THE

# MENOPAUSE ATLAS

*What is happening, what actually helps, and what to ask your doctor about perimenopause and menopause*



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# Please Read This First

This book was written to be used, not admired. That is exactly why this page exists.

**This book is not medical advice, and reading it does not make anyone your clinician.** No doctor–patient, nurse–patient, or any other professional relationship is created by your reading it. Nothing here is personalized to you, because nothing here can be. The author has never examined you, does not know your history, your medications, your family, or your results, and cannot.

**Do not start, stop, or change any prescription, any over-the-counter product, or any supplement on the strength of something you read here.** Take it to the person who prescribes for you. That is what this book is built to help you do, and it is the only thing it is built to do.

**About the numbers.** This book contains drug names, doses from FDA labels, figures from clinical trials, monitoring schedules, and diagnostic thresholds. They are here for one purpose: so that you can understand, verify and question the care you are being offered. They are not recommendations, and they are not instructions. A dose printed in this book is a report of what a trial used or what a label says — never a suggestion of what you should take. Where a treatment needs a prescription, this book tells you what it is for and what to ask. It does not tell you what to take.

**About the red flags.** Every chapter carries a Red Flags box. Those boxes are prompts to seek care. They are not a triage system, they are not complete, and they cannot tell you whether something is serious. If you are frightened, or if something feels wrong and is not on any list in this book, that is reason enough to be seen. **Nothing in this book should ever delay emergency care.** If you think you may be having a medical emergency, stop reading and call your local emergency number.

**About the evidence.** Every claim here describes what happened to groups of people in studies. It cannot tell you what will happen to you. A treatment that helped most women in a trial may not help you; a risk that is small across a thousand women may be your risk. Results vary, and this book cannot predict yours.

**A note on dates and currency.** The science and the regulation in this field move. Drug labels are revised, guidelines are reissued, approvals are granted and warnings are added and removed — this edition documents one such removal that happened while it was being written. Everything here reflects the best information the author could verify as of the date on the copyright page. Check anything that matters to your decision against a current source, and ask your clinician what has changed.

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# Chapter 3: What Is Normal, What Is Not — When to Call a Clinician

### What You May Feel

You are lying awake doing math you never wanted to learn. Is this normal? Is this the thing everyone warned you about, or the thing nobody warned you about because it isn't menopause at all?

Maybe you bled after a year with nothing, just a smear, and your mind went somewhere dark before you could stop it. Maybe the fatigue has gone past tired into something that frightens you a little, and you've started wondering whether "probably just menopause" is a diagnosis or a guess. Maybe a headache arrived unlike any before it, and you sat very still, waiting to see if it would pass, unsure whether stillness was the right response.

This transition produces a symptom list so long (heat, bleeding changes, mood shifts, joint pain, fog, a racing heart) that it can absorb almost anything. That is exactly what makes it dangerous to over-trust. A serious illness can hide inside a menopause label as easily as a harmless symptom can hide inside a frightening one.

You may have picked up this book because something is happening in your body and you don't yet know what to call it. This chapter will not diagnose you; no book can. It will help you sort what you feel into categories you can act on: what can wait for a routine appointment, what needs one this week and what needs attention today. It also gathers, in one place, every symptom in this book that should never be waited out.

If something has frightened you and you are trying to decide whether that fear is reasonable, the red flags come right after the severity guide below. The rest of the chapter will still be here after.

### How to Calibrate: A Severity Guide

This is a tool every woman should be handed at forty. It will not replace a clinician's judgment. It gives you language for what you're carrying, and language changes how a symptom gets taken, by you and by whoever you describe it to.

There are four levels. Ask yourself which one you're in, symptom by symptom; you may sit at different levels for different symptoms.

**Mild.** You notice it, but it does not change what you do. An occasional warm flush that passes in a minute. A single night of restless sleep. A twinge in a joint that's gone by lunch. A period that arrives four days early. Track these, since patterns help, as the chapters that follow show. On their own, they are not a reason to rearrange your week.

**Bothersome.** It costs you something small, again and again. Hot flashes that interrupt a meeting a few times a week. Sleep that leaves you foggy most mornings. Joint stiffness that makes stairs unpleasant. A mood that dips more than it used to, though you can still function. Vaginal dryness that makes sex uncomfortable rather than impossible. Bothersome symptoms call for treatment; you are not meant to endure them. They are not

urgent, though. A routine appointment in the next few weeks is the right pace.

