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**Menopause 101 for the DPC
Physician:
Confidently Evaluating, Supporting,
& Treating Women in Transition**

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- ▶ Navigate to <https://aafp1.cnf.io/> and tap the session titled "Menopause 101 for the DPC Physician: Confidently Evaluating, Supporting, and Treating Women in Transition"
- ▶ OR just point your phone's camera at the QR code to join directly



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Learning Objectives

1. Identify and evaluate the clinical signs and symptoms of perimenopause and menopause using a structured approach appropriate for the DPC setting.
2. Counsel and support women through the menopausal transition, emphasizing lifestyle interventions, mental health, and preventive care.
3. Prescribe and manage hormonal and non-hormonal therapies safely and effectively for menopausal symptom relief.



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Key Points! Pay Attention!



There are 6 Key Points Highlighted Throughout the presentation with this star. Track what they are - if you can recall all 5 you will get a special prize!



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Why It Matters



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Why It Matters

Menopause is Mainstream

- Hormone therapy is back in the conversation
- WHI misconceptions are being corrected
- FDA Black Box Warnings Recently lifted
- Awareness is fueled by celebrity and physician voices



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Why It Matters

Menopause care is more than treating symptoms

Hormone care heavily impacts

- morbidity and mortality of women in mid and late life
- cardiovascular health
- bone health and hip fracture
- Genitourinary health (life threatening UTIs)
- Possible dementia prevention

We can help women live BETTER



Menopause care IS Primary Care



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Why Menopause Belongs in DPC

Direct Primary Care

- ✓ Longer visits
- ✓ Long-term Relationship
- ✓ Evidence-based treatment
- ✓ Whole-person care
- ✓ Better Follow Up

Hormone Clinics & Med Spas

- ✗ Brief, transactional encounters
- ✗ Limited continuity of care
- ✗ Variable adherence to guidelines
- ✗ Symptom-focused care
- ✗ Episodic care



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Definitions



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Pre-
Peri-
Post-



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Figure 1. The Stages of Reproductive Aging Workshop + 10 Staging System

| | | | | | | | | | | |
|------------------------------------|---------------------|---------|---------|-------------------------------|--|------------------------------------|--------------------------------|---|--------------------|------|
| | Menarche | | | | | | FMP (0) | | | |
| Stage | -5 | -4 | -3b | -3a | -2 | -1 | +1a | +1b | +1c | +2 |
| Terminology | REPRODUCTIVE | | | | MENOPAUSE TRANSITION | | POSTMENOPAUSE | | | |
| | Early | Peak | Late | | Early | Late | Early | | | Late |
| Duration | variable | | | | variable | 1-3 | 2 (1+1) | 3-6 | Remaining lifespan | |
| PRINCIPAL CRITERIA | | | | | | | | | | |
| Menstrual cycle | Variable to regular | Regular | Regular | Subtle changes in flow length | Variable length Persistent ≥7-day difference in length of consecutive cycles | Interval of amenorrhea of ≥90 days | | | | |
| SUPPORTIVE CRITERIA | | | | | | | | | | |
| Endocrine FSH | | | Low | Variable* Low | ↑ Variable* Low | ↑ >25 IU/L* Low | ↑ Variable* Low | Stabilizes | | |
| AMH | | | Low | Low | Low | Low | Low | Very low | | |
| Inhibin B | | | Low | Low | Low | Low | Very low | Very low | | |
| Antral follicle count | | | Low | Low | Low | Low | Very low | Very low | | |
| DESCRIPTIVE CHARACTERISTICS | | | | | | | | | | |
| Symptoms | | | | | | Vasomotor symptoms Likely | Vasomotor symptoms Most likely | Increasing symptoms of urogenital atrophy | | |

↑ Indicates elevated.
 a. Blood draw on cycle days 2-5.
 b. Approximate expected level based on assays using current international pituitary standard.
 Abbreviations: AMH, antimüllerian hormone; FMP, final menstrual period; FSH, follicle-stimulating hormone.
 Adapted from Harlow SD, et al.¹ © North American Menopause Society.



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Keep It Simple!!!

