

The Non-Cisgender Experience of Menstruation and Menopause: Literature Review and Recommendations

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ABSTRACT

This communication examines the experience of menstruation and menopause, and the influence of gender identity. Gender affirming hormone therapy and sociocultural contributors in healthcare pose unique challenges for transgenderⁱ and non-binaryⁱⁱ persons in the context of menstruation and menopause. Moreover, gender diverseⁱⁱⁱ persons experience a higher prevalence of chronic pelvic pain, and barriers to diagnosis of endometriosis and pre-menstrual dysphoric disorder. While there is much discussion surrounding menopause hormone therapy, there has been inadequate attention to this topic in the context of gender-diverse experiences. Here we provide clinical and research recommendations for a treatment approach in this population.

RÉSUMÉ

Cette communication examine l'expérience des menstruations et de la ménopause ainsi que l'influence de l'identité de genre.

Keywords: gender identity; sexual and gender minorities; menstruation; menopause

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ⁱ**Transgender** (abbr. “trans”) – An umbrella term for people whose genders do not match the sex assigned to them at birth. “Trans man” refers to a man who was assigned female at birth. “Trans woman” refers to a woman who was assigned male at birth.

ⁱⁱ**Non-binary** – A term for people whose gender identities and expressions do not conform to binary understanding of gender

ⁱⁱⁱ**Gender diverse** – An umbrella term for gender identities that demonstrate a diversity of expression, including cis, trans, nonbinary, and Two-spirit.

^{iv}**Cisgender** (abbr. “cis”) – A person whose gender identity correlates with the sex assigned to them at birth; not transgender. “Non-cis” is used to refer broadly to people who are transgender or non-binary.

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L'hormonothérapie d'affirmation de genre et les contributeurs socioculturels en santé posent des difficultés uniques pour les personnes transgenresⁱ et non binairesⁱⁱ dans le contexte des menstruations et de la ménopause. De plus, un plus grand nombre de personnes issues de la diversité de genreⁱⁱⁱ vivent de la douleur pelvienne chronique et font face à des obstacles au diagnostic d'endométriose et de trouble dysphorique prémenstruel. Bien qu'on parle beaucoup du traitement hormonal de la ménopause, une attention insuffisante est accordée à ce sujet dans le contexte des expériences vécues par les personnes issues de la diversité de genre. Nous formulons donc des recommandations cliniques et de recherche pour un traitement auprès de cette population.

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INTRODUCTION

Menstruation and menopause have been historically under-investigated due to stigmatization, bias towards male research specimens, and physiological complexity. Recent reproductive and sexual health advancement has come from positive pressure of feminist movements, which can now become more nuanced to include an understanding of variation in menstruation/menopause by social determinants, particularly, in understanding the non-cisgender^{iv} experience. A lack of gender diversity in women's health research has been noted, partly attributed to inconsistencies in terminology regarding sex and gender. In short, menstrual and menopausal health knowledge has yet to catch up with our expanded understanding of sex, gender, and sexuality. Reproductive health and menstrual/menopausal pathologies remain research priorities; however, for transgender, gender-diverse, and non-binary persons, goals of care

differ. Here, we briefly review literature on the non-cisgender experience of menstruation and menopause.

Gender Identity and Menstruation

Recent reviews emphasize the heterogeneity of menstrual realities within the non-cis population.¹ Some find menstruation irrelevant to their quality of life or gender identity, whereas others report challenges after menarche because of (1) associated monthly dysphoria, (2) cisnormativity in discourses surrounding menstrual health, and (3) managing menstruation in public spaces.² Despite these heterogeneous attitudes, in interviews with trans men and non-binary persons, menarche has been associated with worsening dysphoria,³ and in clinical experience, ongoing menstruation has been associated with mental health concerns and self-harm.⁴

Non-cisgender persons may choose to therapeutically suppress menstruation. Of 129 trans and non-binary youth, 88% were interested in menstrual suppression for achievement of amenorrhea (97%) and improvement of menstrual-related dysphoria (63%).⁵ Current strategies include hormonal contraception (e.g., combined hormonal contraceptives, depot medroxyprogesterone acetate, levonorgestrel intrauterine device) or gonadotropin-releasing hormone agonists (i.e., puberty blockers). Alternatively, gender-affirming testosterone therapy can lead to menstrual and ovulatory suppression and endometrial atrophy. Opting for a hysterectomy, a common component of gender-affirming genital surgery (colloquially, bottom surgery), menstruation will permanently cease. In a Swedish population, non-binary persons reported particular difficulty accessing testosterone treatment, with testosterone prescription requiring diagnosis of gender identity disorder, and finding their identities to be more likely discredited.¹ Unfortunately, very little research reports separately on menstrual suppression goals or outcomes for non-binary persons.

