Nonhormone Treatments for Hot Flashes and Night Sweats

Hot flashes and night sweats, also called vasomotor symptoms (VMS), are feelings of warmth that can be associated with flushing and sweating. They are very common during menopause, occurring in up to 80% of women and lasting a mean of 7 to 10 years. Vasomotor symptoms may also contribute to sleep and mood issues that can negatively affect quality of life.

Women may choose to use hormone therapy (HT) to treat their VMS, but for those who cannot because of medical conditions (such as breast cancer or a history of heart attack, stroke, or blood clot) or for those who choose not to use HT, there are nonhormone options available to provide relief.

Nonhormone treatment options

**Recommended**
The treatments with research showing that they are effective for treating VMS include

- **Clinical hypnosis**: a mind-body therapy that involves a deeply relaxed state and individualized mental imagery and suggestion. This includes mental imagery for coolness as well as dissociation from VMS, along with a focus on future positive imagery.
- **Cognitive-behavioral therapy**: a form of biofeedback that includes education about the physiology of VMS as well as how thoughts and emotions may affect physical sensations, training in relaxation and paced breathing, identifying and challenging negative beliefs about VMS, monitoring and modifying triggers of VMS, and relaxation exercises.
- **Fezolinetant**: a neurokinin B antagonist that works in the brain to reduce VMS and is FDA approved for VMS management.
- **Gabapentin**: a drug used to treat seizures or nerve pain but has also been found to reduce VMS in multiple studies. Bedtime dosing may be a good choice for women with sleep issues because drowsiness is an adverse event. It can also help with pain and migraine.
- **Oxybutynin**: an antimuscarinic, anticholinergic therapy that is used for the treatment of overactive bladder and urinary urge incontinence and has been found to reduce VMS at low doses. Thus, it could be used to treat both urinary symptoms and VMS.
- **SSRIs/SNRIs**: multiple formulations have been studied and found to be beneficial for VMS management, including paroxetine, escitalopram, citalopram, venlafaxine, and desvenlafaxine, often at lower doses than those used for treatment of anxiety or depression. Only paroxetine mesylate 7.5 mg daily is FDA approved for VMS management specifically. These treatments may be ideal for women with coexisting mood or anxiety symptoms.
- **Stellate ganglion block**: a widely used treatment for pain, including for migraine and complex regional pain syndrome, that involves an injection of an anesthetic agent by a pain specialist targeting a bundle of sympathetic nerves in the front of your neck. It can be considered in select women but is associated with potential risks.
- **Weight loss**: weight loss has been shown to reduce VMS.

**Not recommended**
Although the interventions in this category are not recommended for treating your VMS, some may be beneficial for your health for other reasons, such as with certain dietary modifications and exercise,
which have many proven health benefits. Thus, you may choose to use these options for reasons outside of the treatment of VMS.

Treatments not recommended for VMS either because there is evidence showing that they do not reduce VMS or because there is not enough evidence showing that they are effective in reducing VMS include acupuncture, paced respirations, supplements/herbal remedies, cooling techniques, avoidance of triggers, dietary modification, exercise, yoga, mindfulness-based intervention, relaxation, suvorexant, cannabinoids, calibration of neural oscillations, chiropractic interventions, clonidine, and pregabalin.

There are many dietary supplements available over the counter and advertised as remedies for relief of hot flashes and night sweats. There are limited studies showing that these supplements are effective at relieving VMS, and there is a lack of government regulation ensuring their safety and purity, so none of these are recommended treatments for hot flashes and night sweats.

Despite the lack of evidence supporting their use for VMS, if you plan to use dietary supplements, let your health care professional know so they can ensure they are safe for you, that they don’t interact with any of your medications, and so that they can be appropriately monitored.