**Disruptive.** It is now shaping your choices. You've turned down a work trip because of your bladder. You've stopped sharing a bed with your partner because of night sweats. You've missed work because brain fog made you afraid to drive, or joint pain made you afraid to stand all day. Bleeding is so heavy or unpredictable that you plan your life around a bathroom. Your mood is low enough to wear away at relationships or work you care about.

Disruptive symptoms call for an appointment within days to a couple of weeks, not months. If a clinician answers a disruptive symptom with "that's just menopause, ride it out," get a second opinion.

**Alarming.** Your body has done something it has never done before. It came on suddenly, or it involves bleeding after menopause, chest or head symptoms, a sudden severe change or thoughts of harming yourself. Alarming symptoms are not a "wait and see" category. Call today, or go to urgent or emergency care. The next section is the full list.

A quick way to keep all four in mind: mild is what you notice, bothersome is what costs you, disruptive is what reshapes your life and alarming is what needs attention before the day ends. Most of what you'll feel across this transition lives in the first two, which is why the fourth has to be unmistakable.

## Red Flags — What Needs Attention Today, Not "Eventually"

This is the list this book asks you to come back to. Everything on it comes from the chapters ahead, gathered here so a frightened woman finds it first, without hunting through the book.

None of these mean something is certainly wrong. Several are, more often than not, something ordinary and treatable. What they share is that none should be met with a shrug, a "let's watch it" or a wait until your next scheduled visit. Each calls for a call this week, a call today, a same-day visit or emergency care, depending on severity.

**RED FLAG**

**Bleeding**

- **Any vaginal bleeding after twelve months with no period at all. Call today.** This is the most important red flag in this book. **"Any" means any**: spotting, pink or brown discharge, a single episode, bleeding that stopped on its own. **The section right after this box explains what a proper evaluation looks like.**
- **Bleeding so heavy that you soak through a pad or tampon every hour for several hours in a row**, or bleeding with large clots, dizziness or feeling faint. This needs same-day medical attention, because it can cause dangerous blood loss quickly.

**The heart**

- **Chest pain or pressure, including atypical presentations.** Women's heart attacks are often missed because the "classic" crushing chest pain is often not what shows up. Watch for pressure, tightness or squeezing in the chest; pain spreading to the jaw, neck, back or arm; shortness of breath; nausea or vomiting; cold sweat; or sudden, unusual fatigue, with or without chest pain. Treat any of these as cardiac until proven otherwise and seek emergency care.

**The brain**

- **A sudden, severe headache unlike any you've had before**, described by many women as

"the worst headache of my life," especially if it comes on within seconds to minutes. This needs emergency evaluation.

- **Signs of stroke, remembered with FAST: F**ace drooping on one side; **A**rm weakness, especially one side suddenly weaker than the other; **S**peech that is slurred or hard to produce or understand; **T**ime to call emergency services immediately, noting when symptoms started. Do not wait to see if it passes, and do not drive yourself.

**The body more broadly**

- **Unexplained weight loss together with drenching night sweats, fever or swollen lymph nodes.** This combination needs investigation for infection or, less commonly, blood cancers. In most cases it is not an emergency-room emergency, but it is a "call this week" red flag, not a "mention it at your next physical" one.
- **Hot flashes that begin before age 40.** This may be premature ovarian insufficiency, in which the ovaries slow or stop making hormones decades earlier than usual. Call for an evaluation rather than waiting a year to see what happens. Chapter 26 covers diagnosis and treatment.
- **New bloating, pelvic or abdominal pressure, feeling full quickly or urinary urgency** that happens most days and has lasted more than a few weeks. This is a recognized early pattern for ovarian cancer. Call this week for an evaluation rather than accepting "just menopause." Chapter 24 covers it.
- **Pain, swelling, warmth or redness in one calf, or sudden shortness of breath, chest pain or coughing up blood**, especially if you take estrogen. These can be signs of a blood clot. Calf symptoms need same-day evaluation; breathlessness or chest pain is an emergency. Chapter 20 covers it.

