DEUTSCHE MENOPAUSE GESELLSCHAFT e.V.

FIRST TO KNOW

Schweizerische Gesellschaft für Gynäkologische Endokrinologie, Kontrazeption und Menopause

GUIDELINE OF THE INTERNATIONAL MENOPAUSE SOCIETY (IMS) DECEMBER 2025

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BACKGROUND

The International Menopause Society (IMS) has developed current recommendations and key messages on the health of women in midlife and menopause based on a comprehensive systematic literature review (1). The aim of these guidelines is to provide healthcare professionals with evidence-based, internationally applicable guidance for the care of women in this phase of life and to support individualized, informed decision-making.

The recommendations cover a broad spectrum, including lifestyle, menopausal symptoms, menopausal hormone therapy (MHT), cardiometabolic health, bone health, cognitive and psychological aspects, and oncological issues. In addition to evidence-based recommendations, good practice points (GPP) and key messages (KM) are also formulated to reflect practice-relevant aspects where data is limited but clinical experience allows for clear guidance.

The IMS guideline uses a transparent rating system based on the GRADE and AGREE II criteria. A distinction is made between two dimensions:

- Quality of evidenz (⊕ bis ⊕⊕⊕⊕):

This describes how reliable the underlying scientific data is – from very low to high evidence. High evidence means that further research is unlikely to significantly change the assessment.

- Strength of recommendation (A–D):

This indicates how clearly a measure is recommended. In addition to the quality of evidence, it also takes into account clinical benefits, potential risks, feasibility, and patient values and preferences. A strong recommendation (A) can also be made with moderate evidence if the benefits clearly outweigh the risks.

Good Practice Points (GPP) are based on expert consensus in the absence of or insufficient evidence, while Key Messages (KM) represent evidence-based core statements without formulating a specific recommendation for action.

Due to their length, the recommendations will be presented in two newsletters. This is part 1

STATEMENTS

1. Physical changes in midlife – metabolism and basic principles

- Weight gain in women during menopause is mainly due to the chronological aging process and is not primarily a direct consequence of menopause. ⊕⊕⊕⊕◯ KM
- The age-related decline in total energy expenditure is the most important determining factor for weight gain in middle age. ⊕⊕⊕⊕ KM
- The drop in estrogen levels associated with menopause is the main driver of the redistribution of body fat toward increased abdominal fat accumulation. ⊕⊕⊕⊕ KM
- Increased abdominal obesity in postmenopausal women is associated with a significantly increased cardiometabolic risk, even with a normal body mass index (BMI). ⊕⊕⊕⊕ KM
- Menopausal hormone therapy effectively alleviates menopausal symptoms but has no clinically relevant direct effect on body weight. ⊕⊕⊕⊕ KM

2. Vasomotor symptoms (VMS) during menopause

- Menopausal hormone therapy (MHT) is the most effective treatment available for vasomotor symptoms.
- Estrogen-only therapy is recommended for women without an intact uterus, while combined estrogen-progestogen therapy is indicated for women with an intact uterus. ⊕⊕⊕⊕ A
- Tibolone significantly reduces vasomotor symptoms in postmenopausal women compared to placebo. ⊕⊕⊕⊕ A

- Estetrol (E4)), a natural estrogen produced in the fetal liver and believed to have selective tissue-specific effects, reduced both the frequency and severity of moderate to severe vasomotor symptoms in postmenopausal women at an oral dose of 15 mg daily. (Note: currently not approved for marketing) ⊕⊕⊕⊕ A
- Women should be informed that there is no evidence-based recommendation for the optimal approach to discontinuing MHT and that vasomotor symptoms may recur in up to 87% of cases after discontinuation of therapy. ⊕⊕◯◯ C
- Neurokinin receptor antagonists (NKRA) reduce the frequency and severity of vasomotor symptoms in postmenopausal women by modulating kisspeptin, neurokinin B, and dynorphin neurons (KNDy neurons) in the hypothalamus. Their efficacy is slightly lower than that of MHT. KM
- Due to the high quality of evidence from randomized controlled trials, NKRA should be considered the preferred evidence-based, effective non-hormonal treatment option. KM
- The duration of treatment of vasomotor symptoms with non-hormonal therapies should be reviewed regularly, as is the case with hormonal interventions. GPP

