# Menopause & LAM

A Patient Guide for Women Living with Lymphangioleiomyomatosis

*Written by*
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In collaboration with The LAM Foundation
thelamfoundation.org

*This guide is intended as patient education for women with lymphangioleiomyomatosis (LAM) navigating the menopause transition. It is not a substitute for individualized medical care. References to specific medications and doses are based on current published guidelines; treatment decisions should always be made in consultation with your LAM specialist and menopause clinician.*

# A Letter to You

Dear Reader,
If you are reading this, you are likely a woman living with lymphangioleiomyomatosis (LAM), or someone who loves and supports a woman with LAM. I want to begin by telling you that I see you, I understand some of what you may be going through, and I am so glad you found your way to this guide.

My name is Rachel, and I am a Doctor of Nursing Practice and family nurse practitioner. I am also a LAM patient. Living with this rare disease has shaped not only my own health journey but also the way I think about medicine, patient care, and what it means to feel truly heard by a clinician. There were many moments early in my diagnosis when I sat in waiting rooms feeling invisible, when I was told that nothing could be done, or when I was offered options that did not take into account that LAM made me different from the average patient. I know how that feels — and I know how much it matters when someone finally takes the time to explain things clearly, weighs the evidence with you, and treats you as a whole person rather than a diagnosis.

I created this guide in collaboration with The LAM Foundation because menopause is a chapter of life that very few resources address well for women with LAM. Most general menopause information assumes you can take estrogen, which we cannot. Most LAM resources focus on the lung disease itself, without addressing the very real questions that come up about hot flashes, sleep, mood, bone health, sexual health, and contraception during this transition. I wanted to help fill that gap.

My hope is that this guide gives you three things:

- **Validation** — that what you are experiencing is real, that it has a biological basis, and that you are not imagining it or being dramatic.
- **Information** — about the safe, evidence-based options that do exist for women with LAM, so that you can walk into your next appointment feeling informed and prepared.
- **Encouragement** — to advocate for yourself, to ask questions, and to expect care that takes your whole situation into account.

This guide includes clinical citations so that you and your care team can review the evidence behind the recommendations. The resource page at the end will direct you to additional credible information sources, including The LAM Foundation itself, which remains an extraordinary support to all of us in this community.

Please remember that this document is general patient education and is not a substitute for personalized medical advice. Your situation is unique, and any decisions about your care should be made together with your own LAM specialist and menopause clinician. But I hope this guide will give you the language and the confidence to have those conversations.

With warmth and solidarity,

*Rachel Faleide, DNP, FNP-C*
*LAM patient and clinician*

# Understanding Your Hormones: The Basics

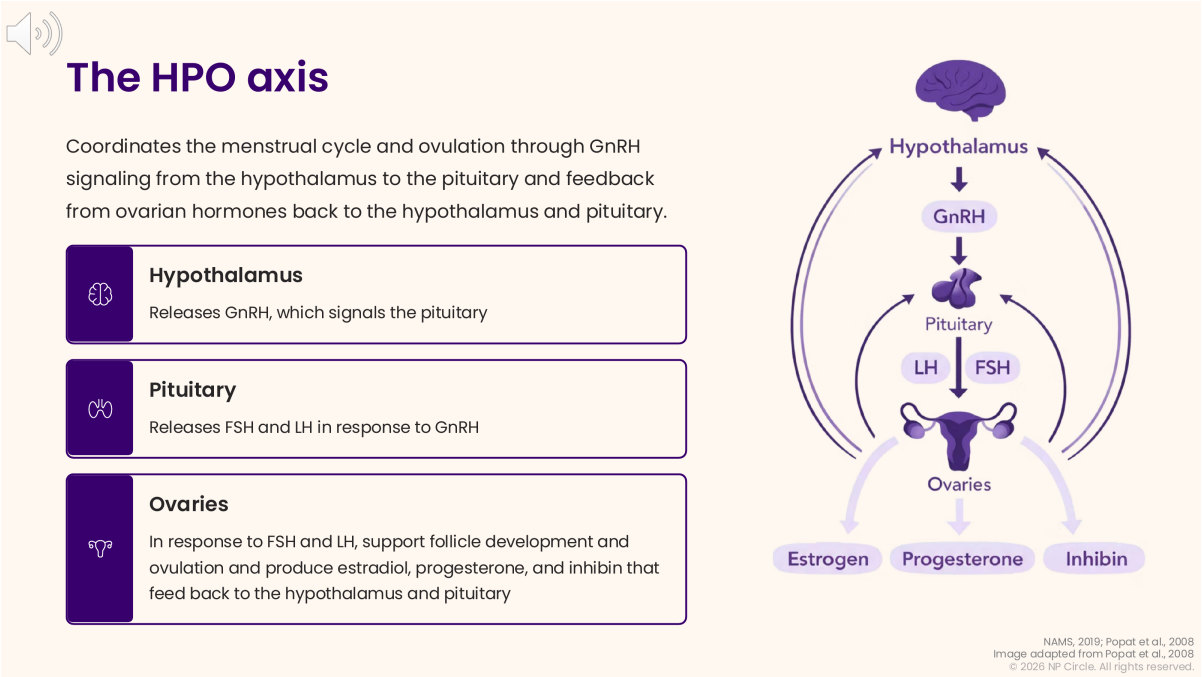
*Before we discuss menopause and its specific implications for women with LAM, it helps to understand how hormones work in your body. This section provides foundational knowledge about the hormonal changes that occur across your lifespan — knowledge that will help you better understand why certain symptoms occur and why some treatments work better than others.*

