

What the Evidence Actually Supports

Which treatments and strategies have evidence behind them — how strong that evidence is — and where the claims run ahead of the science.

START WITH ONE IMPORTANT DISTINCTION

There is no single evidence-based treatment for 'menopause pain'. 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.

Evidence from chronic primary pain should not automatically be presented as evidence for every musculoskeletal condition. Where evidence is specifically from menopausal women, that is stated.

STRONGEST FOUNDATION: MOVEMENT AND EXERCISE

Evidence: strong overall for persistent pain management, but the best programme depends on the condition.

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

In midlife, progressive resistance training has an additional rationale: it protects muscle, strength and function while also 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; there was no clear long-term superiority. The message is not 'push through anything'. It is that some pain during rehabilitation does not automatically mean damage.

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. NICE recommends explaining benefits, harms and uncertainties and agreeing a care plan rather than simply cycling through tests and medicines.

The target is not necessarily zero pain. Useful outcomes include better sleep, more activity, greater strength, fewer flare-ups, improved work or daily function, and reduced interference from pain.

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. 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: promising that better sleep alone will 'reset' a sensitised nervous system or cure chronic pain.

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 (ACT) and cognitive behavioural therapy (CBT) for pain can improve pain-related function, quality of life and psychological distress. A 2023 meta-analysis of 33 ACT trials involving 2,293 people found small-to-moderate benefits for pain intensity and physical function.

Why this matters: these approaches target how pain, attention, behaviour, distress and avoidance interact. They do not imply that the pain is imaginary.

MULTIDISCIPLINARY CARE

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

Persistent pain often has several interacting contributors. Combining appropriately selected movement/rehabilitation, education, psychological support and medical management can be more useful than repeatedly trying isolated treatments.

This is not 'throw everything at it'. It means identifying the dominant problems and choosing a coordinated plan with clear goals and review.

MHT: PLAUSIBLE BIOLOGY, BUT NOT A GENERAL PAIN TREATMENT

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

A 2026 systematic review and meta-analysis included 57 studies and 3,958,702 participants. Pooled analysis found no significant effect of ever-use of HRT versus never-use on generalised musculoskeletal pain (RR 1.00, 95% CI 0.96–1.04). Evidence for osteoarthritis and rheumatoid arthritis was heterogeneous and conflicting.

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.

PAINKILLERS: CONDITION-SPECIFIC, NOT THE DEFAULT ANSWER

NSAIDs: can be useful for some inflammatory or musculoskeletal conditions, but regular use carries gastrointestinal, renal, blood-pressure and cardiovascular risks. NICE recommends against routinely initiating NSAIDs for chronic primary pain because evidence of benefit is poor.

Paracetamol: is not a universal treatment for persistent pain. NICE recommends against initiating it for chronic primary pain because meaningful benefit is not supported. It still has roles in some acute or condition-specific pain, so diagnosis matters.

Opioids: may have a role in selected acute or specialist circumstances, but long-term treatment for most chronic non-cancer pain has important risks and limited evidence of sustained benefit. Persistent use should have a clear indication, goals and review plan.

Ask: “What is this medicine intended to improve? What benefit should I expect? How long should I use it? What is the plan if it does not help?”

ANTIDEPRESSANTS FOR CHRONIC PRIMARY PAIN

Evidence: moderate for selected chronic primary pain; medicine- and condition-specific.

NICE allows consideration of certain antidepressants for chronic primary pain even when the person does not have depression, because some can improve pain, sleep, quality of life and psychological distress.

Important: this is not the same as saying the pain is depression. These medicines have side effects and withdrawal considerations, so the decision should be individualised and reviewed.

ACUPUNCTURE / DRY NEEDLING

Evidence: modest and condition-dependent.

NICE allows consideration of a limited course of acupuncture or dry needling for chronic primary pain. That is a qualified option, not evidence that acupuncture treats the underlying cause of every pain condition.

Good practice: agree what outcome you are testing and when you will decide whether it is worth continuing.

MANUAL THERAPY, TENS AND OTHER PASSIVE MODALITIES

Evidence varies considerably by condition.

Hands-on treatment can be useful for some local musculoskeletal problems, particularly as part of a broader rehabilitation plan. It should not be sold as 'putting something back in place' when the evidence does not support that explanation.

For chronic primary pain, NICE recommends against TENS, ultrasound and interferential therapy because it found no evidence of benefit. That recommendation should not be incorrectly generalised to every diagnosis.

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 vitamin D treats chronic musculoskeletal pain in someone who is not deficient. Magnesium is biologically important, but evidence for using supplements specifically as a menopause pain treatment is limited.

Apply the same rule to collagen, turmeric/curcumin, boron, K2 and other products: a plausible mechanism or biochemical effect does not establish clinically meaningful pain relief. Ask whether the product has been tested in people like you, at the dose you are buying, for the outcome you actually want.

ANTI-INFLAMMATORY DIETS AND OMEGA-3s

Evidence: condition-specific and generally modest.

Some dietary patterns and omega-3 interventions have evidence for particular inflammatory or cardiometabolic outcomes. That does not establish that an 'anti-inflammatory diet' will remove chronic pain. Food quality still matters for overall health, but pain claims should be proportionate to the evidence.

CLAIMS TO BE SCEPTICAL ABOUT

“Your pain is caused by low oestrogen.” Too simple. Menopause can be one contributor among several.

“Your scan is clear, therefore your pain is central sensitisation.” Incorrect. A normal scan does not diagnose nociplastic pain.

“You need to push through the pain.” Too crude. Exercise should match the diagnosis, irritability, capacity and response.

“MHT will fix your joint pain.” Not supported as a general claim by current evidence.

“This supplement reduces inflammation, therefore it treats your pain.” Mechanism is not outcome evidence.

“Pain means damage, so stop moving.” Not generally appropriate for persistent musculoskeletal pain; prolonged avoidance can reduce strength and function.

“Pain is psychological.” A false dichotomy. Biological, psychological and social factors can influence pain without making it imaginary.

HOW TO USE THE EVIDENCE IN YOUR OWN CASE

Ask four questions:

1. What pain mechanism or condition are we treating?
2. What outcome should improve — pain intensity, function, sleep, strength, quality of life or flare frequency?
3. How strong is the evidence for this treatment in people like me?
4. When will we review whether it is working?

This protects against both therapeutic nihilism ('nothing can help') and treatment hype ('this fixes the cause').

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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