A GUIDE FROM PEEDOC.COM

What I wish every woman knew about perimenopause and menopause.

Peri Health & Hormones

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You probably found this because a list of symptoms finally made sense together. Anxiety, joint pain, a bladder that stopped behaving, sleep that fell apart. Maybe you took the symptom quiz on my site and watched the scores stack up in places you did not expect.

This short guide answers the questions I hear most. What is actually happening, when it happens, why the symptoms are so scattered, what the long-term risks are if nothing is done, and what treatment honestly looks like. Use it as a starting point. And when you are ready to make it personal, I would be happy to see you.

WHAT IS ACTUALLY HAPPENING

Perimenopause is the transition into menopause. For most women it begins in the early to mid forties, and it can start as early as 35. You are born with all the eggs you will ever have. As the supply runs low, the brain pushes the ovaries harder to get the remaining ones to respond. Hormone levels stop holding steady and start swinging, sometimes higher than anything you saw when you were younger, sometimes far lower, and sometimes both in the same month.

The swings themselves are what produce most of the symptoms. That is why this stage can feel more erratic than what comes after, and why it can start while your periods are still perfectly regular. The cycle is often the last thing to change, not the first.

Menopause is technically a single day: the one year anniversary of your final period. The average age in the United States is 51. After it, the swings stop and hormone levels settle low and stay there. Symptoms often calm down, and it is easy to read that as the problem resolving. What continues underneath is quieter: bone thins, blood vessels stiffen, skin and joints lose collagen, and the tissue of the vagina, bladder and urethra, built on estrogen for your whole adult life, slowly changes.

The brain deserves its own sentence, because it is one of the most estrogen-dependent organs you have. Estrogen receptors sit throughout it: in the hypothalamus that runs your temperature, which is where hot flashes come from, in the hippocampus that handles memory, which is where brain fog lives, and in the circuits that regulate serotonin and dopamine, which is why mood moves when hormones do. When estrogen falls, the brain is not a bystander. That slower story is the part this guide takes seriously.

WHY YOUR DOCTOR MAY NOT HAVE CONNECTED IT

Only 7 percent of the physicians you would expect to treat menopause, the FP, IM and OB/GYN residents, finish training feeling prepared to manage it. That is not an insult to anyone's doctor. It is a training gap, and I was on the wrong side of it myself before this became a focus of my practice.

The result is predictable. Each symptom gets sent to its own specialty, treated on its own or dismissed on its own, and nobody stands far enough back to see the shape of it. If you have been told more than once that your labs are normal and nothing is wrong, you are in very common company.

THE SYMPTOMS, IN ONE PLACE

Hot flashes get all the attention, but estrogen, progesterone and testosterone act on nearly every tissue in the body. When they swing and then fall, the effects show up in places nobody thinks to blame on hormones.

HOT FLASHES AND NIGHT SWEATS
Flushing, heat intolerance, chills after a flash. These last years, not months.

SLEEP
Trouble falling asleep, 3 a.m. waking, waking unrefreshed. Often the first symptom to arrive.

THINKING AND MOOD
Brain fog, memory slips, anxiety that arrives from nowhere, irritability, mood swings. Frequently misdiagnosed as depression alone.

WEIGHT AND BODY COMPOSITION
Weight that moves to the middle and will not come off the way it used to. Muscle quietly declining.

ENERGY AND MOTIVATION
Fatigue, low drive, less resilience. Harder to get through an ordinary day.

SEXUAL HEALTH
Lower desire, less arousal, vaginal dryness, pain with sex. Common, treatable, and almost never volunteered to a doctor.

BLADDER AND URINARY SYMPTOMS
Urgency, leakage, burning, and urinary infections that keep coming back. My corner of medicine. Hormones are involved more often than women are told.

JOINTS, MUSCLES AND BONES
Joint pain and stiffness with normal X-rays, muscle aches, declining strength. Estrogen is anti-inflammatory, and joints feel its loss.

SKIN, HAIR AND NAILS
Dry or thinning skin, hair shedding, brittle nails. Collagen falls quickly in the first years after menopause.

HEART SENSATIONS AND HEADACHES
Palpitations, racing heart, migraines that change pattern. Common in perimenopause, and usually worked up before anyone mentions hormones.

What happens instead of a diagnosis. When the pattern goes unrecognized, each piece gets treated on its own. Low mood earns a depression diagnosis and an SSRI that was never needed, and SSRIs are famously difficult to come off. Rising cholesterol earns a statin. Thinning bone earns an expensive bone-strengthening drug. Sometimes those prescriptions are the right call. But each one treats a downstream effect, and too often nobody asked the hormone question first. The scale of it is worth sitting with: antidepressant prescriptions in women roughly double across the perimenopausal years, and men of the same age show no similar rise. That difference is not a mystery. It is a hormonal transition being read as a psychiatric one.

HOW IT IS DIAGNOSED, AND WHERE TESTING FITS

Here is something many women are never told. **Perimenopause is diagnosed mostly by the pattern, not by a single blood test.** Because hormone levels swing week to week, one normal lab proves very little. A normal FSH or estradiol on a Tuesday does not mean your symptoms are not hormonal. That is exactly how women end up dismissed.