## The HPO Axis

The hypothalamic-pituitary-ovarian (HPO) axis is the feedback loop that controls your menstrual cycle, ovulation, and ovarian estrogen production. Understanding these four steps is the key to understanding why menopause happens and how the newest non-hormonal medications work:

- **Hypothalamus (kisspeptin neurons):** A small group of neurons in the hypothalamus releases a signaling molecule called kisspeptin. Kisspeptin activates the neurons that produce GnRH (gonadotropin-releasing hormone), which in turn signals the pituitary. These kisspeptin/GnRH neurons are also the pathway targeted by the newer non-hormonal menopause medications called KNDy or neurokinin receptor antagonists (elinzanetant and fezolinetant), which is why kisspeptin matters for treatment.
- **Pituitary:** Releases FSH (follicle-stimulating hormone) and LH (luteinizing hormone) in response to GnRH
- **Ovaries:** In response to FSH and LH, support follicle development and ovulation, and produce estradiol, progesterone, and inhibin that feed back to the hypothalamus and pituitary

*Source: NAMS, 2019; Popat et al., 2008*



## The Menstrual Cycle

Understanding the menstrual cycle helps explain many perimenopausal symptoms:

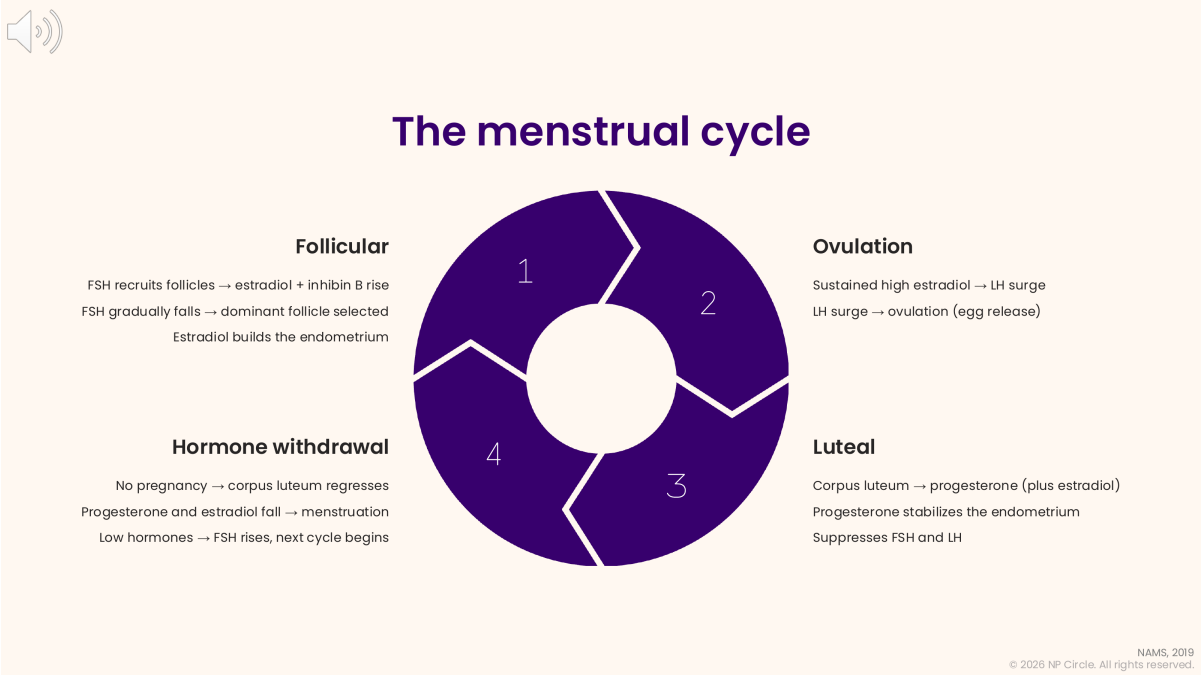
**Follicular Phase:** FSH recruits follicles, causing estradiol and inhibin B to rise. FSH gradually falls as a dominant follicle is selected. Estradiol builds the endometrium.