In addition to distress resulting from menstruation, there may be differences in presentation of menstrual pathology. Chronic pelvic pain affects 51%–72% of trans and non-binary people compared with up to 27% of cisgender females; however, there is very little information on rates of endometriosis in this population. There are significant barriers to endometriosis diagnosis in the general population, with diagnostic delay of ~8 years and few treatment options, with trans persons facing additional barriers to care.⁶ Regarding pre-menstrual dysphoric disorder (PMDD), high suicidality rates in patients with PMDD (7%–16%) and the trans population (32%–50%) may compound the experience.⁷ Although there is no data to date available on prevalence of PMDD in the

trans and gender-diverse populations, treatment can easily complement gender-affirming care. Medical management of menstruation addresses incongruence in bodily perception during menses, noting lower rates of depression and anxiety in gender-diverse persons using gender-affirming hormone therapy (GAHT).⁷

Gender Identity and Menopause

A recent scoping review on the topic of non-cisgender experiences with menopause identified only 3 full-text primary studies.⁸ There is no agreed-upon menopause definition for trans men or non-binary persons because those taking testosterone into older age may not experience any physical symptoms of menopause because testosterone typically overrides endogenous estrogen production. Symptoms may be more likely experienced when starting on testosterone, frequently experiencing vaginal atrophy and associated dryness, dyspareunia, and bleeding.⁹ Symptoms are often treated with topical estrogens, but no investigation has been done into the efficacy of management of genitourinary symptoms specific to trans men at the initiation of GAHT. Although trans men or non-binary persons who do not take testosterone will proceed through “conventional” menopause, typical hormone therapy (HT) may evoke mixed opinions (e.g., introducing estrogen in a trans man).⁹

As trans women reach the age of traditional menopause, some may choose to continue, reduce, or discontinue their estrogen GAHT. The rationale behind dose reduction/cessation is to mitigate the risk of estrogen-related comorbidities with age (cardiovascular disease, hyperlipidemia, cholelithiasis), with symptoms potentially replicating menopause as levels of estrogen drop. Surveying support groups, some trans women did expect a hormone reduction and menopause-like transition in midlife, whereas others expressed an irrelevance of menopause due to their biological differences from cis women.¹⁰ Although the risk-reducing decision for discontinuation of GAHT is often made, there is no clear guideline on what age would be optimal, and there is very little evidence about the impacts of GAHT into the midlife. Conversely, quality of life is significantly improved in trans men and women who continue GAHT into old age, even more so than in younger persons.¹¹

Trans and non-binary persons describe a lack of community discussion relating to menopause, cisnormativity, and stigma in discussions of menopause concerns in health care encounters,⁸ leading to a delay in presentation and more severe menopause symptoms. Conversely, menopause may also contribute to relief of some

menstruation-associated dysphoria. Non-binary and trans respondents to a survey described a shift in their own gender identity at the time of menopause.⁹ For some, this shift was towards femininity (“It’s made me feel more female when I only just became comfortable with being non-binary.”), and for others, away from femininity (“I’m not really sure how it affects other people, but I think my changing hormones made it more obvious to me that I am not fully female”).⁹ For some non-binary persons, menopause can also lead to stressful decision-making regarding masculinizing versus feminizing HT for treatment of menopausal symptoms.⁸

Clinical Recommendations

The World Professional Association for Transgender Health Standards of Care-Eighth Edition (SOC-8) provides a thorough background on menstrual suppression methods for adolescents (statements 6.7 and 12.6). Important takeaways include individualizing treatment plans and noting that ovulation suppression is often not complete with testosterone use, advising contraception if partaking in sex that could lead to pregnancy. The SOC-8 recommends a thorough menstrual history before beginning suppression to avoid undiagnosed menstrual pathology.¹² Although specific prevalence of menstrual pathology is not known or reported in the guidelines, we would add that screening for PMDD and maintaining a low threshold for assessment for endometriosis in the non-cis population would be particularly relevant. This would follow the same investigation pathway as for endometriosis in cis women but acknowledging the potential for late-stage presentation and encouraging frequent follow-up. In screening for PMDD, determining the timing and source of distress (menstruation/social implications vs mood changes in luteal phase) will help ensure that neither PMDD nor menstruation-related dysphoria are missed. Addressing menstruation-related dysphoria ideally uses medical management and systemically addressing cisnormativity of menstruation in health care. Due to variations in experience, a first step recommended by some trans and non-binary persons was that providers ask for consent to discuss menstruation and its management, and, if relevant to the patient, taking the time to understand their goals and concerns.²

