The specialist authority for menopause & post reproductive health

British Menopause Society

Menopausal 'brain fog' or dementia? – a practical guide for clinicians

Key points

- Menopausal 'brain fog' is a cluster of cognitive-related symptoms that can be distressing to individuals.
- Brain fog can occur across the lifespan in both men and women. It is not always hormone related and is multifactorial in origin.[1]
- Addressing brain fog symptoms may include hormone therapy to manage 'triggers' for brain fog, such as poor sleep and tiredness.
- Brain fog symptoms tend to resolve post menopause for most people.
- Dementia under age 65 years is rare – unless there is a family history of early onset dementia and/or unusual presentation and/or a significant and progressive cognitive decline, we can often reassure individuals.
- Lifestyle, nutritional and cognitive approaches are important aspects of improving brain fog symptoms.

Background

"I feel like I am going mad, I am struggling to do my job"
"I am scared this is early dementia"

The average age of menopause in the UK is 51 years, although within some ethnic groups, the average may be lower. From a physiological perspective, it marks the end of the reproductive stage and is when periods have stopped for twelve months.[2] The same STRAW classification describes 'menopause transition, early and late': early stage marked by variability in menstrual cycle length, elevated but variable follicle stimulating hormone (FSH) levels and increased prevalence of anovulation. Late stage transition is marked by amenorrhea of 60 days or longer, wide fluctuations in FSH levels and increased anovulatory cycles.

The term 'perimenopause' is often used to describe the transition phase and is more commonly recognised as all-encompassing term to describe the months or years either side of periods stopping, up to one year after the last period. This transition time is marked by hormonal change and for some, multiple physical and emotional symptoms. Vasomotor symptoms (flushes and sweats) are the most readily recognised symptoms but are not always the ones that are of most concern to symptomatic individuals.[3] In fact, a recent UK analysis of over 14,000 women found 'brain fog' to be the highest reported symptom (in 86% of the sample), compared to 53% reporting hot flushes and 54% reporting sweats.[4]

'Brain fog' was recently defined by Gurvich et al[5] as:

Self-reported impairment in one or more cognitive areas (such as memory, attention, organisation, problem solving, word retrieval) in the absence of a significant, objective cognitive decline. Can fluctuate (for example daily or across a menstrual cycle) and cause mild to significant distress and impact on quality of life. Does not result in sustained changes in capacity to perform activities of daily living.

The most common cognitive symptoms are subjective (or self-reported) symptoms such as:

- losing a train of thought
- word finding difficulties
- loss of immediate focus (what was meant to be done)
- forgetting information
- distraction
- misplacement of items
- difficulties on multitasking

These can lead to anxiety and a concern that they represent the early signs of dementia.

Large reviews and cohort studies estimate that a substantial proportion of perimenopausal women report new or worsening cognitive symptoms, most commonly in attention, working memory and executive function, managing thoughts and decisions to achieve goals.[6] For most, these symptoms resolve after menopause, but they can cause distress and anxiety, associated impact at work and often lead to appointments with primary care teams to rule out early onset dementia.

This leads to a problem in diagnosis and assessment. There are no validated series of tests for 'brain fog' and no guidelines when faced with patients wanting to 'rule out dementia'. Standard memory tests are not designed with this population in mind and lack sensitivity to detect subtle cognitive changes.[4] Longitudinal studies suggest a decline in some areas of cognition (learning, memory, processing speed), but cognitive performance generally remains in expected ranges.[7]

Other contributing factors to brain fog may include nutritional deficiencies, endocrine disease or mental health issues, such as low mood or anxiety.

Why does the distinction matter?

Clinical management

Cognitive complaints related to menopause can be approached with symptomatic management (sleep, mood, cognitive strategies, treating vasomotor symptoms, lifestyle measures and, where appropriate, hormone replacement therapy with individualised benefit/risk discussion and/or Cognitive Behavioural Therapy (CBT). CBT may help break the cycle of '*My brain isn't working properly, therefore I can't do anything*' thinking that sometimes worsens symptoms of brain fog. Dementia requires a different diagnostic workup, risk-factor modification, possible pharmacological or non-pharmacological treatment and planning for progressive care needs.[6]

