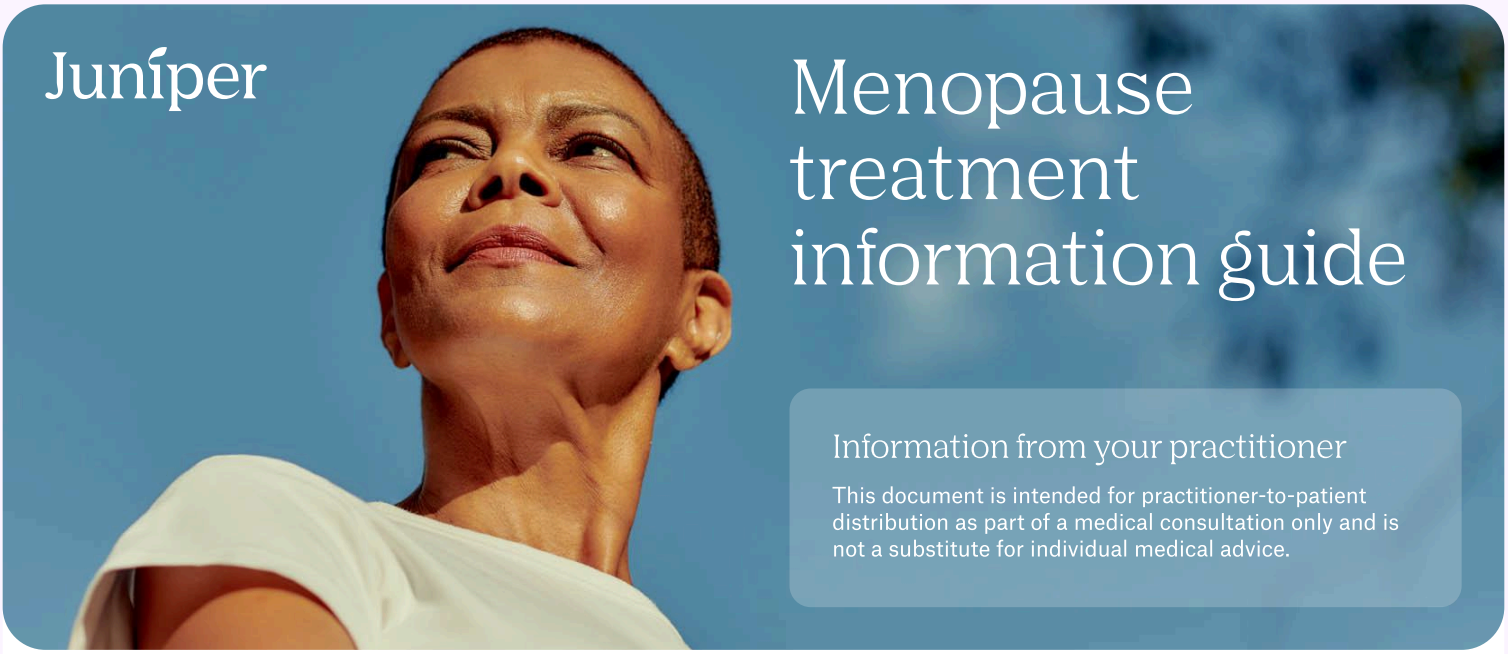
Juníper



Menopause treatment information guide

Information from your practitioner

This document is intended for practitioner-to-patient distribution as part of a medical consultation only and is not a substitute for individual medical advice.

Juniper menopause treatment program options

The Juniper menopause program starts with an assessment so our experienced practitioners can provide you with a personalised care plan. During the consultation, if suitable, a practitioner may prescribe a number of different medications including:

Hormonal

replacing the hormones your ovaries are producing less of

Non-Hormonal

when MHT isn't suitable, or to target specific symptoms

What's the difference?

Hormonal treatment (MHT) works by replacing the oestrogen and progesterone your ovaries are producing less of. It is the most effective treatment for most menopausal symptoms. Examples include oestrogen gel (Estrogel), patches (Estradot) and micronised progesterone (Prometrium).

Non-hormonal treatment does not contain hormones. It is used when MHT is not suitable, for example, if you have a history of certain cancers, prefer to avoid hormones or as an add-on for specific symptoms.

Your practitioner will have recommended the approach best suited to your health history, symptoms and preferences.

Both hormonal and non-hormonal options are evidence-based; the right choice depends on you.

How MHT works:

✓ **Oestrogen**
The primary hormone replaced in MHT. Addresses most menopausal symptoms: hot flushes, night sweats, sleep disruption, brain fog, joint pain, mood changes, vaginal dryness and bladder changes.

✓ **Progesterone**
Added to protect the lining of the uterus (endometrium) in women who still have a uterus. It may help with sleep.

Treatment may improve

- **Hot flushes & night sweats**
- **Sleep quality, brain fog & concentration**
- **Vaginal dryness, discomfort & libido**
- **Energy levels**
- **Joint & muscle pain**

Why transdermal oestrogen?
This route is safer than oral oestrogen, in particular, it does not increase the risk of blood clots or stroke.