**Ovulation:** Sustained high estradiol triggers an LH surge, which causes ovulation (egg release).

**Luteal Phase:** The corpus luteum produces progesterone (plus estradiol), which stabilizes the endometrium and suppresses FSH and LH.

**Hormone Withdrawal:** If no pregnancy occurs, the corpus luteum regresses. Progesterone and estradiol fall, triggering menstruation. Low hormones cause FSH to rise, beginning the next cycle.

*Source: NAMS, 2019*



## Impacts of HPO Axis Changes in Menopause

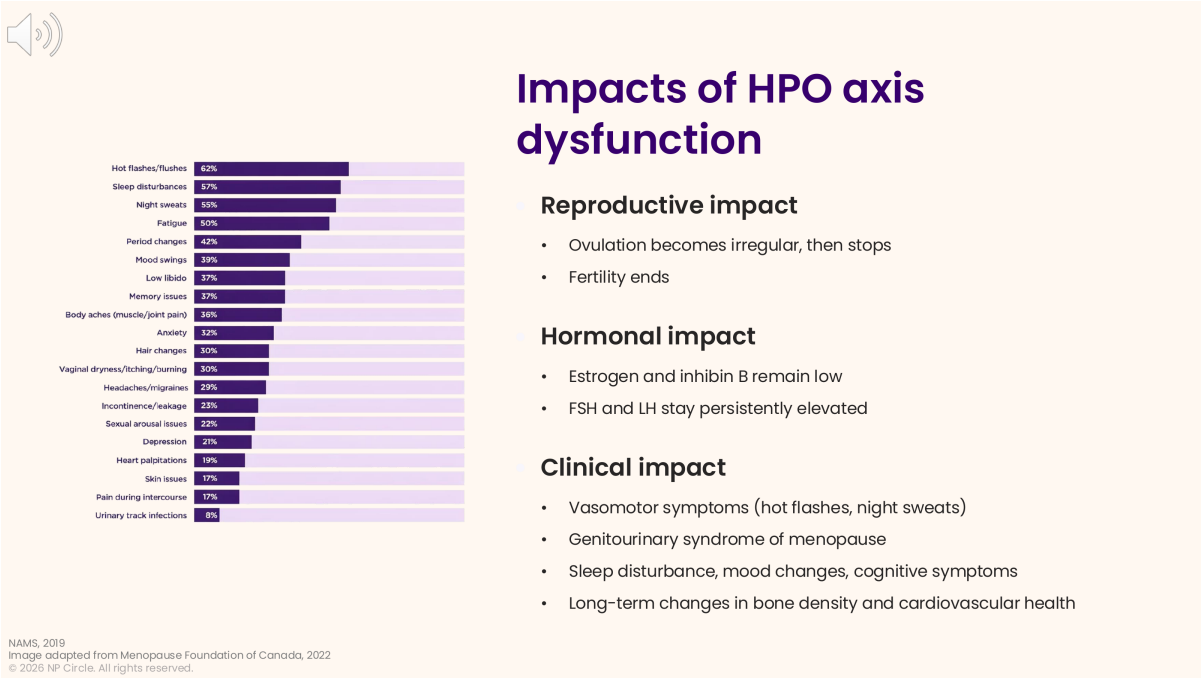
As the HPO axis function declines, you may experience:

**Reproductive impact:** Ovulation becomes irregular, then stops. Fertility ends.

**Hormonal impact:** Estrogen and inhibin B remain low. FSH and LH stay persistently elevated.

**Clinical impact:** Vasomotor symptoms (hot flashes, night sweats), genitourinary syndrome of menopause, sleep disturbance, mood changes, cognitive symptoms, and long-term changes in bone density and cardiovascular health.

*Source: NAMS, 2019*



# What Is Menopause?

Menopause is the permanent end of menstruation. It is officially diagnosed after you have gone 12 consecutive months without a period. The average age in the United States is around 51, with most women reaching menopause between ages 45 and 55. Approximately 7% of women enter menopause early (between 40 and 45), and about 2% experience premature menopause before age 40, which is called primary ovarian insufficiency (POI).

*Source: NAMS 2022 Hormone Therapy Position Statement; Duralde et al., BMJ 2023.*

## The Three Stages

**Perimenopause** is the transition leading up to menopause. Your hormones do not simply decline — they fluctuate dramatically, often with intermittent surges of estrogen. This stage typically lasts about 4 years but can last anywhere from a few months to a decade.

**Menopause** is the single point in time marking 12 months without a period.

**Postmenopausal** follows. Vasomotor symptoms typically improve over years, but vaginal and bone-related changes are progressive without treatment.

### A Word of Reassurance for LAM Patients

If you are living with LAM, there is meaningful good news in the menopause story. In nearly every published cohort, LAM disease progression slows significantly — often to nearly zero — after natural menopause. Postmenopausal women with LAM also experience fewer spontaneous pneumothoraces. The drop in your body's natural estrogen, which is so disruptive in other ways, has a stabilizing effect on LAM. While the menopause transition can be challenging, this knowledge is something to hold on to: for many women with LAM, the years after menopause bring a calmer phase of disease.

*Source: ERS LAM Guidelines 2010; McCormack et al., NEJM 2011 (MILES); Gupta et al., 2018.*

**An important point:** symptoms can begin while your menstrual cycles are still regular. The fluctuating hormones of perimenopause — not estrogen deficiency alone — cause many of the symptoms you may experience. You do not need to wait for your periods to become irregular before talking to your provider about treatment.

# Recognizing Symptoms

Menopausal symptoms vary widely from woman to woman. Some women experience profound symptoms, others notice very little. A common chief complaint is, 'I just don't feel like myself anymore.' If that resonates with you, please know it is real and it is treatable.

## Hot Flashes & Night Sweats (Vasomotor Symptoms)

Approximately 80% of women experience hot flashes and night sweats. Moderate-to-severe symptoms persist for an average of 7–11 years. About 20% of women experience them into their late 50s, 10% into their late 60s, and 5% into their 70s. Black women in the SWAN cohort experienced more severe and longer-lasting symptoms than other racial and ethnic groups.

*Source: Duralde et al., BMJ 2023; SWAN study data.*

## Sleep Disturbance

Approximately 40–60% of women experience significant sleep difficulties during the menopause transition. The pattern is typically waking in the middle of the night and having trouble falling back asleep, rather than difficulty falling asleep initially. Cognitive behavioral therapy for insomnia (CBT-I) has the strongest evidence among non-pharmacologic interventions.

*Source: Duralde et al., BMJ 2023; Voedisch, Stanford.*

## Mood Changes

Perimenopausal women have a threefold increased risk of major depressive episodes compared with premenopausal women. New-onset anxiety occurs in about 16% of women during the transition. These changes are biological — not just stress, not just 'getting older.' They are also treatable.

*Source: Duralde et al., BMJ 2023; Voedisch, Stanford.*

## Brain Fog

Subjective cognitive complaints — trouble concentrating, forgetting words, losing your train of thought — are very common. The reassuring news is that brain fog is usually driven by sleep disruption, mood changes, and hot flashes rather than direct cognitive decline. When the underlying drivers are treated, brain fog typically improves substantially.