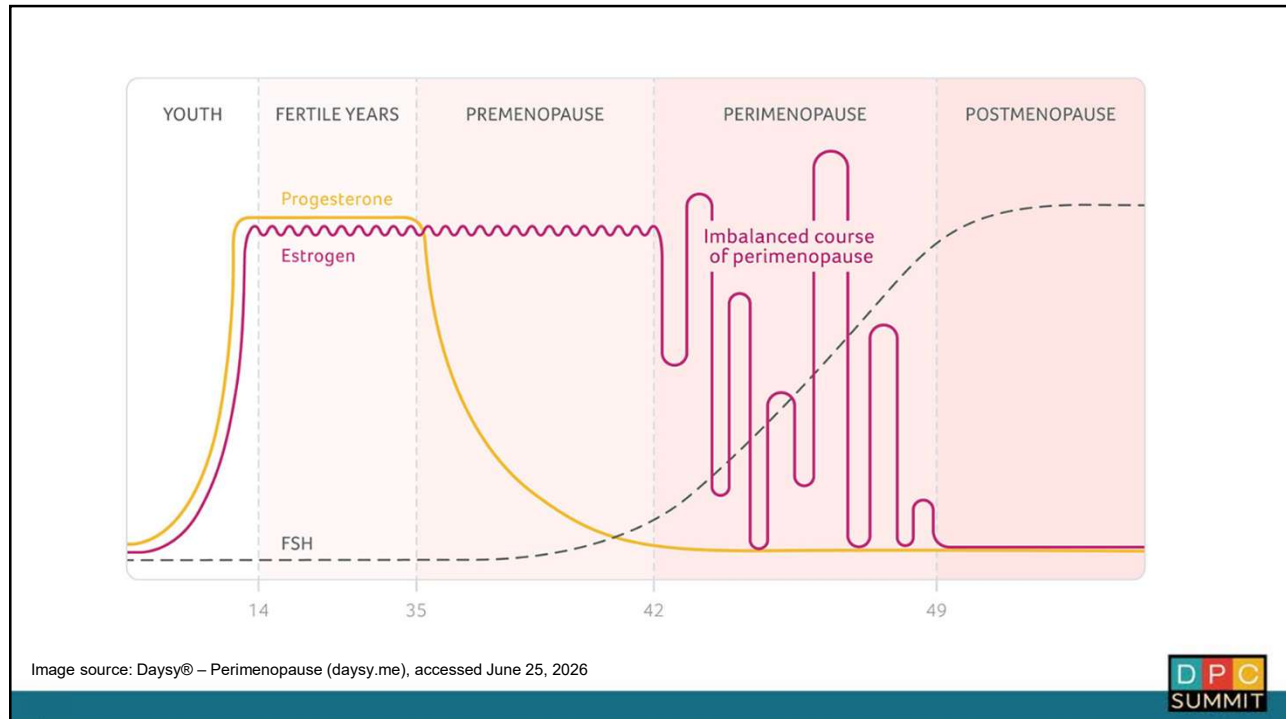
Figure 1. The Stages of Reproductive Aging Workshop + 10 Staging System

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| Terminology | REPRODUCTIVE | | | | MENOPAUSE TRANSITION | | POSTMENOPAUSE | | | |
| | Early | Peak | Late | | Early | Late | Early | | | Late |
| | | | | | Perimenopause | | | | | |
| | PreMenopause | | | | Perimenopause | | PostMenopause | | | |

**Menopause!
One Day!**



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Diagnosing Menopause & PeriMenopause

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Diagnosing Menopause



Easy!