Prognosis and counselling

Most menopausal cognitive complaints do not progress to dementia; misdiagnosis can cause unnecessary anxiety and inappropriate treatments. Conversely, missing early dementia delays access to therapies and planning.[8]

Key differences between 'brain fog' and dementia

1. Age and timing

- **Menopausal brain fog** typically begins during the perimenopausal period (variable ages, often 45-55 years but may be earlier) and can be associated with irregular menses and other menopausal symptoms (hot flushes, sleep disruption). Symptom onset is often subacute and may fluctuate with menstrual cycle and with sleep and mood.[7]
- **Dementia/mild cognitive impairment** usually occurs at older ages, most commonly over age 65 years. It presents as more complex cognitive and behavioural changes beyond memory loss. This may include difficulty recognising common objects or coordinating everyday tasks, such as making a cup of tea. It involves worsening function over time and disturbance of daily living.[9]

2. Affected cognitive domains and pattern

- **Menopause-related complaints** are often difficulty recalling words ('word blindness'), misplacing items, difficulty concentrating, forgetting appointments, losing train of thought. Usually identified by the individual themselves.
- **Dementia** can include more profound difficulty with memory, naming, task coordination, language and judgement, often observed by others.

3. Functional impact

- **Menopausal brain fog**: activities of daily living are generally preserved; difficulties are more likely to be noticed at high-cognitive-load tasks (work multitasking) and may be intermittent.
- **Dementia**: interference with independence (managing finances, medication, complex tasks) is a key diagnostic threshold.

Practical approach

History and assessment of cognitive assessments

- Discuss age of onset, duration and nature of the problem (sudden vs insidious; fluctuating vs progressive).
- Consider the context (any menstrual changes, HRT use, associated with other menopause symptoms).
- Ask about impact: work/functional impact.
- Check family history of neurodegenerative disease.
- Ask about alcohol consumption, smoking and any other substance use.
- Assess and address vascular risk factors.

- Rule out other medical conditions, nutritional deficiencies, psychiatric conditions and psychosocial factors that could contribute to or exacerbate cognitive symptoms during midlife. This may include full blood count, thyroid function, vitamin deficiencies such as B12, folate, vitamin D, HBA1C, liver and kidney function and inflammatory markers.
- This may be an ideal time for a patient to complete a self-assessment of their overall cognitive heath and dementia risk: https://cogdrisk.app/ .[10]

Assessment of other menopause symptoms

- Consider a standardised measure such as the Menopause Rating Scale [11] or Greene Climacteric Scale.[12]
- Specifically ask about mood and consider depression (can use the Meno-D).[13]
- Assess sleep (sleep apnoea, disrupted sleep and insomnia) as well as vasomotor symptoms – which can all exacerbate cognitive symptoms directly or indirectly.
- Educate and reassure about the link between menopause and cognition.
- Remind them that though all woman go through menopause, the large majority will not develop dementia.
- Encourage workplace discussions around anxiety relating to brain fog, for example quiet environment, digital aids and support, regular breaks and flexible approaches.
- The effects of HRT on cognition have not been well researched – findings to date suggest positive or neutral effects on cognitive function in perimenopause or early post menopause. A recent meta-analysis found no evidence that HRT use either increases or decreases the risk of dementia in post-menopausal women.[14] There is insufficient evidence to recommend testosterone therapy specifically for brain fog symptoms.[15] These absences of effect do not mean that HRT and testosterone do not improve cognitive functioning or that there is no impact on dementia, but that there is currently insufficient quality research available to fully understand these relationships.

Treat contributing modifiable risk factors

- Manage mood, sleep and vasomotor symptoms – consider HRT, psychological therapies (CBT or other talking therapies).
- Review medications and consider a test for thyroid disease, B12 deficiency.
- Diabetes management.
- Monitor vascular risk factors and treat accordingly.
- Encourage physical activity, good hydration and stress reduction strategies.

When to escalate

- Atypical features such as neurological signs, seizures, rapid progression.
- Significant and sudden decline, risk to safety.
- Family history of early onset (under 65) cognitive impairment/dementia.
- Cognitive symptoms are progressive and/or interfere substantially with work performance, relationships or quality of life.