*Source: Voedisch, Stanford.*

### A Special Note for LAM Patients on Sirolimus or Everolimus

If you take sirolimus (rapamycin) or everolimus for LAM, please be aware that these medications commonly cause irregular menstrual bleeding and ovarian cysts — affecting more than 1 in 3 women on these therapies. This can be confused with perimenopausal cycle changes or misdiagnosed as polycystic ovary syndrome (PCOS). It is neither. It is a known side effect of your LAM medication. If you experience this, tell your gynecologist or primary care provider so unnecessary testing may be avoided. Management is typically with an intrauterine device (copper IUD or hormonal IUD), not by stopping your LAM treatment.

*Source: McCormack et al., NEJM 2011 (MILES); FDA labeling.*

## Other Symptoms

- Central weight gain and metabolic changes (insulin resistance, increased LDL cholesterol)
- Joint and muscle pain, fatigue
- Decreased libido (multifactorial; testosterone levels do not significantly decline in perimenopause)
- Vaginal dryness and urinary symptoms (covered in a dedicated section)
- Irregular bleeding during the perimenopause

# A Note About Hormone Therapy and LAM

If you have read about menopause anywhere — in magazines, online, or from another clinician — you have almost certainly heard about hormone therapy, sometimes called HRT or MHT. Hormone therapy is the most effective treatment for menopausal symptoms in the general population, and it is having a well-deserved moment of renewed attention after years of being unfairly maligned. You may have friends, family members, or even providers who recommend it enthusiastically.

**Unfortunately, systemic hormone therapy that contains estrogen is generally not safe for women with LAM.** This is one of the most important things to understand about your menopause care, and it is why this guide exists.

## Why Estrogen Is a Problem in LAM

LAM cells have estrogen and progesterone receptors on their surface, and laboratory studies show that estrogen promotes LAM cell growth, survival, and spread. Clinically, this is reflected in the observations that LAM almost always worsens during pregnancy, that case reports describe LAM flares after starting estrogen for menopause or fertility treatment, and that natural menopause — when your body stops making estrogen — is associated with stabilization of disease in nearly every published cohort. Taken together, these findings make it clear that adding exogenous estrogen back into your system carries real risk for women with LAM.

*Source: ERS LAM Guidelines 2010; Yu et al., PNAS 2009; Gupta et al., 2018.*

## What This Means for You

- **Avoid systemic estrogen-containing therapies:** oral hormone therapy, estrogen patches and gels, combined birth control pills, and most fertility treatments
- **Tamoxifen is also contraindicated** — it has estrogen-like activity in tissues of uterine origin (which is the likely tissue of origin of LAM cells)
- **Progestins are less clear-cut** — the evidence is mixed, but they appear to be less risky than estrogen. They can be considered with caution when needed (for example, for contraception or to manage bleeding), preferably as a local delivery like an IUD rather than systemically
- Low-dose vaginal estrogen for vaginal dryness is a special situation discussed in the genitourinary section

If you have been prescribed standard hormone therapy without a discussion of LAM, please bring this up at your next appointment. Many general menopause clinicians are not familiar with LAM and may not realize the contraindication. You are your own best advocate.

## The Good News

There are excellent, effective, evidence-based non-hormonal treatment options for menopausal symptoms — and the field has expanded dramatically in just the past two years. The next section covers them in detail.

# Treatment Options for Menopausal Symptoms

**This is the section that matters most for women with LAM.** There are now several effective, evidence-based options for managing the most common menopausal symptoms. Many of these have become available or improved within just the last few years.

## Newer Non-Hormonal Medications: The Neurokinin Antagonists

This is the most exciting recent development in menopause care, and it is especially relevant for women who cannot use hormones.

**Elinzanetant (Lynkuet)** received FDA approval in October 2025. It is the first dual NK1/NK3 receptor antagonist — a new class of medication that works directly on the part of your brain that controls body temperature. In the Phase 3 OASIS trials, elinzanetant reduced moderate-to-severe hot flash frequency by approximately 74% at 12 weeks (compared with 47% on placebo) and the benefit was sustained for 52 weeks. It also produced significant improvements in sleep quality and overall quality of life. It is taken as a single capsule at bedtime.