- **Clinical diagnosis**
- **12 months (365 days) after the last menstrual period**
- **Labs may confirm:**
 - ↑ FSH - >25–40 IU/L (assay-dependent)
 - ↓ Estradiol - <20 pg/mL

Menopause = 12 months (365 days) after the last menstrual period

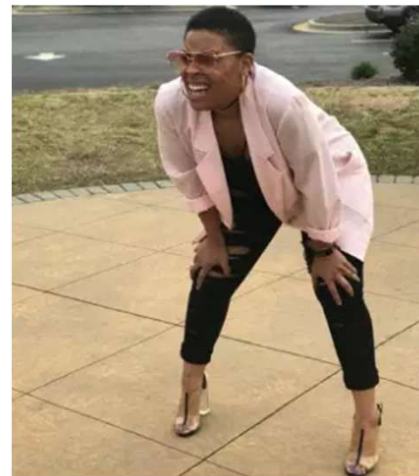


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Diagnosing Peri-Menopause

Trickier...but recognizable

- **Still a clinical diagnosis**
- **Consider:**
 - Age (typically begins in the early 40s)
 - Menstrual cycle changes
 - Vasomotor, mood, sleep & genitourinary symptoms
 - Validated symptom assessment tools can help quantify burden
 - Menopause Rating Scale (MRS)
 - Menopause-Specific Quality of Life (MENQOL)



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Beyond Hot Flashes: Full Symptom Spectrum

COMMONLY RECOGNIZED

- Hot flashes / night sweats
- Irregular or missed periods
- Vaginal dryness
- Sleep disturbance
- Mood changes / irritability
- Decreased libido
- Weight gain

COMMONLY MISSED ^Δ

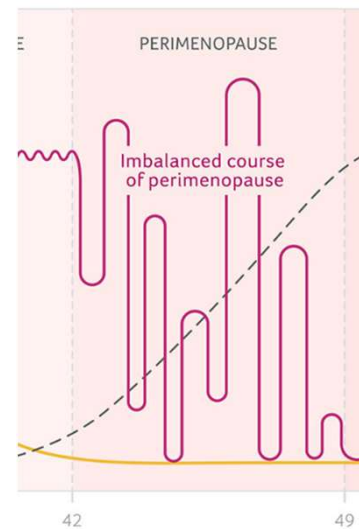
- Brain fog / memory lapses
- New or worsening anxiety / panic
- Palpitations
- Joint & muscle pain
- Tinnitus
- Electric shock sensations
- Urinary urgency / recurrent UTIs
- Dry skin, hair loss, brittle nails
- Worsening migraines



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Diagnosing Peri-Menopause

What Labs Do You Need?



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Diagnosing Peri-Menopause

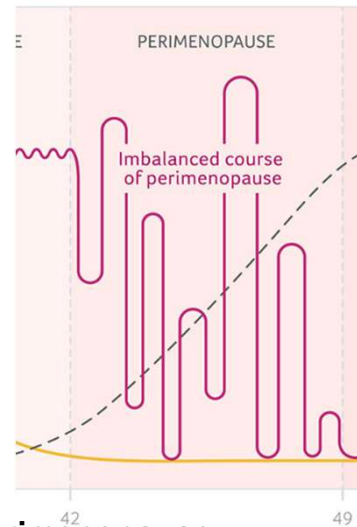
What Labs Do You Need?

NONE

- **✗** Labs **cannot diagnose or exclude** perimenopause
- Hormones fluctuate too rapidly for a single "snapshot" to be reliable



Labs are NOT Needed to Diagnose Perimenopause



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Never tell a woman she **ISN'T** perimenopausal based on normal hormone labs



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If You're Checking Hormone Levels...



Use LC-MS/MS (Liquid Chromatography–Tandem Mass Spectrometry)

- More accurate at the low hormone levels seen in women
- Preferred for measuring **estradiol** and **testosterone**
- Less cross-reactivity than standard immunoassays
- Particularly important for women on hormone therapy



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Exceptions - When Labs May Help

Rule Out Other Causes (Mimics)

- **CBC** → Anemia (fatigue, palpitations, dyspnea)
- **TSH** → Thyroid disease (the great menopause mimic)
- Consider pregnancy testing when appropriate
- Additional testing guided by symptoms



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Think Beyond Menopause

Assess the Midlife Woman

- **Lipid Panel** → Cardiovascular risk increases during menopause
- **Hemoglobin A1c** → Rising insulin resistance & diabetes risk
- **CMP** → Baseline metabolic and liver/kidney health
- **Vitamin D** → Bone health
- **hs-CRP (optional)** → Inflammation/cardiometabolic risk