Figure 1: Top tips for improving brain health

(based on modifiable risk factors for dementia prevention from the World Health Organization (WHO) 2019 guidelines and Maki and Jaff's brain health guidance[7,16])

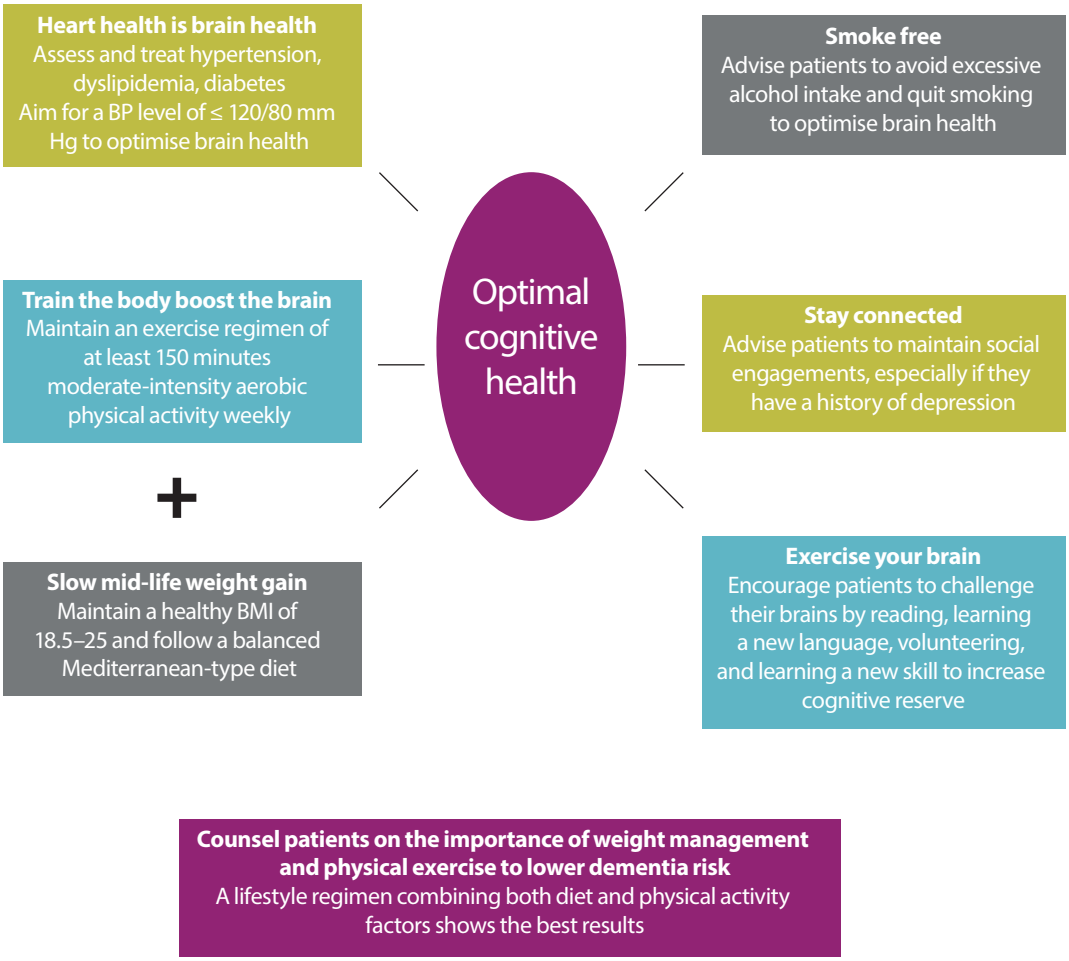

Table 1: Summary – Key differences[4]

	Menopausal 'brain fog'	Dementia
Who it affects	Women (and those with ovaries) primarily aged 40-60 years	Men and women, most commonly those over 65 years
Course and progression	Sudden or gradual onset Unlikely to be associated with significant deterioration over time Can fluctuate during menstrual cycle and typically improves post menopause	Sudden or gradual onset Chronic and progressive, with significant deterioration over time
Key symptoms	Difficulty recalling words and numbers, disturbances in daily life (for example misplacing items), trouble concentrating (absent minded, losing a train of thought, more easily distracted), forgetting appointments	Disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, language and judgement. Commonly accompanied and occasionally preceded, by deterioration in emotional control, social behaviour or motivation.
Impact on independent living	Does not impact on independent living, although impact on quality of life can be mild to severe	Impact ranges from mild to severe
Who tends to notice	Changes more typically observed by the individual affected	Change is typically observed by others in addition or sometimes instead of the individual affected

Summary

With increasing numbers of individuals seeking advice for perimenopausal 'brain fog', it is apparent that it is a common problem, with specific symptoms. In research studies, objective cognitive changes are measurable during the menopause transition, but in everyday practice there is no objective validated test for this population. More research is needed in this area.