**Fezolinetant (Veozah)**, FDA-approved in 2023, is an NK3-selective antagonist in the same class. It produces a mean reduction of 2.55 hot flashes per day compared with placebo and is taken as a daily pill.

Both medications require liver function blood tests at baseline and at 3 months. Both are non-hormonal, both work on a brain pathway rather than through estrogen receptors, and both are appropriate options for women with LAM. If you are taking sirolimus or everolimus, ask your pharmacist to review for drug interactions with elinzanetant, which is processed by the same liver enzyme (CYP3A4).

*Source: Bayer/Lynkuet PI October 2025; OASIS 1, 2, 3 trials; SKYLIGHT trials.*

## Low-Dose Antidepressants (SSRIs and SNRIs)

Several antidepressants reduce hot flashes at doses lower than those used for depression. These have been a mainstay of non-hormonal menopause treatment for years and are well-studied. Options include:

- Paroxetine 7.5 mg (FDA-approved as Brisdelle specifically for hot flashes)
- Escitalopram 10–20 mg
- Venlafaxine XR 37.5–75 mg or desvenlafaxine 100 mg

These medications can also help with mood and anxiety, which often accompany the menopause transition. A common patient concern is weight gain — please be reassured that at the low doses used for hot flashes, weight gain is not considered a significant risk.

*Source: NAMS 2023 Nonhormone Therapy Position Statement.*

## Other Effective Medications

- **Gabapentin 300–900 mg at bedtime** — particularly helpful for nighttime hot flashes and sleep disruption
- **Oxybutynin 2.5–5 mg twice daily** — effective; consider the anticholinergic side effect profile

## Mind-Body and Lifestyle Approaches

- **Cognitive behavioral therapy (CBT) and clinical hypnosis** have Level I evidence for reducing how much hot flashes bother you
- **Regular exercise, particularly resistance training** — helps with mood, sleep, weight, bone health, and cardiovascular health
- Cool environment, layered clothing, paced respiration, and avoiding triggers like alcohol, caffeine, and spicy foods
- **A note on supplements:** phytoestrogens, soy isoflavones, black cohosh, and most herbal supplements have not shown benefit beyond placebo in well-designed studies. Save your money.

*Source: NAMS 2023 Nonhormone Therapy Position Statement; Duralde et al., BMJ 2023.*

# Vaginal and Sexual Health

As estrogen levels drop, the tissues of the vagina, vulva, and bladder become thinner, drier, and more fragile. This is called **genitourinary syndrome of menopause (GSM)**. It affects more than half of postmenopausal women, but only about half ever get treatment for it — often because they are too embarrassed to bring it up. Please know this is common, it is not your fault, and there are effective treatments.

## Symptoms

- Vaginal dryness, burning, or itching
- Pain with intercourse
- Recurrent urinary tract infections
- Urinary urgency or frequency

## Treatment Options for Women with LAM

**First-line, non-hormonal options:** Long-acting vaginal moisturizers (hyaluronic acid-based or polycarbophil) used 2–3 times per week, plus water- or silicone-based lubricants for intercourse, help many women significantly. These are over-the-counter and carry no concerns for LAM.

**Pelvic floor physical therapy** can be very helpful for pain with intercourse, vaginismus, and pelvic floor tightness, and is also non-hormonal.

## The Vaginal Estrogen Question

This is one of the more nuanced decisions in LAM menopause care. Low-dose vaginal estrogen (cream, tablet, ring, or insert) is highly effective for moderate to severe GSM and produces very low blood levels of estrogen — serum estradiol typically remains within the postmenopausal range at standard doses. In the general population it is considered very safe and is not associated with the same risks as systemic hormone therapy.

**However, there are no studies of low-dose vaginal estrogen specifically in LAM patients, so the safety has not been formally established.** Most LAM specialists prefer to avoid all forms of exogenous estrogen when possible and reserve vaginal estrogen for situations where non-hormonal options have failed and symptoms are significantly affecting quality of life. If you and your team decide vaginal estrogen is appropriate, the lowest effective dose should be used, and the decision should be made jointly with your LAM specialist.

**Vaginal DHEA (prasterone, brand name Intrarosa)** is another option that is converted locally to estrogens and androgens with minimal systemic absorption. As with vaginal estrogen, LAM-specific safety data are lacking, so this should also be discussed with your LAM specialist.

