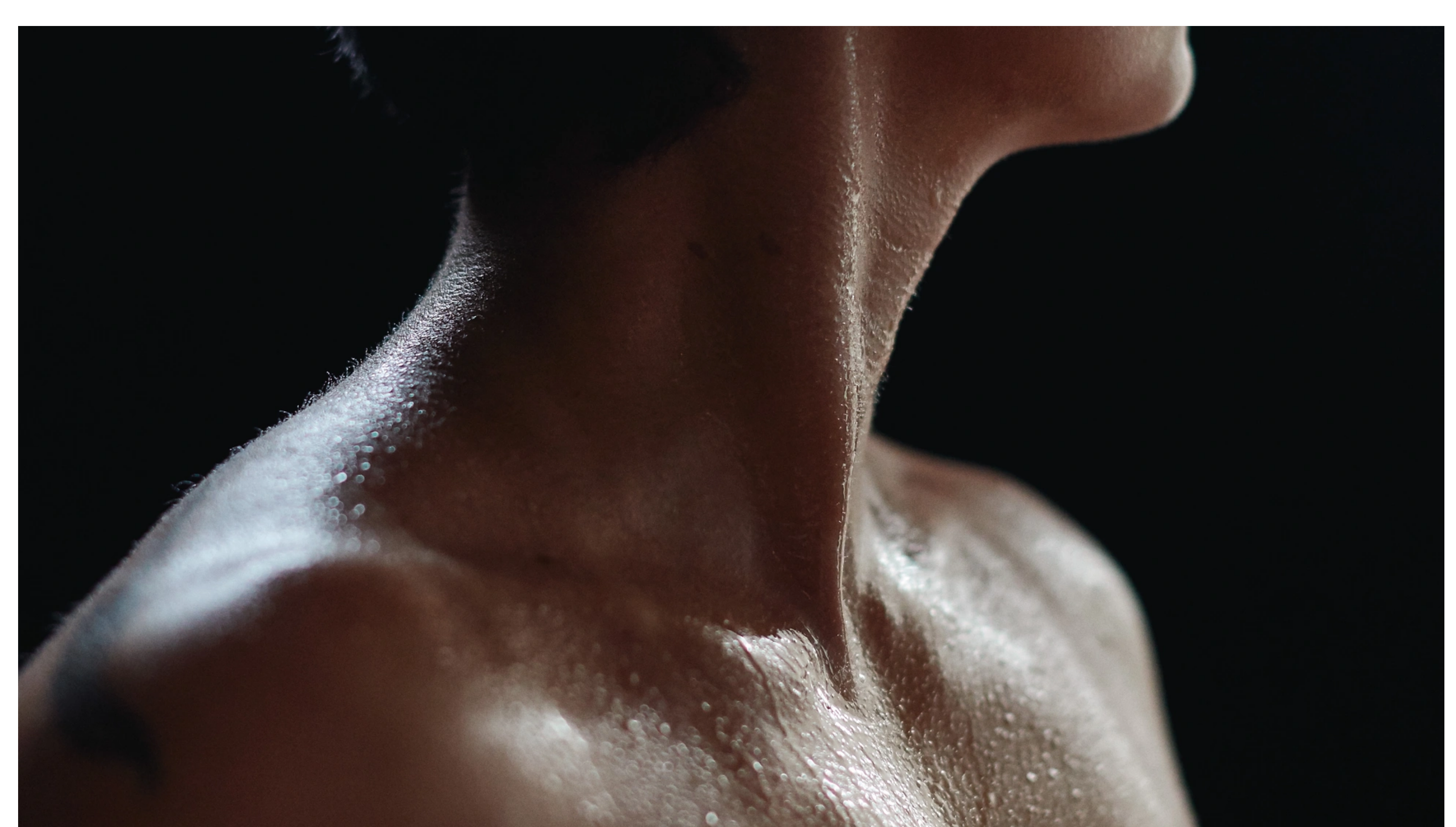
HEALTH

Women in Menopause Are Getting Short Shrift

They could benefit from a diversity of hormones, empathy about their experience, and a frank approach to sexuality—all hallmarks of trans health care.

By Rachel E. Gross



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After a decade working as an obstetrician-gynecologist, Marci Bowers thought she understood menopause. Whenever she saw a patient in her 40s or 50s, she knew to ask about things such as hot flashes, vaginal dryness, mood swings, and memory problems. And no matter what a patient's concern was, Bowers almost always ended up prescribing the same thing. "Our answer was always estrogen," she told me.

