Menopause care in women with diabetes: a practical guide for nurses

Menopause represents a significant physiological transition that can influence metabolic health, cardiovascular risk and quality of life. For women living with diabetes, this transition can be particularly complex, with hormonal changes affecting glycaemic control, weight, lipid metabolism and psychological well-being. Given that the peak incidence of type 2 diabetes occurs in midlife and beyond, nurses are increasingly likely to encounter women managing both conditions simultaneously.

Nurses play a central role in diabetes reviews, cardiovascular risk assessment, lifestyle counselling and medication optimisation. These routine contacts provide valuable opportunities to identify menopausal symptoms, initiate conversations and support holistic management.

This article aims to provide practical guidance on recognising menopause-related issues in women with diabetes, understanding the impact on glycaemic control and cardiovascular risk, and supporting evidence-based management, including hormone replacement therapy (HRT).

Physiology of menopause and metabolic effects

Menopause is defined as the cessation of menstruation for 12 consecutive months due to ovarian follicular depletion and declining oestrogen production. The perimenopause transition can last several years and is characterised by hormonal fluctuation, rather than steady decline.

Oestrogen has important metabolic effects, including:

- Maintenance of insulin sensitivity.
- Regulation of adipose tissue distribution.
- Favourable lipid profile effects.
- Vascular endothelial protection (Mauvais-Jarvis et al, 2017).

Declining oestrogen levels are associated with:

- Increased central adiposity.
- Reduced insulin sensitivity.
- Rising LDL (low-density lipoprotein) cholesterol and triglycerides.
- Increased cardiovascular risk.

These changes may exacerbate existing type 2 diabetes or contribute to new-onset type 2 diabetes. Women with type 1 diabetes may also experience changes in insulin requirements due to hormonal variability during perimenopause.

Impact of menopause on glycaemic levels

Many women report worsening glucose control during the perimenopause transition. Factors contributing include:

- Increased insulin resistance.
- Weight gain and redistribution of body fat.
- Sleep disturbance from vasomotor symptoms.
- Mood changes and reduced motivation.
- Reduced physical activity due to fatigue or joint pain.

In type 1 diabetes, fluctuating hormone levels may increase glycaemic variability and hypoglycaemia risk.

Night sweats can sometimes be mistaken for nocturnal hypoglycaemia, and conversely, hypoglycaemia may be overlooked if attributed solely to menopause.

Nurses should encourage:

- More frequent glucose monitoring during symptomatic periods.
- Review of medication or insulin regimens if HbA_{1c} rises unexpectedly.
- Discussion of sleep quality and fatigue.

Cardiovascular and metabolic risk

Menopause is associated with an acceleration in

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Patient resources.

- Diabetes UK. *Menopause and diabetes.* Information and resources from the UK's biggest diabetes charity. **Here**
- NHS. *Menopause and perimenopause help and support.* Patient information and links to national charities and support networks. **Here**
- Local NHS menopause clinics through GP referral.
- Women's health support groups.
  - Local groups can be found through Facebook.
  - National organisations, including **Menopause Support** and **Menopause Matters**.

cardiovascular risk factors, including hypertension, dyslipidaemia and central obesity. Women with diabetes already have elevated cardiovascular risk, making this a critical period for intervention.

Key care priorities include:

- Blood pressure optimisation.
- Lipid optimisation.
- Weight and waist circumference monitoring.
- Smoking cessation support.
- Physical activity promotion (Rodriguez and Michos, 2025).

Annual reviews should incorporate discussion of menopause status where relevant, as this may explain deteriorating risk profiles.

Recognising menopause symptoms in women with diabetes

Common symptoms include:

- Hot flushes and night sweats.
- Sleep disturbance.
- Mood changes and anxiety.
- Brain fog and fatigue.
- Joint pain.
- Reduced libido.
- Vaginal dryness and urinary symptoms.

Some symptoms overlap with diabetes complications or medication effects, requiring careful assessment.

Simple screening questions may include:

- "Have you noticed changes in your periods?"
- "Are you experiencing hot flushes or night sweats?"
- "How has your sleep been recently?"
- "Have you noticed changes in your glucose levels?"

Hormone replacement therapy and diabetes

Diabetes is **not** a contraindication to HRT. In fact, evidence suggests potential metabolic benefits, including improved insulin sensitivity and possible reduction in type 2 diabetes risk in women using HRT.

Guidance from NICE and the British Menopause Society supports the use of HRT in women with diabetes when clinically appropriate.