**Ospemifene (Osphena)** is an oral selective estrogen receptor modulator (SERM) used for GSM in the general population. It is not recommended for women with LAM because of its estrogen-receptor agonist activity in some tissues, by analogy with tamoxifen.

*Source: NAMS 2020 GSM Position Statement; clinical consensus for LAM-specific adaptations.*

# Cardiovascular Health

Heart disease is the leading cause of death in women, and the risk increases significantly after menopause. The drop in estrogen affects cholesterol, blood pressure, blood sugar, and where the body stores fat — all in unfavorable directions. For women with LAM, cardiovascular risk reduction is even more important because the protective benefits of hormone therapy that some women receive are not available to you.

## What You Can Do

- **Know your numbers:** blood pressure (goal generally <130/80), cholesterol (LDL, HDL, triglycerides), fasting blood glucose or A1c, and waist circumference
- **Move regularly, at a level that works for your body:** regular movement supports mood, sleep, weight, bone health, and cardiovascular health. Because LAM affects lung function differently in every patient, exercise capacity varies widely — some women can do vigorous aerobic activity, while others need gentler or lower-intensity approaches. Talk with your LAM specialist and pulmonologist before starting or changing an exercise routine so you can set goals that are safe for your lungs. The LAM Foundation's **LAMFit** program is a free, LAM-specific exercise resource developed by respiratory therapists and is a great place to start.
- Eat a heart-healthy diet rich in vegetables, fruits, whole grains, lean proteins, and healthy fats
- Do not smoke, and limit alcohol
- Manage stress and prioritize sleep — both have meaningful cardiovascular effects
- If you take sirolimus or everolimus, these medications can cause elevated cholesterol and blood sugar — ask your provider how often these should be monitored

Statins, blood pressure medications, and other standard cardiovascular preventive therapies are all appropriate for women with LAM and should be used when indicated. Talk with your primary care provider about your individual risk and screening schedule.

*Source: NAMS 2022 HT PS; American Heart Association guidelines.*

# LAM-Specific Considerations: Putting It All Together

Lymphangioleiomyomatosis (LAM) is a rare cystic lung disease that almost exclusively affects women and is influenced by estrogen exposure. Menopause management in LAM patients requires special considerations.

## Why Estrogen Matters in LAM

LAM cells express estrogen and progesterone receptors, and preclinical studies demonstrate that estrogen promotes LAM cell survival, proliferation, and pulmonary metastasis through MAPK/ERK activation. Clinically, LAM almost always progresses during pregnancy and may worsen with exogenous estrogen exposure. Conversely, in nearly every published cohort, LAM progression slows to nearly zero after natural menopause, and postmenopausal women experience fewer spontaneous pneumothoraces.

*Source: ERS LAM Guidelines 2010; McCormack et al., NEJM 2011 (MILES); Gupta et al., 2018.*

## Cornerstone Principles

- **Avoid systemic estrogen** — including combined hormonal contraceptives and standard hormone therapy
- **Tamoxifen is contraindicated** — ER agonist activity in tissues of uterine origin
- **Progestin safety in LAM is uncertain** but generally less concerning than estrogen
- All decisions should be coordinated with your LAM specialist

## Recommended Approach

**Contraception:** The copper IUD is the preferred option, providing high efficacy with no hormonal exposure. Tubal ligation, partner vasectomy, and barrier methods are also acceptable. LNG-IUS and other progestin-only methods are reasonable second-line options.

**Vasomotor symptoms:** Elinzanetant or fezolinetant, low-dose SSRIs/SNRIs, gabapentin, or CBT. Note that elinzanetant is metabolized by CYP3A4 — review interactions with sirolimus or everolimus.

**Bone health:** Particularly critical because estrogen is not available as a preventive option. Baseline DXA, calcium and vitamin D, weight-bearing exercise, and bisphosphonates or denosumab when indicated.

## mTOR Inhibitor Side Effects

If you take sirolimus or everolimus for LAM, more than 35% of patients develop irregular menstrual bleeding and ovarian cysts. This is frequently misdiagnosed as polycystic ovary syndrome. It is a known medication side effect, not a new gynecologic condition. Management focuses on symptom mitigation, typically with a copper IUD or LNG-IUS.