<table>
<thead>
<tr>
<th>Recommended Treatments for Vasomotor Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical hypnosis, cognitive-behavioral therapy, stellate ganglion blockade, weight loss, and certain prescription medications including</td>
</tr>
<tr>
<td>Fezolinetant—45 mg daily. Possible adverse events include headaches, and it is recommended that your liver tests are checked before, and then at 3, 6, and 9 months.</td>
</tr>
<tr>
<td>Gabapentin—start with 100 to 300 mg at bedtime, increasing to 600 mg or 900 mg daily if needed. Possible adverse events include dizziness, unsteadiness, and drowsiness, which typically improve with time.</td>
</tr>
<tr>
<td>Oxybutynin—start with 2.5 mg daily and increase to 5 mg twice daily after one week. Possible adverse events include dry mouth and urinary difficulties. Long-term use of this type of medication may be associated with cognitive decline, especially in older people.</td>
</tr>
<tr>
<td>SSRIs/SNRIs—paroxetine, citalopram, escitalopram, desvenlafaxine, or venlafaxine. Possible adverse events include gastrointestinal symptoms that typically improve. For women using tamoxifen to treat or prevent breast cancer, paroxetine should be avoided.</td>
</tr>
</tbody>
</table>

This MenoNote, developed by The Menopause Society, provides current general information but not specific medical advice. It is not intended to substitute for the judgment of a person’s healthcare professional. Additional information can be found at [www.menopause.org](http://www.menopause.org)

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Vaginal Dryness
The *genitourinary syndrome of menopause* (GSM) includes bothersome vaginal, vulvar (lips of the vagina), and urinary symptoms that can affect quality of life, sexual satisfaction, and even your relationship with your partner. Unlike hot flashes, which typically improve with time, GSM usually worsens over time without treatment.

Menopause and aging can affect the genitourinary system in these ways:
- Loss of estrogen at menopause may cause the vaginal tissues to become thin and dry, with decreased elasticity and lubrication, often resulting in pain with sexual activity, routine pelvic examinations, and even discomfort wiping after urination or wearing certain clothing.
- Symptoms such as burning, itching, or irritation of the vulva; lack of lubrication and vaginal dryness; and discomfort or pain with sexual activity are common.
- Burning on urination, increased frequency or urgency of urination, and increased risk for urinary tract infections also can occur.
- Symptoms may be more severe in women who undergo menopause as a result of the surgical removal of both ovaries (surgical menopause) or because of chemotherapy for cancer treatment and in those who receive aromatase inhibitors for prevention or treatment of breast cancers.

Treatment options
There are many effective treatment options for GSM, including over-the-counter and prescription therapies. First-line therapies for less severe symptoms include nonhormone over-the-counter lubricants used as needed for sexual activity and moisturizers used regularly (several times per week) to maintain moisture. Prescription therapies include low-dose vaginal estrogens, vaginal dehydroepiandrosterone inserts, and oral ospemifene. Nonhormone lubricants and moisturizers can be combined for optimal symptom relief and can be used in combination with prescription therapies for more severe symptoms.

Nonhormone remedies
- **Vaginal lubricants** are used with sexual activity and reduce discomfort and increase pleasure by decreasing friction. These include water-, silicone-, and oil-based products. Oil-based lubricants may damage condoms and may increase the risk of vaginal infections. Lubricants should not contain flavors (sugar), warming properties, or solvents and preservatives such as propylene glycol and parabens that may cause irritation in some women.
- **Vaginal moisturizers** are used regularly, often several times weekly to maintain vaginal moisture, with a goal of reducing the daily symptoms of GSM.
- **Regular sexual stimulation** promotes vaginal blood flow and secretions. Sexual stimulation with a partner, alone, or with a device (such as a vibrator) can improve vaginal health.
- **Expanding your views of sexual pleasure** to include *outercourse* options, such as extended caressing, mutual masturbation, and massage, provide a way to remain sexually intimate in place of intercourse.
- **Vaginal dilators** can stretch and enlarge the vagina if it has become too short and narrow or if involuntary tightening occurs, preventing comfortable sexual activity. Dilators can be purchased and used with the guidance of a gynecologist, physical therapist, or sex therapist. You can find dilators online or at specialty stores.
- **Pelvic floor exercises** can strengthen weak pelvic floor muscles and relax tight ones. Pelvic floor physical therapy is available with trained therapists or there are at-home devices to help strengthen the pelvic floor and treat incontinence.
Vaginal hormone therapy
• An effective and safe treatment, **low-dose local estrogen** applied directly to the vagina relieves vaginal dryness and discomfort with sexual activity. Improvements usually occur within a few weeks or months with consistent use.
• **FDA-approved low-dose vaginal estrogen products** are available by prescription as vaginal creams (used two or three nights/wk), a vaginal estradiol tablet or insert (used twice/wk), and an estradiol vaginal ring (changed every 3 mo).
• **Dehydroepiandrosterone** (DHEA; prasterone) is a hormone-containing insert placed in the vagina nightly that reduces vaginal dryness and discomfort with sexual activity.
• Low-dose vaginal estrogen or DHEA may be options for women with a history of breast or uterine cancer after careful consideration of risks and benefits in collaboration with their primary care professionals and their oncologists.