Testing still has a real job. It has to be done thoughtfully and read in context. A proper evaluation looks at your symptom pattern and timing, your cycle history, a full hormone panel including thyroid and other look-alikes such as iron and vitamin D, and screening for the things that matter long term, bone density among them. Labs are there to check for other issues, establish a baseline, and guide treatment safely.

> **Bring your quiz printout.** If you took the symptom quiz, the printed sheet with your scores by area is a better starting document than most intake forms. It shows the whole pattern on one page.

WHAT HAPPENS IF NOTHING IS DONE

Symptoms are only half the story. The quieter half is what the loss of estrogen does over years, and it is the reason women should take this stage of life seriously rather than waiting it out.

- **Bone.** Women lose roughly ten percent of the bone density in their spine across the menopause transition, and most of that happens in a narrow window around the final period. Bone lost then is difficult to rebuild. Acting before it goes beats trying to recover it after.
- **Heart.** Cardiovascular disease is the leading cause of death in women, and risk climbs after menopause as estrogen's protective effects on vessels and cholesterol fade.
- **Mood.** The hormonal swings of perimenopause raise the risk of new anxiety and depression, even in women who have never struggled with either.
- **Brain.** The dementia finding that frightened a generation of physicians came from women who started hormones in their sixties and seventies, well past menopause. Starting close to menopause is a different proposition, and some of that evidence points toward lower risk rather than higher.
- **Bladder and vagina.** The tissue of the vagina, urethra and bladder depends on estrogen. Without it, that tissue thins and dries, pH rises, protective bacteria decline, and urinary infections recur. Unlike hot flashes, this gets worse with time, and in older women a urinary infection can escalate to urosepsis, a bloodstream infection. I treat the end stage of this story every week. Most of it is preventable.

TREATMENT, HONESTLY

In perimenopause, the problem is instability, so the goal is to steady it. A stable dose of bioidentical progesterone, estradiol or testosterone, chosen to match your pattern, can smooth the swings and bring symptoms down.

After menopause, treatment aims at both halves: the symptoms you can feel and the tissue changes you cannot. Systemic estradiol, usually through the skin, paired with progesterone. Progesterone is often treated as nothing more than uterine protection, but I use it whether or not you have a uterus. It protects the uterus when one is present, and it carries benefits of its own for sleep and for calming the nervous system either way. Testosterone where libido, energy and muscle are the story. And **vaginal estrogen,** a low-dose local treatment that restores the tissue that drives dryness, painful sex and recurrent urinary infection. It is one of the most effective and most underused treatments in this entire field.

Bioidentical versus synthetic. Bioidentical means the molecule is identical to the one your body makes: the same estradiol, the same progesterone. A synthetic hormone is a different molecule, altered so it can be patented or survive digestion. It acts on the same receptors without being the same substance, and the body does not handle the two identically. The distinction matters because much of the frightening data was generated with the older formulations: conjugated estrogens derived from horse urine, paired with a synthetic progestin. Head-to-head trials are limited, but modern practice has largely moved to the bioidentical forms.

About the fear. In 2002 a large study called the Women's Health Initiative was stopped early, and the headline said hormones cause breast cancer. Here is what got lost. The women in that study averaged 63 years old, more than a decade past menopause, and they were taking the older synthetic formulations described above. The increase was small in absolute terms, under one extra case per thousand women per year, and the arm taking estrogen alone showed no increase at all. None of that made the news. A generation of women was taken off hormones, or never offered them, over a finding that does not describe a woman starting bioidentical therapy near menopause.

Hormones are not for everyone. A history of certain cancers, clots or strokes changes the conversation, and some women simply prefer other routes. Non-hormonal options exist for hot flashes, sleep, mood and bone, and lifestyle work carries real weight at this stage. The right plan is the one built on your history.

The part I want you to keep. This is one of the most treatable stages in a woman's life. Nearly every symptom in this guide has an answer, most of the long-term risks can be lowered, and women who get properly evaluated routinely tell me they feel more like themselves than they have in years. The window for doing something about it is open right now.

QUESTIONS I HEAR EVERY WEEK

I still have regular periods. Is it too early?
No. Symptoms often start while cycles are still regular. The cycle is frequently the last thing to change.

How long do hot flashes last?
Longer than most people expect. Years is typical, not months.

Is it too late for me?
Timing matters, and the studies are clearest about the benefits of starting earlier. But most experts are comfortable starting later for what it does for bone and the urinary tract, even though the cardiovascular benefit is probably smaller by then. It is a conversation, not a deadline you already missed.

Do I have to take hormones?
No. The evaluation is worth doing either way. It looks at the things that change quietly after menopause, bone, heart and bladder among them, and what you do with the findings is a decision you make with full information.

Why is a urologist writing this?
Urology training is steeped in hormones, and my exam rooms are full of the downstream effects. I got tired of treating the end of the story and started treating the beginning. My own wife's experience of being passed around the system is part of why.

WHERE TO GO FROM HERE

I practice at Peri Health & Hormones in Draper, Utah. It is a small private concierge practice built for exactly the visit this guide describes: time given to hear your experience and your pattern, testing read in context rather than in isolation, and a plan matched to your history.

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GET EVALUATED. STOP GUESSING.

If this guide sounded like your life, the next step is a real evaluation: your symptom pattern, a thoughtful hormone panel, and screening for bone, heart and bladder risk. Bring your quiz printout and we will start from what you already know.

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