Then, in the mid-2000s, Bowers took over a gender-affirmation surgical practice in Colorado. In her new role, she began consultations by asking each patient what they wanted from their body—a question she'd never been trained to ask menopausal women. Over time, she grew comfortable bringing up tricky topics such as pleasure, desire, and sexuality, and prescribing testosterone as well as estrogen. That's when she realized: Women in menopause were getting short shrift.

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Menopause is a body-wide hormonal transition that affects virtually every organ, from skin to bones to brain. The same can be said of gender transition, which, like menopause, is often referred to by doctors and transgender patients as "a second puberty": a roller coaster of physical and emotional changes, incited by a dramatic shift in hormones. But medicine has only recently begun connecting the dots. In the past few years, some doctors who typically treat transgender patients—urologists, gender-affirmation surgeons, sexual-medicine specialists—have begun moving into menopause care and bringing with them a new set of tools.

"In many ways, trans care is light years ahead of women's care," Kelly Casperson, a urologist and certified menopause provider in Washington State, told me. Providers who do both are well versed in the effects of hormones, attuned to concerns about sexual function, and empathetic toward people who have had their symptoms dismissed by providers. If the goal of menopause care isn't just to help women survive but also to allow them to live their fullest life, providers would do well to borrow some insights from a field that has been doing just that for decades.

From the October 2019 issue: The secret power of menopause

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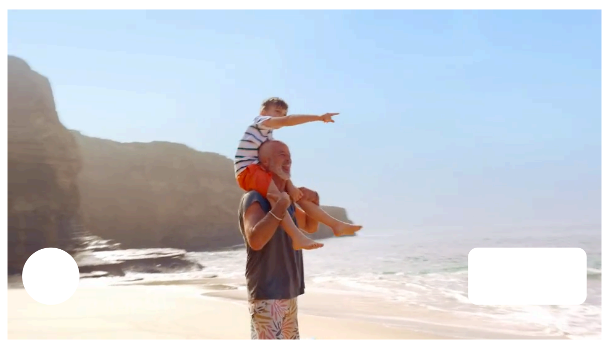

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American women's relationship with estrogen has been a rocky one. In the 1960s, books such as *Feminine Forever*, written by the gynecologist Robert A. Wilson, framed estrogen as a magical substance that could make women once again attractive and sexually available, rendering the menopausal "much more pleasant to live with." (*The New York Times* later reported that Wilson was paid by the manufacturer of Premarin, the most popular estrogen treatment at the time.) Later, the pitch switched to lifelong health. By 1992, Premarin was the most prescribed drug in the United States. By the end of the decade, 15 million women were on estrogen therapy, with or without progesterone, to treat their menopause symptoms.

Then, in 2002, a large clinical trial concluded that oral estrogen plus progesterone treatment was linked to an increased risk of stroke, heart disease, and breast cancer. The study was an imperfect measure of safety—it focused on older women rather than on the newly menopausal, and it tested only one type of estrogen—

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but oral-estrogen prescriptions still plummeted, from nearly a quarter of women over 40 to roughly 5 percent. Despite this blow to the hormone's reputation, evidence has continued to pile up confirming that oral estrogen can help prevent bone loss and treat hot flashes and night sweats, though it can increase the risk of strokes for women over 60. Topical estrogen helps address genital symptoms, including vaginal dryness, irritation, and thinning of the tissues, as well as urinary issues such as chronic UTIs and incontinence.

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But estrogen alone can't address every menopause symptom, in part because estrogen is not the only hormone that's in short supply during menopause; testosterone is too. Although researchers lack high-quality research on the role of testosterone in women over age 65, they know that in premenopausal women, it plays a role in bone density, heart health, metabolism, cognition, and the function of the ovaries and bladder. A 2022 review concluded, "Testosterone is a vital hormone in women in maintaining sexual health and function" after menopause.

Yet for decades, standard menopause care mostly ignored testosterone. Part of the reason is regulatory: Although estrogen has enjoyed FDA approval for menopausal symptoms since 1941, the agency has never green-lit a testosterone treatment for women, largely because of scant research. That means doctors have to be familiar enough with the hormone to prescribe it off-label. And unlike estrogen, testosterone is a Schedule III controlled substance, which means more red tape. Some of Casperson's female patients have had their testosterone prescription withheld by pharmacists; one was asked if she was undergoing gender transition.