3. Urogenital syndrome of menopause and sexuality

- Genitourinary syndrome of menopause (GSM) is a chronic, progressive condition that does not remit without treatment and may recur after discontinuation of therapy. ⊕⊕⊕◯ B
- No systemic risks have been demonstrated for low-dose vaginal estrogens. ⊕⊕⊕◯ B
- Intravaginal dehydroepiandrosterone (DHEA) can be used as an alternative treatment option to vaginal estrogen therapy. ⊕⊕⊕◯ B
- Women with symptoms such as vaginal dryness and dyspareunia should be offered treatment with vaginal lubricants and moisturizers. These can be used as monotherapy or in combination with other forms of treatment. ⊕⊕⊕⊕ A
- Women should be informed that there is currently insufficient evidence to recommend the use of vaginal laser therapy. ⊕⊕◯◯ C
- The simultaneous occurrence of bladder symptoms and menopause does not necessarily imply that menopause is the primary causative factor. ⊕⊕⊕◯ B
- Non-pharmacological measures, in particular lifestyle modification and bladder training, should be recommended as the primary treatment for symptoms of an overactive bladder. ⊕⊕⊕⊕ A
- Vaginal estrogen therapy should be considered for postmenopausal women with lower urinary tract symptoms. ⊕⊕⊕⊕ A
- Vaginal estrogen therapy is recommended for the prevention of recurrent urinary tract infections. ⊕⊕⊕⊕ A
- Systemic menopausal hormone therapy should not be used to treat urinary incontinence or recurrent lower urinary tract infections. ⊕⊕◯◯ C
- For non-estrogen-based therapies, including DHEA and vaginal laser therapy, there is currently insufficient evidence to recommend their use for the treatment of lower urinary tract tract symptoms in postmenopausal women. ⊕◯◯◯ D
- Menopausal hormone therapy prescribed for other indications may be associated with an improvement in sexual function; however, the clinical benefit is generally small. ⊕⊕⊕⊕ A

- The use of transdermal testosterone at doses corresponding to physiological premenopausal levels may be considered for the treatment of sexual dysfunction in menopausal women diagnosed with hypoactive sexual desire disorder (HSDD) and significant distress. ⊕⊕⊕⊕ A
- Vaginal lubricants and moisturizers should be offered as first-line therapy for the treatment of vaginal dryness and dyspareunia in women with GSM following breast cancer. ⊕⊕⊕⊕ A
- Vaginal estrogen therapy or DHEA may be considered in selected breast cancer survivors. The available evidence, tumor biological characteristics, individual preferences and needs of women, and access to treatment options should be included in shared decision-making. GPP

4. Osteoporosis and joints

- Menopause is associated with accelerated bone loss, which can be effectively prevented or slowed down by a range of pharmacological interventions. ⊕⊕⊕⊕ A
- Although reduced bone mineral density is a key feature of osteoporosis, it is only one of several risk factors for osteoporotic fractures. The assessment of individual fracture risk and the determination of intervention thresholds should take all relevant clinical risk factors into account. This can best be done using validated risk calculators, such as the Fracture Risk Assessment Tool (FRAX).
- All women in perimenopause and women with early menopause should initially be assessed using FRAX (without DXA) or locally established screening instruments. If the risk is elevated, bone density should be measured using DXA. In addition, all women aged 65 should undergo a DXA examination, unless this has already been done previously. GPP
- Menopausal hormone therapy is a first-line treatment for the prevention of menopause-associated bone loss. The benefits likely outweigh the potential risks if therapy is initiated within 10 years of menopause or before the age of 60. After discontinuation of therapy, bone loss rapidly resumes. MHT has been shown to reduce the risk of osteoporosis-related fractures. ⊕⊕⊕◯ A
- Estrogen deficiency is associated with an increase in musculoskeletal complaints, especially joint pain, and with thinning of the joint cartilage. ⊕⊕◯◯ KM