Every Menopause Visit Is a Prevention Visit



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Special Circumstances

PCOS/PMOS

- Irregular cycles complicate diagnosis
- Symptoms often overlap with perimenopause
- Focus on **age + symptom pattern**, not labs alone

Hysterectomy

- No uterus = no menstrual clues
- Rely on symptoms and clinical history
- Women with ovarian preservation may still experience **earlier menopause**



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Don't Miss This Diagnosis

Premature Ovarian Insufficiency (POI)

- **Menopause before age 40**
- Elevated FSH + low estradiol
- Confirm with repeat testing
- Requires evaluation for underlying causes
- Refer to **Reproductive Endocrinology and/or Endocrinology**
- Early hormone therapy is often indicated unless contraindicated



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One More Time!
 Never tell a
 woman she
ISN'T
 perimenopausal
 based on normal
 hormone labs



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Treatment



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Lifestyle of First Line Therapy

Exercise

Evidence:
Strong

150 min/week moderate aerobic + 2x resistance training. Reduces vasomotor symptoms, improves mood, preserves bone density, and mitigates metabolic risk. Most evidence-supported lifestyle intervention.

Sleep Hygiene

Evidence:
Moderate

CBT-I preferred over sedatives. Address sleep apnea first. Temperature regulation: fans, moisture-wicking fabrics, cooling mattress pads. Consistent sleep/wake schedule.

Nutrition

Evidence:
Moderate

Mediterranean diet reduces CV risk and may ease symptoms. Reduce alcohol (worsens hot flashes, disrupts sleep). Adequate calcium (1200mg/day food-first) and Vitamin D (1500-2000 IU/day). Limit processed sugar.

Stress & Mind-Body

Evidence:
Moderate

Mindfulness-based stress reduction (MBSR) shown to reduce hot flash severity and improve quality of life. Cognitive behavioral therapy (CBT) for menopause is evidence-based. Acupuncture has modest evidence.

Avoid Triggers

Evidence:
Expert Opinion

Hot flash triggers: alcohol, caffeine, spicy food, hot environments, smoking. Smoking accelerates menopause onset by 1-2 years and worsens symptom burden and bone loss.

Social Connection

Evidence:
Emerging

Midlife social isolation increases depression risk. Normalize menopause discussion. Support groups, online communities, and partner education all improve outcomes.



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Hormone Replacement Therapy (HRT)

Estrogen & Progesterone



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Testosterone

Very Important
But We Don't Have Enough Time Y'all!

Request for Next Year!



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What Does "Bioidentical" Mean?

Bioidentical = Same molecular structure as human hormones



FDA-Approved Bioidentical Hormones

- ✓ Estradiol
- ✓ Micronized progesterone

NOT Bioidentical (Synthetic)

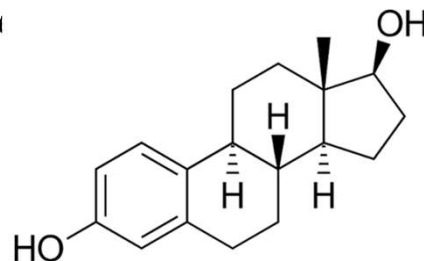
- Estrogens
 - Ethinyl estradiol (birth control)
 - Conjugated equine estrogens (Premarin®)
- Progestogens
 - Medroxyprogesterone acetate (Provera®)
 - Norethindrone
 - Levonorgestrel
 - Drospirenone