Meanwhile, we can educate and inform, dispel myths, reassure and offer practical tips, as well as consider prescribing hormone replacement therapy where indicated, to alleviate symptoms which can impact on cognition such as flushes and sleep disturbance. Current research is exploring the best screening methods for midlife cognitive impairment versus early dementia; and updated guidelines will provide more specific guidance on this.

References

1. Denno P, Zhao S, Husain M, Hampshire A. Defining brain fog across medical conditions. *Trends Neurosciences*. 2025;48(5):330-348.

2. Harlow SD, Gass M, Hall JE, et al. Executive summary of the Stages of Reproductive Aging Workshop + 10. *Menopause*. 2012;19(4):387-395.

3. Balfour J, Smellie A. Empowering change: insights from the Menopause Mandate Big Menopause Survey 2024 overview. *Maturitas*. 2025. doi:10.1016/j.maturitas.2025.108416.

4. Spector A, Gurvich C. Differentiating cognitive challenges during menopause transition from dementia: key considerations. *Australasian Journal of Ageing*. 2025;44. doi:10.1111/ajag.70102.

5. Gurvich C, Spector A, Hickey M. Advances in understanding of cognitive symptoms during menopause. *Lancet Obstet Gynaecol Women's Health*. 2026;2:e335-e345

6. Conde DM, Verdade RC, Valadares ALR, Mella LFB, Pedro AO, Costa-Paiva L. Menopause and cognitive impairment: a narrative review of current knowledge. *World J Psychiatry*. 2021;11(8):412-428.

7. Maki PM, Jaff NG. Brain fog in menopause: a health-care professional's guide for decision-making and counseling on cognition. *Climacteric*. 2022;25(6):570-578.

8. National Institute for Health and Care Excellence (NICE). Dementia: assessment, management and support. *NICE Guideline NG97*; 2018. Reviewed 2025.

9. Dickerson BC, Atri A, Clevenger C, et al. The Alzheimer's Association clinical practice guideline for the Diagnostic Evaluation, Testing, Counseling, and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD). *Alzheimer's and Dementia*. 2025;21(1):e14337.

10. Anstey KJ, Kootar S, Huque MH, Eramudugolla R, Peters R. Development of the CogDrisk tool to assess risk factors for dementia. *Alzheimer's Dement (Amst)*. 2022;14(1):e12336.

11. Heinemann LA, DoMinh T, Strelow F, et al. The Menopause Rating Scale (MRS) as outcome measure for hormone treatment? A validation study. *Health Qual Life Outcomes*. 2004;2:67.

12. Greene JG. Constructing a standard climacteric scale. *Maturitas*. 1998;29(1):25-31.

13. Kulkarni J, Gavrilidis E, Hudaib AR, et al. Development and validation of a new rating scale for perimenopausal depression—the Meno-D. *Translational Psychiatry*. 2018;8(1):123.

14. Melville M, He L, Desai R, et al. Menopause hormone therapy and risk of mild cognitive impairment or dementia: a systematic review and meta-analysis. *Lancet Healthy Longev*. 2025;6(12).

15. Sultana F, Davis SR, Bell RJ, Islam RM. Association between testosterone and cognitive performance in postmenopausal women: a systematic review of observational studies. *Climacteric*. 2023;26(1):5-14.

16. World Health Organization. Risk reduction of cognitive decline and dementia: WHO guidelines. Geneva: World Health Organization; 2019.

Authors: Kathy Abernethy, Associate Professor Caroline Gurvich and Professor Aimee Spector in collaboration with the medical advisory council of the British Menopause Society

PUBLISHED: JUNE 2026
AMENDED: AUGUST 2026 (*Referencing updated*)

This BMS Tool for Clinicians will be updated when guidance changes and/or new data becomes available.

Reg Charity No: 1015144 Company Reg No: 02759439