Systemic estrogen therapy
Systemic estrogen therapy provided for treatment hot flashes also treats vaginal dryness, although some women still benefit from additional low-dose vaginal hormone treatment. If only vaginal symptoms are present, low-dose vaginal hormone treatments are recommended.

Other therapies
• **Ospemifene** is a prescription selective estrogen receptor modulator(SERM) available as an oral tablet taken daily for the treatment of vaginal dryness and sexual pain.
• **Vaginal laser therapy** such as fractional CO\textsubscript{2} laser or radiofrequency devices are FDA cleared for vaginal use but not specifically for treatment of GSM. Treatments are costly and generally not covered by insurance. Additional, longer-term studies are needed to establish efficacy and safety before these therapies can be routinely recommended for treatment of GSM.

### Treatment Options Summary

<table>
<thead>
<tr>
<th>Vaginal lubricants (nonprescription)</th>
<th>Many available products.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal moisturizers (nonprescription)</td>
<td>Many available products.</td>
</tr>
<tr>
<td>Vaginal estrogen therapy (prescription required)</td>
<td>Estrace or Premarin vaginal cream (0.5-1 g placed in vagina 2-3 times/wk: generic available). Estrin (small, flexible estradiol ring placed in vagina and changed every 3 mo: 7.5 µg/d). Vagifem (estradiol tablet placed in vagina twice/wk, 10 µg: generic available). Imvexxy (estradiol softgel insert placed in vagina twice/wk: 4 µg, 10 µg).</td>
</tr>
<tr>
<td>Intravaginal dehydroepiandrosterone (Intrarosa; prescription required)</td>
<td>A 6.5 mg vaginal insert used nightly.</td>
</tr>
<tr>
<td>Ospemifene (Osphena; prescription required)</td>
<td>Oral 60 mg tablet taken once daily.</td>
</tr>
<tr>
<td>Vaginal “exercise”</td>
<td>Sexual activity (with or without a partner). Stretching exercises with lubricated vaginal dilators. Pelvic floor physical therapy.</td>
</tr>
</tbody>
</table>

**Notes:** Vaginal and vulvar symptoms not related to menopause include yeast infections, allergic reactions, and certain skin conditions, so consult your healthcare professional if symptoms do not improve with treatment.

Compounded vaginal estrogen and testosterone are not FDA regulated or recommended for treatment of GSM in most cases.

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Deciding About Hormone Therapy Use

Many women experience hot flashes, vaginal dryness, and other physical changes with menopause. For some women, the symptoms are mild and do not require any treatment. For others, symptoms are moderate or severe and interfere with daily activities. Hot flashes improve with time, but some women have bothersome hot flashes for many years. Menopause symptoms often improve with lifestyle changes and nonprescription remedies, but prescription therapies also are available, if needed. Government-approved treatments for bothersome hot flashes include hormone therapy (HT) containing estrogen, as well as a nonhormone medication (paroxetine).

Hormone therapy involves taking estrogen in doses high enough to raise the level of estrogen in your blood in order to treat hot flashes and other symptoms. Because estrogen stimulates the lining of the uterus, women with a uterus need to take an additional hormone, progestogen, to protect the uterus. Women without a uterus just take estrogen. If you are bothered only by vaginal dryness, you can use very low doses of estrogen placed directly into the vagina. These low doses generally do not raise blood estrogen levels above postmenopause levels and do not treat hot flashes. You do not need to take a progestogen when using only low doses of estrogen in the vagina. (The MenoNote “Vaginal Dryness” covers this topic in detail.)

Every woman is different, and you will decide about whether to use HT based on the severity of your symptoms, your personal and family health history, and your own beliefs about menopause treatments. Your healthcare professional will be able to help you with your decision.

Potential benefits
Hormone therapy is one of the most effective treatments available for bothersome hot flashes and night sweats. If hot flashes and night sweats are disrupting your daily activities and sleep, HT may improve sleep and fatigue, mood, ability to concentrate, and overall quality of life. Treatment of bothersome hot flashes and night sweats is the principal reason women use HT. Hormone therapy also treats vaginal dryness and painful sex associated with menopause. Hormone therapy keeps your bones strong by preserving bone density and decreasing your risk of osteoporosis and fractures. If preserving bone density is your only concern, and you do not have bothersome hot flashes, other treatments may be recommended instead of HT.