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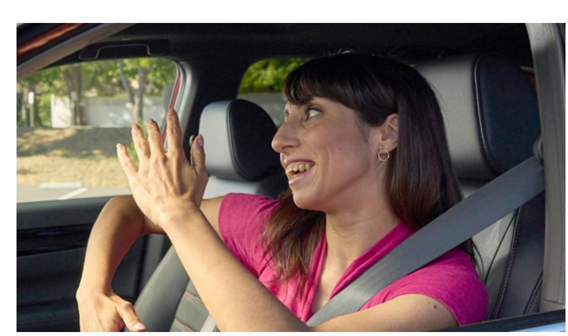

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The other hurdle is cultural. These days, providers such as Casperson, as well as menopause-trained gynecologists, might prescribe testosterone to menopausal women experiencing difficulty with libido, arousal, and orgasm. Many women see improvements in these areas after a few months. But first, they have to get used to the idea of taking a hormone they've been told all their lives is for men, at just the time when their femininity can feel most tenuous (see: *Feminine Forever*). Here, too, experience in trans care can help: Casperson has talked many transmasculine patients through similar hesitations about using genital estrogen cream to balance out the side effects of their high testosterone doses. Taking estrogen, she tells those patients, "doesn't mean you're not who you want to be," just as taking testosterone wouldn't change a menopause patient's gender identity.

Many trans-health providers have also honed their skills in speaking frankly about sexuality. That's especially true for those who do surgeries that will affect a patient's future sex life, Blair Peters, a plastic surgeon at Oregon Health & Science University who performs phalloplasties and vaginoplasties, told me. Experts I spoke with, including urologists and gynecologists with training in sexual health, said that gynecologists can often fall short in this regard.

Despite treating vaginas for a living, they can often be uncomfortable bringing up sexual concerns with patients or inexperienced at treating issues beyond vaginal dryness. They can also assume, inaccurately, that concerns about vaginal discomfort always center on penetrative sex with a male partner, Tania Glyde, an LGBTQ+ therapist in London and the founder of the website Queer Menopause, told me. A 2022 survey of OB-GYN residency programs found that less than a third had a dedicated menopause curriculum.

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Bowers, who is herself transgender, told me she got comfortable talking about sexuality in a clinical setting only after moving into trans care. If she were to return to gynecology today, she said, she would add some frank questions to her conversations with midlife patients who share that they're having sexual issues: "Tell me about your sexuality. Tell me, are you happy with that? How long does it take you to orgasm? Do you masturbate? What do you use?"

Menopause care has already benefited from decades of effort by queer people, who have pushed doctors to pay more attention to a diversity of experiences. Research dating as far back as the 2000s that included lesbians going through menopause helped show that common menopause stereotypes, such as anxiety over remaining attractive to men and disconnect between members of a

couple, were far from universal. Trans people, too, have benefited from advances in menopause care. Because both gender transition and menopause involve a sharp drop in estrogen, many transmasculine men who take testosterone also lose their period, and experience a similar (though more extreme) version of the genital dryness and irritation. That means they can benefit from treatments developed for menopausal women, as Tate Smith, a 25-year-old trans activist in the U.K., realized when he experienced genital pain and spotting after starting testosterone at 20. After he found relief with topical estrogen cream, he made an Instagram post coining the term *trans male menopause* to make sure more trans men were aware of the connection.

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The more menopause and gender care are considered together in medical settings, the better the outcomes will be for everyone involved. Yet menopause studies rarely consider trans men and nonbinary people, along with younger women and girls who experience menopause due to cancer treatment, surgery, or health conditions that affect ovarian function. Although these patient populations represent a small proportion of the patients going through menopause, their experiences can help researchers understand the effects of

low estrogen across a range of bodies. Siloing off menopause from other relevant fields of medicine means menopausal women and trans people alike can miss out on knowledge and treatments that already exist.

Unlike gender transition, menopause is generally not chosen. But it too can be an opportunity for a person to make choices about what they want out of their changing body. Not all women in menopause are worried about their libido or interested in taking testosterone. Like trans patients, they deserve providers who listen to what they care about and then offer them a full range of options, not just a limited selection based on outdated notions of what menopause is supposed to be.

Rachel E. Gross is a science journalist who has written for *The New York Times*, *Scientific American*, and the BBC. She is the author of *Vagina Obscura: An Anatomical Voyage*.

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