*Source: McCormack et al., NEJM 2011 (MILES); FDA labeling; LAM Foundation.*

# When to Contact Your Provider

## Seek Emergency Care Immediately For:

- Chest pain, shortness of breath, or sudden severe headache
- Sudden weakness, numbness, or facial drooping (possible stroke)
- Unilateral leg swelling, redness, or severe pain (possible DVT)
- Sudden vision changes or loss
- New breast lump or bloody nipple discharge
- Any vaginal bleeding after your final menstrual period

## Schedule a Visit to Discuss:

- Vasomotor symptoms or sleep disruption affecting daily function
- New or worsening anxiety, depression, or mood symptoms
- Vaginal dryness, dyspareunia, or recurrent UTIs
- Heavy, prolonged, or unusual bleeding during perimenopause
- Cardiovascular risk factor management or bone density screening
- Coordination of care between your LAM specialist and menopause clinician
- Irregular bleeding or ovarian cysts if you take sirolimus or everolimus

## Questions to Discuss at Your Visit

Because LAM adds complexity to menopause care, the most useful conversations are often the ones that connect both halves of your medical team. The questions below are designed to start those conversations.

- How can my LAM specialist and menopause clinician coordinate my care, and who should I contact first when a new symptom comes up?
- Given that systemic estrogen is contraindicated in LAM, which non-hormonal treatments would you recommend first for my symptoms?
- If I am taking sirolimus or everolimus, are there drug interactions I should know about with elinzanetant, fezolinetant, SSRIs, or any other menopause medications I might be prescribed?
- How should we monitor my bone health given that I cannot use estrogen for prevention? When should I have a DXA scan, and what other steps should I take?
- If my vaginal symptoms do not improve with moisturizers and lubricants, what is your recommendation about trying low-dose vaginal estrogen or vaginal DHEA, and how would that decision be made together with my LAM specialist?
- How should we evaluate and manage the irregular bleeding or ovarian cysts that can come with sirolimus or everolimus, so that I do not undergo unnecessary testing for PCOS or other conditions?
- What cardiovascular risk reduction strategies are most important for me, knowing that the protective benefits of hormone therapy are not available?
- What contraception do you recommend during my perimenopause, and how long should I continue it?
- Are there any new LAM research findings or treatments that might change the recommendations for menopause care in the near future?

# Credible Resources for More Information

The following are reliable, evidence-based resources for additional information about menopause, hormone therapy, and related topics. Be cautious of websites that sell products or offer treatments without scientific support.

## Professional Medical Organizations

- **The Menopause Society (formerly NAMS)** — menopause.org — the leading North American professional society for menopause clinicians
- **International Menopause Society (IMS)** — imsociety.org — the global counterpart
- **American College of Obstetricians and Gynecologists (ACOG)** — acog.org/womens-health
- **Endocrine Society** — endocrine.org
- **National Institute on Aging (NIA)** — nia.nih.gov/health/menopause

## LAM-Specific Resources

- **The LAM Foundation** — thelamfoundation.org — clinician directory, clinical trials, peer support
- **LAM Action (UK)** — lamaction.org
- **LAM Australasia Research Alliance (LARA)** — lara.org.au

## Bone Health

- **Bone Health and Osteoporosis Foundation** — bonehealthandosteoporosis.org
- **FRAX Fracture Risk Calculator** — sheffield.ac.uk/FRAX

## Heart Health

- **American Heart Association — Go Red for Women** — goredforwomen.org

## Mental Health

- **National Alliance on Mental Illness (NAMI)** — nami.org — 1-800-950-NAMI
- **988 Suicide and Crisis Lifeline** — call or text 988

## Books for Further Reading

- *Menopause: What Your Ob-Gyn Wants You to Know* by ACOG (2026)
- *The Menopause Manifesto* by Jen Gunter, MD
- *Blood: The Science, Medicine, and Mythology of Menstruation* by Jen Gunter, MD

**A note on online information:** menopause is currently a popular topic on social media, and not all of the information you encounter is accurate. When in doubt, ask your provider, or check whether the source is affiliated with a recognized medical organization. Be especially skeptical of any source that recommends a single product or treatment as a solution for everyone.

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