Although the SOC-8 does not discuss menopausal care for non-cis persons, the National Institute for Health and Care Excellence provides a menopause guideline with a few distinguishing recommendations for non-cis persons that have previously used GAHT,

recommending (1) expert consultation for these persons who are experiencing menopause symptoms and (2) to consider menopause-specific cognitive behavioural therapy for vasomotor, sleep, or depressive symptoms.¹³ Based on the literature reviewed, we would also recommend that practitioners explore their patient’s understanding of menopause, relevance to their own clinical situation, review menopausal symptoms and how these may overlap GAHT effects, discuss the pros and cons of GAHT discontinuation, and provide treatment options for bothersome menopause-like symptoms. It is important to carefully discuss menopause treatment options for these persons not taking GAHT and experiencing significant menopausal symptoms because typical HT may evoke mixed opinions (e.g., introducing estrogen in a trans man).

For menstrual and menopausal care, using inclusive language, signage, and asking permission when discussing potentially sensitive/gendered topics can help reduce the barriers to accessing care, particularly, addressing the fear/discomfort of menstruation in public toilets due to gendered toilet designs, lack of product disposal bins, and gaps in cubicle doors.² Terms such as “menstruators” or “people who menstruate” have been suggested to replace “women” and “girls” in menstrual health research and, similarly, to opt for “gynaecology” rather than “women’s health” to increase accessibility. Some controversy arises here because menstrual health movements have been advanced by feminist language strongly tied to women’s health. Gunter (2024) suggests interchanging between terms of women, people, and people who menstruate, based on context.¹⁴ Even menstrual products are highly gendered (e.g., “feminine hygiene products”) and often designed specifically for feminine-type underwear.¹ De-gendering medical terminology in patient care and advocating for gender-neutral toilets are frequently recommended first steps to address the othering of non-cis persons in menstrual health.

Research Recommendations

Advancement in menstrual health research requires a comprehensive understanding of basic uterine and menstrual physiology. Reviewing endocrine physiology, menstrual/menopausal publications can help learners’ understanding of where gender-diverse populations may differ, with important ties between physical and social experiences of menstruation and menopause. The social determinants literature informs our understanding of variation in menstrual pathology and severity of

menopause (e.g., burden of symptoms by race and socioeconomic status). However, little is known about the impact of gender identity and GAHT on the experience of menstruation/menopause.

Future research should report on the non-cis menstrual experience regarding (1) prevalence, severity, and management of symptoms; (2) access to medical management for menstrual pathology, and (3) intersections of marginalization (e.g., unhoused gender-diverse population) to help identify those most in need of care. The Williams Institute reports poverty rates of 33.7% for trans men and 23.8% for gender non-conforming persons compared with 13.4% for cis-gender men in the United States. These rates were accentuated at intersections of racial and gender minorities.¹⁵ Impacts of period poverty on non-cis menstruation would be valuable to explore in Canada because the menstrual experiences of non-cis people might be further impacted in those experiencing poverty without proper access to menstrual products.

Future menopause research should (1) seek to understand symptoms expressed by non-cisgender females and by present/past use of GAHT; (2) longitudinally assess the long-term effects of GAHT to inform standards of care in midlife; and (3) conduct broader qualitative research to understand the diversity of experience for trans men, women, and non-binary persons, respectively. Compared with other sexual and gender minority groups, non-binary persons report the longest delays in health care seeking due to fear of discrimination⁸ and should be prioritized for research inclusion because they are under-represented thus far in the literature.

CONCLUSION

Non-cisgender persons have a unique and under-investigated experience with menstruation and menopause. Currently, to appropriately support gender-diverse patients in primary care scenarios, an individualized approach is essential. Based on literature regarding non-cisgender menstruation and menopause, we have suggested additional avenues for research and clinical action.

ETHICS

Ethics approval was not applicable as this communication includes a narrative literature review and related clinical recommendations, with no new data collected.

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