Vaginal or bladder symptoms

Genitourinary Syndrome of Menopause (GSM) affects up to half of postmenopausal women. Symptoms include vaginal dryness, discomfort during sex, urinary urgency and recurrent UTIs. Unlike hot flushes, GSM does not resolve on its own and typically worsens over time without treatment.

Hormonal

Local vaginal oestrogen or hormone-like therapy is highly effective for GSM. It does not self-resolve, so there is no reason to stop once it is working.

Options include:
- Vagifem
- Ovestin cream
- Ovestin pessary

Non-Hormonal

- Vaginal moisturisers (daily, not just for intercourse
- Water- or silicone-based lubricants for sex
- Wash with water only - avoid soaps, scented products
- Cotton, loose-fitting underwear
- Pelvic floor exercises for bladder symptoms

Medication information

Administration

Gel | Patch | Oral | Vaginal

MHT comes in several forms including gels, patches, tablets, and vaginal pessaries or creams.

Dosing Schedule

Low starting dose | Titrate as needed

MHT is started at the lowest effective dose and adjusted based on how you respond. There is no one-size-fits-all dose; your practitioner will personalise this for you.

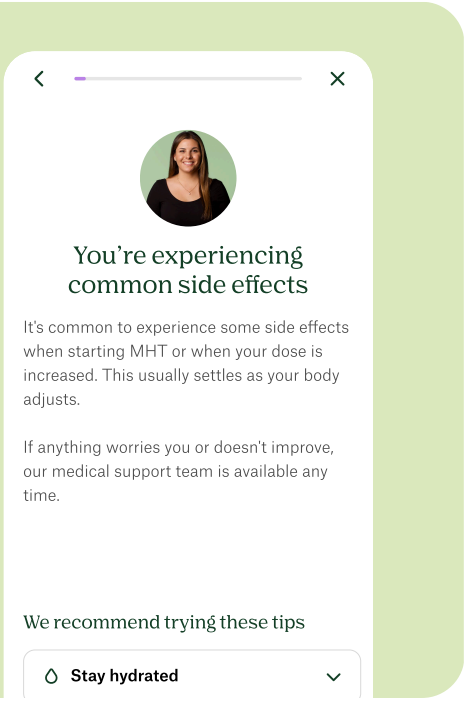
Side effects

It is common to experience some adjustment effects when starting MHT or increasing your dose. Most settle within a few weeks.

Side effects can often be managed with interventions, and our medical team is on hand to support when you need.

Common side effects may include:
- Breast tenderness
- Breakthrough bleeding
- Bloating
- Mood changes
- Indigestion

Detailed information on side effects will also be provided with the medication.



Lifestyle and Long Term Health

Treatment works best alongside healthy lifestyle habits. These recommendations support your treatment and benefit your overall health during and beyond the menopause transition.

Exercise: Aim for at least 150 minutes of moderate-intensity activity per week. Include strength or resistance training to protect bone density and muscle mass, both of which decline with oestrogen loss. Exercise also improves mood, sleep and cardiovascular health.

Sleep: Treating vasomotor symptoms with MHT significantly improves sleep for most women. Support this with consistent sleep and wake times, a cool and dark bedroom, and reducing caffeine and alcohol in the evening.

Nutrition: Prioritise protein at each meal to maintain muscle mass.

Alcohol and smoking: Both worsen menopausal symptoms. Alcohol raises breast cancer risk even at low levels and disrupts sleep. Smoking worsens hot flushes, accelerates bone loss and increases cardiovascular risk.

Mental wellbeing: CBT has strong evidence for both mood symptoms and hot flushes. Mindfulness and stress reduction are useful adjuncts. The menopause transition can be emotionally challenging, seeking psychological support is a sign of good self-care, not weakness.

Health screening: Use this as an opportunity to make sure your mammogram, cervical screen and blood pressure checked. If you have risk factors for osteoporosis, discuss a bone density scan with your GP.

How long do I need to stay on the program?

Your plan & recommended duration will be personalised by your practitioner. Menopause should be thought of as long-term journey rather than a quick fix

Treatment optimisation phase

1-3 months

- You will likely start at a lower dose to allow your body to adjust and minimise side effects.
- Most women notice a response between 8–12 weeks.
- Your symptoms will be reassessed and your dose adjusted if needed.

Maintenance phase

Ongoing

- You will have an annual review to reassess benefits, risks and whether to continue.
- There is no fixed end date. MHT can be continued as long as benefits outweigh risks, with annual review.

Still have questions?

If you have any questions, you can ask your practitioner in your consultation, or contact our support team here.

Remember: MHT is NOT a contraceptive. If you are still in perimenopause, you may still ovulate. Women under 50 should continue contraception for 2 years after their last period; women over 50 for 1 year. Speak to your practitioner if you need guidance on this.