Potential risks
As with all medications, HT is associated with some potential risks. For healthy women with bothersome hot flashes aged younger than 60 years or within 10 years of menopause, the benefits of HT generally outweigh the risks. Hormone therapy might slightly increase your risk of stroke or blood clots in the legs or lungs (especially if taken in pill form). If started in women aged older than 65 years, HT might increase the risk of dementia. If you have a uterus and take estrogen with progestogen, there is no increased risk of cancer of the uterus. Hormone therapy (combined estrogen and progestogen) might slightly increase your risk of breast cancer if used for more than 4 to 5 years. Using estrogen alone (for women without a uterus) does not increase breast cancer risk at 7 years but may increase risk if used for a longer time.

Some studies suggest that HT might be good for your heart if you start before age 60 or within 10 years of menopause. However, if you start HT further from menopause or after age 60, HT might slightly increase your risk of heart disease. Although there are risks associated with taking HT, they are not common, and most go away after you stop treatment.
Potential adverse events
Hormone therapy can cause breast tenderness, nausea, and irregular bleeding or spotting. These adverse effects are not serious but can be bothersome. Reducing your dose of HT or switching the form of HT you use often can decrease adverse effects. Weight gain is a common problem for midlife women, associated with both aging and hormone changes. Hormone therapy is not associated with weight gain and may lower the chance of developing diabetes.

Hormone therapy options
Each woman must make her own decision about HT with the help of a healthcare professional. If you decide to take HT, the next step is to choose between the many HT options available to find the best dose and route for you. With guidance from your healthcare professional, you can try different forms of HT until you find the type and dose that treats your symptoms with few adverse effects.

Pill or non-pill
Hormone therapy is available as a daily pill, but it also may be taken as a skin patch, gel, cream, spray, or vaginal ring. Non-pill forms may be more convenient. Hormone therapy pills need to be taken every day, but skin patches are changed only once or twice weekly, and the HT vaginal ring is changed only every 3 months. Hormone therapy taken in non-pill form enters your blood stream more directly, with less effect on the liver. Studies suggest that this may lower the risk of blood clots in the legs and lungs compared with HT taken as a pill.

Estrogen alone or estrogen plus progestogen
If you have a uterus, you will need to take progestogen with your estrogen. Many pills and some patches contain both hormones together. Otherwise, you will need to take two separate hormones (eg, estrogen pill with progestogen pill or estrogen patch with progestogen pill). Taking both hormones every day usually results in no bleeding. Women who prefer regular periods can take estrogen every day and progestogen for about 2 weeks each month. Another option is to take estrogen combined with a nonhormone medication (bazedoxifene) to protect the uterus. If you do not have a uterus, you can take estrogen alone, without a progestogen.

Dose of estrogen
As with all medications, you should take the lowest dose of estrogen that relieves your hot flashes. You can work with your healthcare professional to find the right dose for you. It typically takes about 8 to 12 weeks for HT to have its full effect, so doses should be adjusted slowly. Even low doses of estrogen will preserve your bone density and reduce your risk of a fracture.

Stopping hormone therapy
There is no “right” time to stop HT. Many women try to stop HT after 4 to 5 years because of concerns about potential increased risk of breast cancer. Other women may lower doses or change to non-pill forms of HT. Hot flashes may or may not return after you stop HT. Although not proven by studies, slowly decreasing your dose of estrogen over several months or even over several years may reduce the chance that your hot flashes will come back. You and your healthcare professional will work together to decide the best time to stop HT. If very bothersome hot flashes or night sweats return when you stop HT, you will need to reassess your individual risks and benefits to decide whether to continue HT. Because there may be greater risks with longer duration of use and as you age, you and your healthcare professional will work together to decide what is the best option for you.
Bioidentical Hormone Therapy: Custom Compounded versus Government Approved

Many types of hormone therapy are available for you to use for your menopause symptoms. These include hormones that are manufactured to be chemically identical to the naturally occurring hormones produced by your ovaries during the reproductive years, principally estradiol, progesterone, and testosterone. Many of these products are derived from natural sources, including yams or soy. Although the term bioidentical hormones often is used to refer to these identical copies of natural hormones (typically prescribed as custom mixes or compounds for an individual woman), bioidentical hormones is a term invented by marketers and has no clear scientific meaning.