**Your mind**

- **Thoughts of harming yourself.** If you are having these thoughts, please tell a clinician or call a crisis line today. In the United States, the 988 Suicide & Crisis Lifeline is available by call or text, any hour. You do not have to explain or justify the thought to get help for it, and you do not have to wait for a scheduled appointment. This is treatable, and reaching out is the next right step, not a last resort.
- **Any symptom that frightens you**, even if it isn't on this list. You know your body's baseline better than any list can. If something feels wrong enough to keep you up at night, that feeling is itself a reason to call.

If you are reading this list because something on it is happening to you right now, put the book down and make the call first.

Chest symptoms are on this list for a reason that starts at this age. A 2020 American Heart Association scientific statement found that the menopause transition itself, apart from aging, changes cholesterol, body fat and blood vessel health in ways that raise cardiovascular risk. That is part of why chest symptoms call for attention from now on, not decades later.

#### If the bleeding is what brought you here

This is the one entry on the list that gets a second page, because knowing a little more changes what happens to you.

Most postmenopausal bleeding has a benign cause, but roughly one woman in ten who has it turns out to have endometrial cancer. That cancer is among the most treatable there is when it is caught early. That is a reason to call, not to panic.

**It counts even if it was once, and light, and it stopped.** By morning it will feel like it might not have happened. Brief, light or only the one time, it still needs the same evalua-

tion.

**What an adequate evaluation looks like.** In 2026, US guidance changed. Most women with postmenopausal bleeding should now have both a transvaginal ultrasound and an endometrial biopsy, a brief in-office procedure that takes a tissue sample. In the guidance's own words, the scan by itself is "generally insufficient evaluation." The older approach, a scan alone and a wait if the lining measures thin, is still widely used. Some specialists still defend it, on the grounds that universal sampling puts many women through a procedure they did not need. Chapter 13 sets out that disagreement and the narrow cases in which skipping the biopsy is still considered reasonable.

So if you are told over the phone that your scan was normal and to come back if it happens again, treat that as the start of a conversation. Ask two things. **"Was my lining fully visualized?"** A scan that could not see the whole lining is an incomplete test, and an unclear picture is not the same as a thin one. Then ask: **"Am I being offered the scan alone because I meet the criteria for deferring the biopsy, or for another reason?"** Both can be legitimate. Only one means you were assessed against the criteria.

**If you are Black, know this.** The thin-lining threshold works far less well for Black women. In a simulated cohort of 367,073 women, it identified 87.9% of cancers in White women and 47.5% in Black women, more than four times as many missed (Doll et al., 2021, *JAMA Oncology*). Much of the gap comes from higher rates of fibroids, which obscure the measurement, and of aggressive tumor types that never thicken the lining. The 2026 guidance names Black race among the risk factors that rule out deferring the biopsy. **So if you are Black, the scan alone is not the recommended evaluation for you, whatever it measures.** If a thin result is being used to reassure you, say so.

**If the bleeding continues, or stops and comes back, it needs a tissue sample whatever the scan showed.** A reassuring number early does not close the question.

## When "Just Menopause" Is the Wrong Diagnosis

This section protects you from a common harm: losing a year of your life to the wrong label while the right one goes untreated.

Most of what you feel during this transition really is the transition. Menopause is not a diagnosis you reach only after ruling out everything else. Several serious, common and treatable conditions, though, overlap with it closely enough to hide behind it. A good clinician keeps both possibilities open, and so should you.

**Thyroid disease.** Your thyroid, the small gland in your neck that sets the pace of your metabolism, can slow down (hypothyroidism) or speed up (hyperthyroidism) at exactly the age menopause arrives, and the two borrow each other's symptoms freely. An underactive thyroid causes fatigue, weight gain, low mood, dry skin and feeling cold, all easily filed under menopause. An overactive thyroid causes heat intolerance, sweating, a racing heart, anxiety and weight loss, a near-perfect disguise for hot flashes. Thyroid disease is common in midlife women and found with one blood test. If yours hasn't been checked and your symptoms fit poorly with what you read in this book, ask for it.

**Anemia from heavy bleeding. Perimenopause**, the years of irregular cycles leading up to your final period, often brings heavier or less predictable bleeding. **Fibroids**, benign growths in the muscle of the uterus, are common at this age and don't reliably shrink; some keep growing through the transition. Heavy bleeding month after month can cause **iron-deficiency anemia**, a shortage of the iron needed to make healthy red blood cells.

