who are younger than 50 years. Pregnancy must be ruled out as a cause of amenorrhea. Excessive dieting (including the eating disorders anorexia and bulimia) or exercising can cause hypothalamic amenorrhea; in these women, follicle stimulating hormone levels will be normal or low rather than increased.

#### Thyroid abnormalities

Perimenopausal women should be screened for thyroid dysfunction. A thyroid-stimulating hormone level using a sensitive thyroid-stimulating hormone assay is the initial screening test. If the thyroid-stimulating hormone level is abnormal, then thyroid function should be evaluated further.

#### Premenstrual syndrome

Because symptoms are restricted to the premenstrual phase, timing is important in differentiating premenstrual syndrome from other conditions. Normal symptoms reported by menstruating women are similar to those who experience premenstrual syndrome; they typically are present for a few days before the onset of menses but do not interfere with daily functioning. Premenstrual syndrome is confined to the luteal phase, approximately 14 days before the onset of menses, and symptoms interfere with daily functioning. Age of onset and prospective timing of symptoms should be assessed. Women in their 40s

commonly assume that the onset of perimenopause is premenstrual syndrome because the symptoms are so similar.

### Acute perimenopause symptoms

Data support the association of various acute symptoms with perimenopause. In addition, data confirm that perimenopausal physiological changes may be associated with long-term problems. Acute symptoms in perimenopause initiated by altered secretion of ovarian hormones include menstrual irregularities, vasomotor symptoms, and sleep disturbances. Behavioral changes have been variously ascribed to psychosocial/cultural factors and may possibly be affected by endocrine factors.

### Vasomotor symptoms

The hot flash or flush is the most frequent perimenopausal vasomotor symptom, experienced by up to 85% of women. A few women will have hot flashes years before menopause; others experience them for years after menopause. Hot flashes that occur with perspiration during sleep are termed night sweats.

Hot flashes can be associated with palpitations and feelings of anxiety. The unsettling feeling that precedes a hot flash can trigger an anxiety (or panic) attack. Clinicians should rule out cardiovascular causes when these symptoms are observed.

### Sleep disturbances

Sleep disturbances of varying degrees of severity are frequently reported by perimenopausal women. The extent to which sleep disturbances are due specifically to the hormonal changes of perimenopause is uncertain. Sleep disturbances may vary widely and may be chronic or transient. Several common patterns have been reported, including difficulty falling asleep, awakening in the middle of the night with trouble resuming sleep, and early morning awakening with an inability to resume sleep. Sleep disturbances can seriously affect quality of life, resulting in fatigue, irritability, and inability to concentrate.

There are other situations associated with sleep disturbances. These include hypothalamic disturbances; habits such as daytime naps and an irregular sleep schedule; stimulants such as caffeine, alcohol, nicotine, and some prescription drugs; illness; anxiety or emotional concerns; physical discomfort such as pain from arthritis; and nocturia.

### Genitourinary effects

As women make the transition from late perimenopause into early postmenopause, vulvovaginal atrophy and urinary tract conditions may manifest. These conditions are not in the scope of this Consensus Opinion, and discussion of these issues can be found in published reviews of the treatment of the postmenopausal woman.

### Therapeutic Options

The majority of women do not require specific medical management. However, screening, counseling, and lifestyle changes are advisable for all.

Various treatment options are available for the symptoms associated with perimenopause—both acute conditions and potential chronic diseases—including

lifestyle changes, prescription and nonprescription therapies, and alternative/complementary approaches. In selecting the optimal treatment plan, the clinician needs to discuss in-depth the pros and cons of each option with the woman, with the goal of fully involving her in the decision-making process.

The healthcare provider can use the woman's concern about perimenopausal changes, such as irregular menses, as a forum to initiate a discussion of lifestyle modification. Although these recommendations are not specific to perimenopause, this transition period is a good time to assess each patient's lifestyle habits. Lifestyle modifications should include smoking cessation, physical exercise, proper diet and nutrition (especially regarding adequate intake of calcium and vitamin D), weight maintenance, and stress reduction. Because clinical research data on women in perimenopause are limited, healthcare providers may consider extrapolating data on postmenopausal women as well as clinical experience when considering management recommendations.