Potential benefits

- Reduction in vasomotor symptoms.
- Improved sleep and quality of life.
- Possible improvement in insulin sensitivity.
- Favourable lipid effects (depending on preparation).

Risk considerations

- Cardiovascular risk profile.
- BMI and venous thromboembolism risk.
- Smoking status.
- Hypertension control.

Transdermal oestrogen is often preferred in women with metabolic risk factors owing to lower thrombotic risk compared with oral preparations.

Nurses should support shared decision-making and refer to the GP or menopause specialist when prescribing is being considered.

Contraception in perimenopause

Women may still require contraception until menopause is confirmed. Key points include:

- Contraception recommended until 55 years of age or menopause confirmation.
- Progesterone-only methods are often suitable.
- Intrauterine systems may provide both contraception and endometrial protection for HRT.

Lifestyle and self-management support

Lifestyle advice remains fundamental in both diabetes and menopause management.

Priority areas

- Strength-based physical activity to preserve muscle mass.
- Weight-management strategies.
- Mediterranean-style dietary patterns.
- Sleep hygiene interventions.
- Alcohol moderation.
- Smoking cessation.

Motivational interviewing techniques can help address barriers related to fatigue, mood or competing life demands.

Case study

Sarah, aged 52

Sarah attends her annual type 2 diabetes review. She was diagnosed 5 years ago and takes metformin 1 g twice daily. Her HbA_{1c} has increased from 52 mmol/mol to 64 mmol/mol over the past year, despite adherence to medication.

During consultation, she reports:

- Poor sleep.
- Night sweats.
- Fatigue.
- Weight gain (5 kg in 12 months).
- Reduced motivation for exercise.

She assumed symptoms were "just ageing" and had not mentioned them previously.

Assessment

- BMI increased from 28 to 31 kg/m².
- Blood pressure mildly elevated.
- Lipids slightly worsened.
- Irregular periods over past year.

Symptoms were consistent with perimenopause contributing to metabolic deterioration.

Management

The nurse:

- Discussed menopause and its metabolic impact.
- Encouraged glucose monitoring during symptomatic periods.
- Provided lifestyle support focusing on resistance exercise.
- Referred to GP to discuss HRT options.
- Arranged follow-up in 3 months.

Outcome

Sarah commenced transdermal HRT. Six months later:

- HbA_{1c} improved to 56 mmol/mol.
- Sleep improved significantly.
- Weight stabilised.
- Energy levels increased.

This case highlights the importance of recognising menopause as a contributor to worsening diabetes control.

Psychological and psychosocial considerations

Menopause can affect identity, relationships and emotional well-being. Women with diabetes already have higher rates of depression and anxiety, making holistic assessment important.

Nurses should consider:

- Screening for depression or diabetes distress.
- Discussing sexual health openly.
- Signposting to counselling or support groups.
- Encouraging peer support.

Consultation tips

Menopause discussions can be integrated into routine diabetes care. A simple framework can help:

Ask – symptoms, menstrual history, concerns.
Assess – metabolic control, cardiovascular risk, impact on life.
Advise – lifestyle, treatment options, monitoring.
Act – medication review, referral, follow-up.

When to refer

Referral may be appropriate when:

- Symptoms persist despite first-line management.
- Premature ovarian insufficiency is suspected.
- Complex comorbidities exist.
- HRT risks require specialist input.
- Significant psychological distress is present.

Key practice points.

- Menopause can worsen glycaemic control and cardiovascular risk.
- Diabetes is not a contraindication to HRT.
- Transdermal HRT may be preferable in women with metabolic risk.
- Nurses are ideally placed to identify symptoms during routine reviews.
- Holistic management improves both metabolic outcomes and quality of life.

Read more online

Genitourinary syndrome of menopause (GSM)

An overview of this under-reported chronic condition, which women living with diabetes may experience with greater severity.

Journal of Diabetes Nursing

Read here

Female sexual dysfunction in women living with diabetes

An outline of the often overlooked burden of sexual dysfunction in women living with diabetes, including its causes, consequences, and practical approaches to assessment and management.

Journal of Diabetes Nursing

Read here

Mauvais-Jarvis F, Bairey Merz N, Barnes PJ et al (2017) Sex and gender: modifiers of health, disease, and medicine. *Lancet* **389**: 106–18

Rodriguez CP, Michos ED (2025) Menopause and diabetes: Interconnected associations of risk. *Endocr Res* **50**: 127–37