Anemia brings exhaustion, breathlessness, dizziness and a pounding heart that are easy to mistake for menopause fatigue. If your bleeding is heavy or your fatigue feels out of proportion, ask for a simple blood count. It is one of the most fixable causes of feeling terrible.

**Sleep apnea. Sleep apnea** means repeated, brief pauses or shallow breathing during sleep, often with snoring, gasping or waking without knowing why. It is underdiagnosed in midlife women, partly because the textbook image is a heavyset, snoring man. A woman waking soaked and exhausted is more often told her broken sleep is a hot flash problem. One study using repeated in-home sleep testing found that sleep apnea grew more severe as women moved through perimenopause into postmenopause, independent of aging or weight change. If your "night sweats" come with loud snoring, pauses in breathing that someone has noticed, gasping awake or morning headaches, ask about a sleep study. That is a different problem from vasomotor night sweats, and it needs a different treatment; Chapter 10 explains screening.

**Diabetes and blood sugar changes. Diabetes** is a condition in which the body cannot properly regulate blood sugar, because it doesn't make enough insulin or can't use it well. It becomes more common in midlife; Chapter 16 explains how the shift toward belly fat and insulin resistance leads toward it. Undiagnosed diabetes causes fatigue, blurred vision, unusual thirst, frequent urination and slow-healing cuts, all easy to wave off as midlife tiredness. A routine blood sugar check, part of most primary care visits, closes this gap. Don't skip that visit because you think you already know what's going on.

**Depression as its own illness.** Mood changes are a biologically grounded part of this transition; Chapter 11 explains the hormonal mechanism. A low mood that rises and falls with the transition differs from a **major depressive episode**, a distinct psychiatric illness with its own diagnostic criteria and effective treatments.

An expert panel convened by The Menopause Society and a consortium of women's mental health researchers found that most women who have a major depressive episode during perimenopause have had one before. The panel concluded that antidepressants and psychotherapy remain first-line treatment, and that estrogen therapy, though not approved for depression, has antidepressant effects in perimenopausal women, particularly those with hot flashes. A separate long-running cohort study found that women with no history of depression were roughly twice as likely to have a first episode during the transition as women who were still premenopausal.

If your low mood is severe, lasts most of the day for two weeks or more, or comes with hopelessness, loss of interest in nearly everything or thoughts of death, it needs to be treated as depression. Don't wait for your hormones to settle. It needs its own evaluation, whether or not menopause is also part of the picture.

**Autoimmune disease.** In **autoimmune disease**, the immune system mistakenly attacks the body's own tissue. Rheumatoid arthritis inflames and damages the joints. Lupus can inflame joints, skin, kidneys and other organs. Both, along with autoimmune thyroid disease, become more common in women in this age range, for reasons only partly understood. They overlap heavily with menopause: joint pain and stiffness, fatigue, skin changes, low-grade fevers, hair changes.

Clues that point toward autoimmune disease include joints that are visibly swollen or warm, pain on both sides of the body, morning stiffness lasting more than thirty minutes and symptoms that don't come and go with your cycle. If your joint pain looks like this,

ask for a direct conversation and often a referral to a rheumatologist. Menopausal joint pain has its own chapter, Chapter 17.

**Cancers that present with overlapping symptoms.** Ovarian cancer can show up as bloating, pelvic pressure, feeling full quickly and urinary urgency, which are easy to dismiss as midlife digestion, especially when they're vague and come and go at first. Endometrial cancer, cancer of the uterine lining, shows up overwhelmingly as abnormal bleeding, which is why the bleeding red flags above carry such weight. Colon cancer can cause fatigue from slow, hidden blood loss, changed bowel habits or unexplained weight loss. Any persistent, new or worsening symptom of this kind, lasting more than a few weeks, needs a direct answer from a clinician rather than a menopause label applied by default.

Most fatigue in this decade is not thyroid disease. Most joint pain is not lupus. Most bloating is not ovarian cancer. The point is only that if your problem is your thyroid, your iron, your mood or something rarer, you should not lose a year because nobody said these words out loud. Say them yourself if you need to: "Could this be something else? What would you check before we call it menopause?"

