Domain	NAMS (TMS) (2022)	ACOG (PB-141, reaffirmed 2024)	American Heart Assoocaition (2020)	International Menoapause Society (2024–25)	NICE NG23 (2024)	Australasian Menopause Society / Toolkit (2023)	SOGC 422a (2021)
MHT is first-line for VMS	**Yes** Most effective treatment for VMS	**Yes** Effective; SDM required	**Yes Offer MHT**	**Yes** Most effective for VMS and urogenital symptoms	**Yes** Offer HRT for VMS; use lowest effective dose	**Yes** Endorsed TMS 2022; SDM-guided	**Yes** Systemic MHT first-line for VMS with no contraindications
Timing / age guidance	**Benefits > risks for women <60 or within 10 yrs of menopause onset**; less favorable >60 or >10 yrs out	People in **early menopause in good CV health** at low CV risk are candidates; approved for osteoporosis risk	**Earlier menopause = higher CVD risk**; **early intervention important**; emphasizes timing hypothesis,<60 years old, within 10 years of initiation	**Benefits outweigh risks for perimenopausal and younger postmenopausal women with symptoms**; 5Ws framework guides individualization	For early menopause (40–44), benefits and risks lie between POI and typical menopause; consider HRT up to average age of menopause	**Aligned with TMS 2022;** strong SDM emphasis at all ages	**Benefits outweigh risks for most healthy women under 60 or within 10 yrs of onset**
Duration	**No fixed maximum;** individualize; may continue beyond 65 for persistent VMS, QOL, or osteoporosis with periodic re-evaluation	Periodic reassessment recommended; **no arbitrary cut-off endorsed**	Not addressed explicitly, references ACOG, NAMS, Endocrine Societies	Lower doses can maintain quality of life in many for longer duration; individualize approach; **no fixed maximum** duration	Use the lowest effective dose; review regularly; **no duration limit specified** but periodic reassessment required	**No fixed duration**; individualize based on indication	Reassess annually; **ongoing therapy acceptable** for documented indications
Route preference	**Transdermal preferred to reduce VTE and stroke risk**; oral option for many; vaginal	Route individualized; **transdermal lowers VTE risk vs. oral**	**Transdermal recommender for everyone** who is not at low risk of complications	Multiple routes acceptable; lower doses even at non-standard routes may suffice	Route not prescribed; individualize; **transdermal noted as potentially lower**	**Transdermal preferred for VTE risk** reduction in eligible women	**Transdermal route preferred** especially where VTE risk is a concern

	estrogen appropriate for GSM at any age				**thrombotic risk**		
Compounded preparations	**Not recommended** FDA-approved preferred; lack safety/efficacy data	**Not recommended** Clinical Consensus No. 6 (2023): explicitly against routine compounding	**Not recommended;** emphasize harm of unregulated hormones	**Not recommended** Regulatory-approved preparations preferred globally	**Not directly addressed** Licensed doses only in scope	**Not recommended;** Aligned with TMS and IMS positions	**Not recommended;** FDA/Health Canada-approved products preferred
Testosterone	Recommended for hypoactive sexual desire disorder (HSDD); not FDA-approved; off-label with SDM	No FDA-approved formulation for menopause; use compounded testosterone with SDM; recommend against pellet therapy	Not addressed	Androgen replacement for clinical signs of androgen insufficiency; individualize	Not addressed in NG23 directly	Emerging evidence; off-label; SDM required	Brief sexual history at initial assessment; testosterone options reviewed; SDM framework
Vaginal estrogen / GSM	**Low-dose vaginal estrogen appropriate at any age and extended duration** for GSM; may be used in breast cancer survivors (observational support)	**Appropriate for urogenital symptoms;** consider in breast cancer survivors after non-hormonal options exhausted	**Recommended for GSM**; low risk as its not systemic	Vaginal estrogen for urogenital atrophy does not require progestogen co-medication; **effective and low systemic absorption**	**Offer vaginal oestrogen for GSM**; consider in breast cancer survivors if non-hormonal insufficient (off-label noted)	**Low-dose vaginal estrogen appropriate for GSM at any age**; endorsed for breast cancer survivors with caution	**Local vaginal estrogen appropriate for GSM;** not contraindicated in most breast cancer survivors
HT for bone protection	**Supported FDA-approved for prevention**	Supported; **Approved for osteoporosis prevention**;	Not addressed	**Supported;** Effective for all osteoporosis-related fractures	**Conditional HRT** offers bone protection;	**Supported MHT for bone loss prevention**; gap identified for	**Supported MHT approved for bone loss prevention**; use with

	(not treatment) of osteoporosis; reduces fracture risk Level I	periodic reassessment		including vertebral and hip; even lower doses effective	may use for this in early menopause; not offered primarily for prevention at average menopause age	asymptomatic women	documented indication
HT for CVD prevention	**Not recommended** Not for primary CVD prevention in average-age menopause	**Not recommended** Against primary or secondary CVD prevention	**Not recommended** Does not recommend HT for cardiovascular protection	**Not recommended;** Primary CVD prevention not an indication; timing hypothesis supported but not CVD prevention framing	**Not recommended**; Do not offer HRT for primary or secondary CVD prevention	**Not recommended;** Aligned with NAMS (TMS) and IMS	**Not recommended**; MHT should not be prescribed for primary or secondary CVD prevention
POI / early menopause	**HT recommended** until at least average age of menopause (~52); higher risks without treatment (CVD, bone, cognitive)	**HT supported;** evaluate risks and benefits given longer exposure period	Earlier menopause = higher CVD risk; screening and prevention critical	**HT strongly supported;** benefits clearly outweigh risks; duration to natural menopause age at minimum	**HRT until average age of menopause;** benefits and risks between POI and typical menopause age group	**HT recommended until average age of menopause**; higher absolute benefit in this group	**HT recommended until ~52 unless contraindicated**; oral contraceptives as alternative in younger women