Although natural hormones are not necessarily safer or more effective than other forms of estrogen and progestogen, some women prefer to use hormones after menopause that are identical to those their ovaries produced when they were younger.

If you prefer to treat your bothersome menopause symptoms with hormones that are chemically identical to those you produced naturally before menopause, ask your healthcare provider to prescribe estradiol and progesterone products that are scientifically tested and government approved. Estradiol is available as an oral tablet, skin patch, topical gel, topical spray, and vaginal ring. Low doses of estradiol used in the vagina (to treat vaginal dryness and painful intercourse but not hot flashes) are available as a vaginal tablet, cream, and ring. Progesterone is available as an oral capsule (see table below for product names).

Bioidentical custom-compounded hormones

Some healthcare providers prescribe custom-mixed (custom-compounded) bioidentical hormones containing one or more natural hormones mixed in differing amounts. These products not only contain the active hormone(s) but also other ingredients to create a cream, gel, lozenge, tablet, spray, or skin pellet. Healthcare providers who prescribe bioidentical hormones often claim that these products are more safe and effective than clinically tested and government-approved hormones produced by large pharmaceutical companies. They also may assert that bioidentical hormones slow the aging process. There is no scientific evidence to support any of these claims.

Government-approved hormone products are required by law to come with a package insert that describes possible risks and side effects. Custom-compounded hormones are not required to come with this information, but this does not mean they are safer. They contain the same active hormones (such as estradiol and progesterone), so they share the same risks.

Custom-compounded hormones allow for individualized doses and mixtures; however, this may result in reduced efficacy or greater risk. These compounds do not have government approval because individually mixed recipes are not tested to verify that the right amount of hormone is absorbed to provide predictable hormone levels in blood and tissue. If you have a uterus, there are no studies showing that the amount of progesterone in these custom-mixed hormones is enough to protect you from developing uterine cancer.
There is a long history of pharmacies providing a wide range of compounded products, typically when an equivalent government-approved product is not available. Because preparation methods vary from one pharmacist to another and between pharmacies, you may receive different amounts of active medication every time you fill the prescription. Inactive ingredients may vary from batch to batch as well. Sterile production technique and freedom from undesired contaminants are additional concerns. Expense is another issue, because most custom-compounded preparations are viewed as experimental drugs and are not covered by insurance plans.

**Determining the right dose**

The right dose of hormones for you is the lowest dose of estrogen that treats your menopause symptoms combined with enough progestogen to protect your uterus from cancer. It is not necessary to check blood, urine, or saliva hormone levels to find the right dose. During reproductive life, estrogen levels vary throughout the menstrual cycle and during each day, so there is no perfect hormone level for any woman.

**Recommendations for natural hormone therapy options**

If you prefer to use hormones for your menopause symptoms that are identical to the hormones you produced naturally before menopause, ask your healthcare provider for government-approved products containing estradiol and progesterone. There is no benefit to using custom-compounded hormones, and there may be additional risks.

<table>
<thead>
<tr>
<th>Government-Approved Natural Hormone Therapy Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systemic doses of estradiol/progesterone for treatment of hot flashes</strong></td>
</tr>
<tr>
<td>- Estradiol oral tablet: Estrace, generics</td>
</tr>
<tr>
<td>- Estradiol skin patch: Alora, Climara, Esclim, Menostar, Vivelle (Dot), Estraderm, generics</td>
</tr>
<tr>
<td>- Estradiol skin gel/cream: EstroGel, Elestrin, Divigel, Estrasorb</td>
</tr>
<tr>
<td>- Estradiol skin spray: Evamist</td>
</tr>
<tr>
<td>- Estradiol vaginal ring: Femring</td>
</tr>
<tr>
<td>- Progesterone oral tablet: Prometrium, generics</td>
</tr>
<tr>
<td>- Estradiol plus progesterone combined oral capsule: Bijuva</td>
</tr>
</tbody>
</table>

| **Low doses of vaginal estradiol for treatment of vaginal dryness and pain with intercourse** |
| - Vaginal cream: Estrace vaginal cream |
| - Vaginal ring: Estring |
| - Vaginal tablet: Vagifem |
| - Vaginal insert: Imvexxy |

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Menopause and Sleep Problems

Some women experience menopause-related sleep problems, especially if hormone changes cause hot flashes or sweats during the night. Lack of sleep and poor-quality sleep can make you tired, irritable, and moody. When you are tired, you may have difficulty concentrating, remembering things, working efficiently, and coping with daily stresses. You may be less patient with family and friends. Difficulty coping can lead to more stress, which can make sleep problems even worse. Adequate sleep is required for good health.