#### Preventive screening and the annual health examination

The annual health examination is valuable for the perimenopausal woman and should include comprehensive screening for physical and psychological problems as well as for appropriate lifestyle counseling. The annual physical examination provides clinicians with the opportunity to address disturbances that cause women to seek medical care, screen for disease risk factors, and assess the woman's perimenopause status. It is recommended that the physical examination include the following:

- Complete medical and personal histories (especially for cardiovascular disease, osteoporosis, cancer, health status, diet/nutritional assessment, and physical activity)
- Complete physical examination, including breast, pelvic, and rectovaginal examinations as well as standard measurements (e.g., weight, height, blood pressure)
- Laboratory testing, such as standard blood/urine screens, Papanicolaou test, stool guaiac, mammography, serum cholesterol levels, thyroid testing, and, when indicated, screens for sexually transmitted diseases
- Appropriate testing for specific chronic conditions
- Counseling regarding health changes related to menopause, including acute symptoms (e.g., hot flashes, sleep disturbances), sexuality (e.g., contraceptive options, high-risk sexual behaviors, sexual function), hygiene (e.g., dental care), psychosocial concerns (e.g., family relationships, job/work satisfaction), cardiovascular and osteoporosis risk factors (e.g., hypertension, obesity), health/risk behaviors (e.g., smoking, exercise, proper diet, nutrition), and treatment options, both nonprescription and prescription
- Encouraging the patient to keep a personal health maintenance schedule

#### Vasomotor symptoms

Behavioral changes, such as moderate exercise and avoidance of potential hot-flash triggers (e.g., caffeine, spicy foods, alcohol, warm room) may prevent some hot flashes. However, only anecdotal data support the efficacy of these measures. The efficacy of paced respiration—deep, slow abdominal breathing—as a modality to lessen hot flashes has been shown in a small trial. Various alternative therapies, such as botanicals, acupuncture, massage, meditation, and some soy products, also may provide benefits, although efficacy has not been documented

in clinical trials, except for moderate quantities of soy products. Healthcare providers should query women about their use of alternative therapies and over-the-counter medications. At this time, although the use of these substances is becoming more widespread, clinical trials have not confirmed their effectiveness.

Few data are available on the effects of estrogen replacement therapy or hormone replacement therapy (i.e., estrogen plus progestogen, or hormone replacement therapy) on perimenopausal women; most studies to date have been on postmenopausal women. Until more studies are available, data from postmenopausal women may serve as general guides to cautious decision making, combined with the healthcare provider's clinical experience. Therefore, prescription estrogen replacement therapy may be considered for perimenopausal women. For almost all women with an intact uterus, clinicians should add progestogen to estrogen replacement therapy to guard against an increased risk of endometrial carcinoma from unopposed estrogen.

For perimenopausal women who are prescribed estrogen replacement therapy/hormone replacement therapy, it is important to use the lowest possible effective dosage. If estrogen replacement therapy/hormone replacement therapy is contraindicated and nonprescription remedies fail to control the vasomotor symptoms, then other prescription medications can be used, such as clonidine, progestogen alone, or megestrol acetate.

In postmenopausal women, use of estrogen replacement therapy/hormone replacement therapy has been shown to be effective for the treatment of hot flashes. Low doses of estrogen replacement therapy/hormone replacement therapy can be effective in relieving moderate to severe vasomotor symptoms in postmenopausal women and might be preferentially considered in perimenopausal women.

Transitioning a woman from combination (estrogen/progestin) oral contraceptives to estrogen replacement therapy/hormone replacement therapy should be done as soon as is appropriate. Even oral contraceptives with very low hormone doses still provide significantly more hormone than in standard estrogen replacement therapy/hormone replacement therapy, which may increase exposure to unnecessary risks from long-term use. Timing of the switch is often difficult, because cessation of menses (the hallmark of menopause) is not observed while the patient is taking oral contraceptives. Some clinicians choose age 51, the median age of natural menopause in Western women. Clinicians also must consider the woman's need for contraception when making the transition.