Two more patterns are not look-alikes, but they are worth raising at any visit. If you have **migraine with aura**, meaning visual disturbances or other neurological symptoms before a headache, a 2026 clinical review notes it needs particular attention around menopause. Hormonal shifts during the transition can affect both migraine and stroke risk, so discuss it with your clinician, especially before starting or continuing any estrogen-containing therapy (see Chapter 18). And if your hot flashes started early, mention it: early hot flashes have been linked to higher heart risk later, which is a reason to have your blood pressure, cholesterol and blood sugar checked. Chapter 9 explains how far that evidence goes.

## Finding a Menopause-Literate Clinician

Not every clinician has been well trained to sort menopause from its look-alikes. Surveys of medical residents find that most finish training without feeling prepared to manage menopause care, through no fault of their own.

Chapter 8 is the place to go next. It explains how to find a menopause-literate clinician, including through The Menopause Society's practitioner directory, how to build a small care team when your picture is complicated and what to say when you feel dismissed.

One piece belongs here: **a red flag calls for care whoever your clinician is.** You do not need the perfect specialist before you act on chest pain, sudden severe bleeding or a stroke warning sign. You need the nearest available care, today. Finding the right long-term clinician is a project for next week. The red flags above are not.

## What to Expect at Your First Appointment

A first visit usually covers your period history, a full run-through of symptoms and your personal and family history of clots, stroke, heart disease and cancer, often with a blood pressure check and bloodwork to rule out the look-alikes above. It may end with a prescription or, just as often, with a plan to gather more information, which is a fine start. Chapter 8 walks through the visit itself, including how to prepare a one-page brief and how to bring someone with you or record the conversation.

## Questions to Ask Your Clinician

For a routine visit, bring the questions from the symptom chapter that matches what you feel most; Chapters 9 through 18 each end with a tailored list. For a first visit, when you're still sorting out what's going on, start with these:

1. Based on my age, my symptoms and my period history, where do you think I am in the menopause transition?
2. Given what I'm describing, is there anything else you want to rule out before we call this menopause: thyroid, blood count, blood sugar or anything else?
3. Which of my symptoms would you consider mild, which would you consider worth treating now and which would you want me to call you about immediately if they happen?
4. If my bleeding pattern changes going forward, at what point should I call you rather than wait for my next visit?
5. Do I have any personal or family history that changes how urgently we should look at something, or that would make certain treatments unsafe?
6. Who else should I be seeing, based on what you're hearing today: an endocrinologist (a physician specializing in hormone-related conditions), a gynecologist or a mental health provider?
7. What is the plan if this turns out not to be menopause?
8. When should I come back, and what should prompt me to call sooner?

## Practical Next Step

**Sort what you are feeling into the four levels, on one page.**

List every symptom you notice now and label each one mild, bothersome, disruptive or alarming, using the guide above. Don't round up or down.

Below that, write anything from the red-flag list that applies to you, even partly, even if you're not sure it counts. Uncertainty is the reason to write it down and ask.

If anything lands in the alarming column, the page has one job tonight: get you to a phone. If nothing does, bring it to your next appointment, or let it decide whether that appointment should be next month or next week.

You don't need to solve this alone, or all of it tonight. You need one clear page, and the willingness to make one call.

Most of what you will feel across this transition is not an emergency, and you now know how to recognize the few things that are. Trust the list when it's alarming, and trust your own unease when nothing on it quite fits. For everything else, the ordinary, ongoing hard, the rest of this book is here to walk beside you.

END OF THE FREE SAMPLE

# That was Chapter 3 of 37.

Chapter 3 is the one the book tells frightened readers to open first. The other thirty-six do the slower work: what is happening in your body, what each option actually does, the evidence behind it in plain numbers, and the questions to take to the person who prescribes for you.

**Inside the full book:**

- Hormone therapy, from the decision to the delivery, and the full risk picture in absolute numbers
- Nonhormonal prescription options, including the newest drugs for hot flashes
- Sleep, mood, brain fog, bleeding, vaginal and urinary health, sex, weight, joints, skin and hair
- Bones, heart, cancer screening, and brain health for the decades ahead
- Early, premature and surgical menopause
- What supplements, acupuncture and Ayurveda can and cannot do
- A first-thirty-days plan and a one-page summary to hand your clinician

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