You have had enough sleep when you can function in an alert state during waking hours. Most adults need between 7 and 9 hours of sleep each night. During the menopause transition, you may find that you have more trouble falling asleep, staying asleep, or waking up feeling refreshed. These interventions may improve your sleep:

### Lifestyle changes

- Maintain an environment that promotes sleep. Think quiet, cool, and dark. A white noise machine may be helpful. If you have night sweats, try a bedside fan, light pajamas and bedding, and placing an ice pack under your pillow—turning the pillow over during the night so that your face rests on the cool side.

- Try relaxation techniques such as meditation or slow deep-breathing exercises. You can learn these techniques through books, videos, and classes.

- Avoid TV, computer screens, smart phones, and electronic readers for at least an hour before bedtime, because the light from these devices may disrupt sleep.

- Follow the 15-minute rule. If you do not fall asleep within 15 minutes, get up, leave the bedroom, and do something relaxing in another room, such as reading a book or magazine or listening to quiet music. Return to bed when you are drowsy.

- Follow a regular sleep routine. Try to wake up and go to bed at about the same time each day, even on weekends.

- Use the bedroom only for sleep and sex.

- Avoid stimulants such as alcohol, caffeine, and nicotine throughout the entire day, not just during the evening. Although alcohol is initially a sedative, it often results in disrupted sleep. The stimulant effects of caffeine may last up to 20 hours. Coffee, tea, and cola are not the only culprits. Many pain relievers, diuretics, allergy and cold medications, and weight-control aids also contain caffeine.

- Avoid eating a large meal or sweets right before bedtime. This may disrupt sleep—and also promote weight gain.

- If your sleep is disrupted by your partner’s late-night activities or snoring, discuss how this is affecting your sleep and consider solutions. Snoring may be a sign of sleep apnea, so your partner may benefit from seeing his or her healthcare provider.
• Exercise almost every day. Daily exercise improves sleep, but avoid strenuous exercise close to bedtime.

• If your sleep problems do not respond to lifestyle changes, consult your healthcare provider about other treatment options and to rule out specific causes of sleep problems such as thyroid abnormalities, depression, anxiety, allergies, restless leg syndrome, or sleep apnea (breathing problems during sleep). Women with serious sleep disturbances may benefit from consultation with a sleep specialist.

Treatments

• Herbs and supplements: Melatonin, valerian, chamomile, lavender, lemon balm, and passion flower may be mild sedatives, although scientific data are limited. Government oversight of herbs and supplements is limited, so purchase products made in the United States under good manufacturing practices.

• Over-the-counter sleep aids: Many contain diphenhydramine (eg, Benadryl) and may help you fall asleep and stay asleep. Try low doses (25 mg or less) to reduce the risk of morning grogginess.

• Cognitive behavioral therapy (CBT): CBT is a specific form of psychotherapy that effectively treats many sleep problems.

• Prescription sleep medications: Medications approved to treat sleep problems may be helpful to break a cycle of insomnia but ideally should be used only as a short-term solution. Some result in morning fatigue, they can become less effective over time, and they can be habit forming. The grogginess associated with sleep medications can increase the risk of falls, so try to avoid sleep medications if you are at increased risk of falling.

• Treatments for night sweats: If you have bothersome hot flashes and/or night sweats that disrupt sleep, consider treating your nighttime symptoms to improve your sleep. Effective treatments for night sweats include hormone therapy and nonhormonal medications such as certain low-dose antidepressants. Hormone therapy has other benefits and risks, so you should speak with your healthcare provider to see whether hormones or other medications that treat night sweats are right for you.

• With any medication you choose for sleep, always use the lowest dose that treats your sleep problems for the shortest time needed.

For more information about sleep problems, review Your Guide to Healthy Sleep (www.nhlbi.nih.gov/files/docs/public/sleep/healthy_sleep.pdf) from the National Heart, Lung, and Blood Institute, as well as the National Sleep Foundation website, www.sleepfoundation.org.

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