#### Sleep disturbances

Healthcare providers are advised to approach treatment of insomnia through measures that improve the woman's sleep routine, such as keeping a regular sleep schedule; keeping the bedroom cool; and avoiding ingesting alcohol, caffeine, or spicy foods before bedtime.

In postmenopausal women, estrogen replacement therapy improves symptoms of insomnia such as restlessness, nocturnal awakenings, and inability to fall asleep. Improved sleep is associated with alleviation of vasomotor symptoms, somatic symptoms, and mood. Anecdotal experience has revealed that this approach also may be effective with some perimenopausal women. As with managing hot

flashes, the lowest effective dose should be used. For women who need protection against an unwanted pregnancy, prescribing a low-dose combination oral contraceptive (estrogen plus progestin) may be a good approach.

Depression-related insomnia may be treated with antidepressants and/or with a referral for specialized psychiatric care. Insomnia from other causes may respond to prescription sleeping aids or may require referral to a sleep disorder clinic.

### General Counseling

Perimenopause is an appropriate time to consider other issues: changes in sexual function, psychological effects, and osteoporosis and cardiovascular disease.

### Changes in sexual function

An assessment of all potential physical, psychological, or social factors amenable to intervention should be the primary therapeutic consideration for perimenopausal women who express a specific complaint of loss of libido.

In postmenopausal women, estrogen therapy has been shown to improve vaginal health and may improve sexual function by reducing dyspareunia; however, its role in libido is uncertain. There are no studies regarding estrogen's effects on perimenopausal women, yet anecdotal evidence suggests that low doses provide similar benefits. Another ovarian hormone, testosterone, may play a role in women's sex drive, but there are no published data in perimenopausal women.

Some perimenopausal women report vulvovaginal changes, such as vaginal dryness. Often, the first noticeable change is reduced vaginal lubrication during sexual arousal. All women of perimenopausal age should have a thorough evaluation of vaginal health, regardless of whether they are symptomatic or sexually active. Women who have sexual dysfunction of extended duration or who do not respond to medical intervention and simple counseling should be referred to a specialist in the treatment of sexual problems.

### Psychological effects

Healthcare providers can help diminish fear and even help prevent some psychological symptoms by counseling patients on what to expect at menopause, both physically and psychologically. Relaxation and stress-reduction techniques, including lifestyle modification, may help women cope with stress-producing factors in their lives.

Perimenopausal women who are exhibiting relevant symptoms should be screened for clinical depression. A medical history, physical examination, and routine laboratory tests should be performed to rule out illnesses that are often associated with depression. Simple tools, such as the Beck Depression Inventory or the Zung Self-Rating Depression Scale, may assist clinicians in identifying depressed women.

In addition, an evaluation of anxiety is needed to differentiate normal day-to-day anxiety from pathological responses that require pharmacological intervention and/or psychotherapy. Anxiety needs to be differentiated from other psychiatric conditions, such as obsessive-compulsive and posttraumatic stress disorders.

For perimenopausal women who are moody, tired, and irritable from sleep deprivation as a result of hot flashes and night sweats, clinicians should provide therapies that are focused specifically on those symptoms. Synthetic progestins may worsen mood in some women, particularly those with a history of premenstrual syndrome. In these patients, clinicians can try switching to another progestin, switching to a continuous-combined hormone replacement therapy regimen, or using a natural progesterone.

If psychological disturbances persist after 6-8 weeks of hormone treatment, further evaluation is indicated, perhaps by a mental health professional.

#### Osteoporosis and cardiovascular disease

When counseling a woman who is in perimenopause, the healthcare provider must consider her risk factors for developing chronic diseases related to estrogen depletion, primarily osteoporosis and cardiovascular disease. For women who are at high risk, estrogen replacement therapy/hormone replacement therapy should be considered. However, the decisions of women who choose to make lifestyle changes or take therapies other than estrogen replacement therapy/hormone replacement therapy also need to be supported. All women require yearly examination to identify markers for increased risk for developing cardiovascular disease, osteoporosis, or genitourinary problems.

