

What the Evidence Actually Supports

Which treatments have evidence behind them, how strong it is, and where the claims run ahead of the science

KEY MESSAGE

There is no single treatment for menopause pain, and matching treatment to the diagnosis matters more than any one remedy.

Treatment depends on whether pain is primarily nociceptive, neuropathic, nociplastic or mixed, whether there is an identifiable condition, and how long the pain has persisted. Where evidence comes specifically from menopausal women, that is stated.

1 Movement and exercise

Evidence: strong overall for persistent pain; the best programme depends on the condition.

Exercise is one of the most consistently supported non-drug approaches for persistent pain, and NICE recommends supervised exercise and ongoing physical activity for chronic primary pain, adapted to the person's abilities and preferences.

^{1,2} In midlife, progressive resistance training has an additional rationale, because it protects muscle, strength and function while providing a structured way to load painful tissues appropriately.

Do you have to exercise completely pain-free? No. A systematic review found that allowing some pain during therapeutic exercise was not a barrier to improvement and produced a small short-term advantage in chronic musculoskeletal pain, with no clear long-term superiority.³ The message is not to push through anything, it is that some discomfort during rehabilitation does not automatically mean damage.

2 Education, self-management and a clear plan

Evidence: strong as part of good chronic pain care.

Good pain care starts with a person-centred assessment, a working explanation, realistic goals and shared decisions, and NICE recommends explaining benefits, harms and uncertainties and agreeing a care plan rather than simply cycling through tests and medicines.² The target is not necessarily zero pain, because useful outcomes include better sleep, more activity, greater strength, fewer flare-ups and reduced interference from pain.

3 Sleep: important, but not a cure

Evidence: biologically convincing and clinically relevant; direct menopause-specific pain trials are more limited.

Sleep and pain influence each other, so experimental sleep disruption can increase pain sensitivity while pain can fragment sleep. For a woman whose pain and poor sleep reinforce one another, treating insomnia, vasomotor symptoms or another sleep disorder is a legitimate part of pain management. What the evidence does not justify is promising that better sleep alone will reset a sensitised nervous system or cure chronic pain.

4 Psychological therapies: real benefit, not "it's all in your head"

Evidence: moderate, with small-to-moderate effects depending on outcome.

Acceptance and commitment therapy and cognitive behavioural therapy for pain can improve pain-related function, quality of life and psychological distress, and a 2023 meta-analysis of 33 ACT trials involving 2,293 people found small-to-moderate benefits for pain intensity and physical function.⁴ These approaches target how pain, attention, behaviour, distress and avoidance interact, and they do not imply that the pain is imaginary.

5 Multidisciplinary care

Evidence: strong in selected chronic pain populations; the exact programme matters.

Persistent pain often has several interacting contributors, so combining appropriately selected movement or rehabilitation, education, psychological support and medical management can be more useful than repeatedly trying isolated treatments. This is not throwing everything at it, it means identifying the dominant problems and choosing a coordinated plan with clear goals and review.

6 MHT: plausible biology, but not a general pain treatment

Evidence for musculoskeletal pain: currently insufficient to recommend MHT as a general pain treatment.

A 2026 systematic review and meta-analysis included 57 studies and almost four million participants, though only a minority were randomised trials, and pooled analysis found no significant effect of ever-use of MHT versus never-use on generalised musculoskeletal pain, with heterogeneous and conflicting evidence for osteoarthritis and rheumatoid arthritis.⁵ That does not mean MHT cannot help an individual woman, it means pain alone is not a reliable indication on which to promise benefit. If MHT is otherwise appropriate for recognised indications, pain can be part of the overall discussion, but it should not be presented as a proven analgesic.

7 Medicines: condition-specific, not the default answer

Evidence: varies by medicine and by diagnosis.

NSAIDs can help some inflammatory or musculoskeletal conditions, but regular use carries gastrointestinal, renal, blood-pressure and cardiovascular risks, and NICE recommends against routinely initiating them for chronic primary pain because evidence of benefit is poor.² **Paracetamol** is not a universal treatment for persistent pain, and NICE recommends against initiating it for chronic primary pain, though it still has roles in some acute or condition-specific pain. **Opioids** may have a role in selected acute or specialist circumstances, but long-term treatment for most chronic non-cancer pain carries important risks and limited evidence of sustained benefit, so persistent use should have a clear indication, goals and review plan.

WORTH ASKING

What is this medicine intended to improve, what benefit should I expect, how long should I use it, and what is the plan if it does not help?

8 Supplements: correct a deficiency, do not confuse biology with proof

Evidence: generally limited for treating pain in otherwise nutrient-replete women.

Vitamin D has an established role in bone and calcium physiology, but that is not the same as evidence that taking it treats chronic musculoskeletal pain in someone who is not deficient, and evidence for magnesium, collagen, turmeric, boron and similar products as menopause pain treatments is limited. A plausible mechanism or biochemical effect does not establish clinically meaningful pain relief, so it is worth asking whether a product has been tested in people like you, at the dose you are buying, for the outcome you actually want.

THE BOTTOM LINE

The evidence does not point to one miracle treatment. It points to matching treatment to mechanism and diagnosis, building physical capacity, addressing sleep and other modifiable contributors, using psychological

therapies when appropriate, reviewing medicines carefully, and being honest about where menopause-specific evidence is still uncertain.

Good pain care is not about finding the most expensive treatment. It is about finding the treatment with a credible benefit-to-harm ratio for the problem you actually have.

KEY SOURCES

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5. Overton R, et al. The effect of menopausal hormone therapy on musculoskeletal pain in menopausal women: a systematic review and meta-analysis. Post Reprod Health. 2026;32(1):52–68.

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