5. Cardiometabolic system

- Certain cardiovascular risk factors occur exclusively or disproportionately frequently in women, particularly diabetes mellitus. Gender-specific risk factors include early menopause or premature ovarian insufficiency (POI), hypertensive pregnancy disorders, gestational diabetes, premature births, polycystic ovary syndrome, and autoimmune diseases. The systematic recording and evaluation of these factors is essential for adequate cardiovascular risk stratification. ⊕⊕⊕◯ A
- In women under 60 who are in early postmenopause and have no manifest cardiovascular disease, estrogen therapy is associated with a reduction in the risk of coronary heart disease (CHD) and overall mortality. Several sources of evidence, including Cochrane reviews, meta-analyses, and the 18-year follow-up of the Women's Health Initiative (WHI), show consistent mortality benefits when MHT is initiated before the age of 60 or within 10 years of menopause. ⊕⊕⊕⊕ A
- Starting menopausal hormone therapy after age 60 is not recommended if the sole goal is primary prevention of coronary heart disease. ⊕⊕⊕◯ A

- Menopausal hormone therapy is associated with a reduction in the incidence of new-onset diabetes mellitus. This effect should be included in the individual risk-benefit assessment for women under the age of 60 without known cardiovascular disease, in addition to other preventive effects of MHT, including the reduction of osteoporosis, fractures, colorectal cancer, cardiovascular disease, and overall mortality. ⊕⊕⊕◯A
- Menopausal hormone therapy should not be used for the secondary prevention of cardiovascular disease; however, it is not associated with an increased risk of cardiovascular events. ⊕⊕⊕◯B
- Transdermal estrogen may be a suitable treatment option for menopausal symptoms in women with existing or inadequately controlled cardiovascular risk factors due to its lower risk of thromboembolic events and inflammatory effects. ⊕⊕◯◯B

6. Coagulation: Venous thromboembolism

- Oral estrogen therapy is associated with an increased risk of venous thromboembolism (VTE) and should not be used in women with an increased risk of VTE. ⊕⊕⊕⊕A
- In contrast, transdermal estrogen therapy is not associated with an increased risk of VTE, even in the presence of additional risk factors such as obesity, hereditary thrombophilia, or a history of VTE. ⊕⊕⊕◯B
- When using combined menopausal hormone therapy, the choice of progestogen is important. It is recommended to use progestogens with a favorable safety profile, such as micronized progesterone, dydrogesterone, or a levonorgestrel-releasing intrauterine system. ⊕⊕⊕◯B
- Routine thrombophilia testing before starting menopausal hormone therapy is not indicated. GPP
- If women undergoing oral menopausal hormone therapy develop venous thromboembolism, it is not absolutely necessary to discontinue hormone therapy immediately while anticoagulation is ongoing. ⊕⊕⊕◯B

7. CNS, dementia, and stroke in menopause

- The combination of conjugated equine estrogens (CEE) and medroxyprogesterone acetate (MPA) is associated with an increased risk of dementia from all causes in women who start menopausal hormone therapy at age 65 or later; the most common form of dementia is Alzheimer's disease (AD). ⊕⊕⊕◯B
- Estrogen monotherapy is associated with a reduced risk of dementia in premenopausal women after bilateral oophorectomy. These data support the use of estrogen therapy for dementia prevention in women with premature ovarian failure or early menopause.
- The currently available evidence does not support the initiation of menopausal hormone therapy for the primary prevention of Alzheimer's disease in women with natural menopause. ⊕⊕⊕◯B
- The influence of menopausal hormone therapy on stroke risk is time-dependent and depends largely on the timing of the start of therapy. ⊕⊕⊕⊕A
- Women who start menopausal hormone therapy within 10 years of the onset of menopause or before the age of 60 have a comparable risk of stroke to women without MHT. ⊕⊕⊕⊕A
- If menopausal hormone therapy is started more than 10 years after menopause or at the age of 60 or older, oral estrogen-containing MHT in particular is associated with an increased risk of stroke. ⊕⊕⊕⊕

- Transdermal forms of administration and lower doses of menopausal hormone therapy may be associated with a lower risk of stroke compared to oral administration or higher doses. ⊕⊕◯◯C
- In postmenopausal women with migraine, transdermal MHT formulations should be preferred over oral preparations, as they are associated with less variability in estrogen levels. ⊕⊕◯◯C
- In women with migraine, transdermal MHT formulations are preferable to oral formulations due to their more favorable thromboembolic risk profile. ⊕⊕⊕◯B

REFERENCES

(1) Panay N, Fenton A, Hamoda H, Hillard T, Islam R, Pedder H, Romero L, Vincent AJ; (IMS Publication Steering Committee) and The IMS Recommendations Writing Group; IMS Recommendations Writing Group;

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