#### Selecting a treatment plan

Healthcare providers should follow perimenopausal women regularly and discuss with each woman the therapeutic options, both prescription and nonprescription, for the management of perimenopausal disturbances. In selecting a treatment plan, if any, the healthcare provider and the woman must consider the following:

- The woman's general health status
- The severity of her hormone-related disturbances
- The woman's risk for developing serious disorders, such as osteoporosis and cardiovascular disease
- The potential risks and benefits of each available treatment
- The woman's lifestyle
- The woman's view of each treatment

The healthcare provider also must reassess therapy if the woman's needs change or if new therapies become available. Most women require reminding that the disturbances of perimenopause are mostly temporary and that "doing nothing" is an option.

#### CLINICAL ALGORITHM(S)

None provided

### EVIDENCE SUPPORTING THE RECOMMENDATIONS

#### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

In general, both published literature and clinical experience were evaluated by a panel of experts as a basis for the recommendations, and the most scientifically

rigorous studies are cited in the full-text consensus opinion document. If the evidence was contradictory or inadequate to form a conclusion, a consensus-based opinion was made.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

To optimize a woman's health and quality of life during and after perimenopause

Subgroups Most Likely to Benefit:

Perimenopausal women with menopause-related vasomotor symptoms, sleep disturbances, changes in sexual function, psychological effects, and those women at risk later in life for osteoporosis and cardiovascular disease.

### POTENTIAL HARMS

Risks from long-term use of combination (estrogen/progestin) oral contraceptives and estrogen replacement therapy/hormone replacement therapy.

Subgroups Most Likely to be Harmed:

For almost all women with an intact uterus, clinicians should add progestogen to estrogen replacement therapy (i.e., hormone replacement therapy) to guard against an increased risk of endometrial carcinoma from unopposed estrogen.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- Clinical trial data are insufficient to establish evidence-based treatment standards regarding the diagnosis and treatment for acute and chronic symptoms and conditions of perimenopausal women.
- The consensus conference did not include a discussion of women who have medically induced menopause, women who are menstruating irregularly before perimenopause, or women who are already receiving hormone therapy. Because standards of care and available treatment options differ throughout the world, the participants limited their focus to patients and perimenopause therapies available in North America.
- Because clinical research data on women in perimenopause are limited, healthcare providers may consider extrapolating data on postmenopausal women as well as clinical experience when considering management recommendations.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Clinical challenges of perimenopause: consensus opinion of The North American Menopause Society. *Menopause* 2000 Jan-Feb;7(1):5-13. [68 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2000 Jan

### GUIDELINE DEVELOPER(S)

The North American Menopause Society - Private Nonprofit Organization

### SOURCE(S) OF FUNDING

The consensus conference was supported by an unrestricted educational grant from Parke-Davis Women's Healthcare.

### GUIDELINE COMMITTEE

Expert Consensus Committee

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Robert W. Rebar, MD (chairperson); Lila E. Nachtigall, MD (rapporteur); Nancy E. Avis, PhD; Fredi Kronenberg, PhD; Nanette F. Santoro, MD; Mary Fran Sowers, PhD; and David F. Archer, MD.

### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

#### GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

#### GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from [The North American Menopause Society \(NAMS\) Web site](#).

Print copies: Available from NAMS, P.O. Box 94527, Cleveland, OH 44101, USA (Order forms are available at [The North American Menopause Society \[NAMS\] Web site](#)).

#### AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Boggs PP, Utian WH. The North American Menopause Society develops consensus opinions. Menopause 1998 Summer; 5(2): 67-8.

Electronic copies: Available from [The North American Menopause Society \(NAMS\) Web site](#).

Print copies: Available from NAMS, P.O. Box 94527, Cleveland, OH 44101, USA (Order forms are available at [The North American Menopause Society \[NAMS\] Web site](#)).

#### PATIENT RESOURCES

None available

#### NGC STATUS

This summary was completed by ECRI on January 2, 2001. It was verified by the guideline developer as of March 29, 2001.

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