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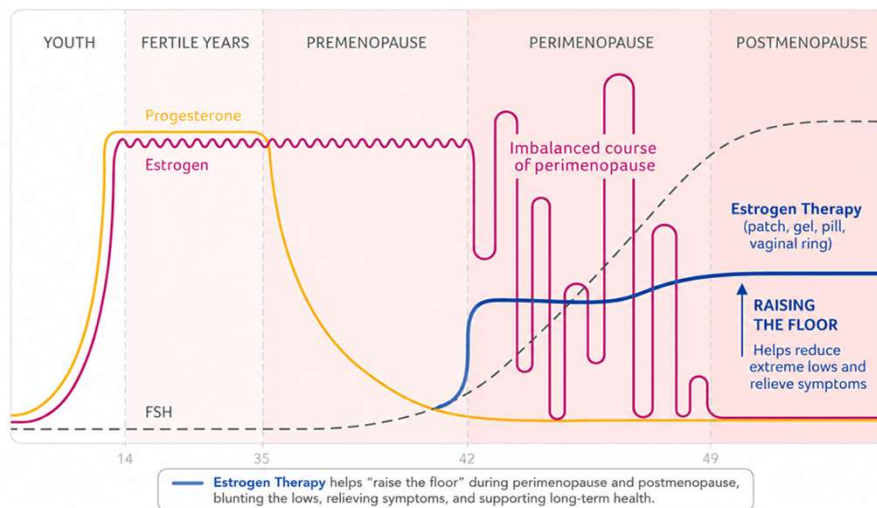
Estrogen: The Foundation of Menopause Care

- Primary hormone responsible for most menopausal symptoms
- Think of estrogen as **"raising the floor"**
- In perimenopause: blunts extreme hormonal fluctuations
- In menopause: relieves symptoms and addresses consequences of estrogen deficiency



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Estrogen: Raising the Floor



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Estrogen Therapy

FDA- Approved Treatments

- Moderate to severe vasomotor symptoms 🔥
- Genitourinary Syndrome of Menopause (GSM)
- Prevention of postmenopausal osteoporosis 🦴
 - appropriate
- Hypoestrogenism
 - Premature ovarian insufficiency (POI)
 - Surgical menopause
 - Ovarian failure

Additional Benefits

(Evidence Based - Not FDA Approved)

- sleep
- mood
- joint pain
- cardiometabolic health, cognition



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Estrogen Therapy - Available Formulations



Patch

Twice weekly or weekly



Oral Tablets

Simple- Inexpensive



Ring

Systemic estradiol (e.g., Femring®)

Do not be confused with low-dose local vaginal rings (e.g., Estring®)



Gel

Daily Transdermal Application



Spray

Daily Transdermal Application



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Transdermal Estrogen - My Preference!

- Avoids first-pass liver metabolism
- Lower risk of VTE than oral estrogen
- Minimal effect on triglycerides & clotting factors
- Preferred for women with:
 - Migraine
 - Obesity
 - Hypertension
 - Diabetes
 - Elevated VTE risk*



*Individualize therapy for women with a personal history of VTE.



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What About Breast Cancer?

Family history?

- **NOT a contraindication**

Personal history?

- Generally avoid systemic hormone therapy unless recommended with the patient's oncology team.

Remember the WHI

- Estrogen-alone (women without a uterus) showed **reduced breast cancer incidence and mortality** on long-term follow-up.
- The small increase in breast cancer risk occurred with **combined estrogen + medroxyprogesterone acetate (Provera®)** after several years of use.



Make Sure Your Patients Are Up To Date With Breast Cancer Screening



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Estrogen Side Effects

Common (Usually Dose-Related)

- Breast tenderness
- Nausea
- Bloating
- Headache
- Breakthrough bleeding (early in therapy)
- Fluid retention

Management

- Lower the dose
- Change the formulation
- Switch to a transdermal route
- Reassess in 6–8 weeks



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Estrogen Contraindications

Avoid Systemic Estrogen In Patients With:

- ✗ Active or recent estrogen-sensitive breast cancer*
- ✗ Active or unexplained vaginal bleeding
- ✗ Active DVT/PE or thrombophilia
- ✗ Active stroke or myocardial infarction
- ✗ Active liver disease
- ✗ Pregnancy

Use Caution

- ⚠ Migraine with aura (prefer transdermal)
- ⚠ Elevated VTE risk (prefer transdermal)
- ⚠ Established cardiovascular disease

*Coordinate with oncology for women with a history of breast cancer.



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Progesterone

One Very Important Rule

If she has a uterus...protect it!

- Systemic estrogen **must** be paired with adequate progestogen
- Prevents endometrial hyperplasia & cancer
- **No uterus?** No progesterone needed*

*Unless used for another indication (sleep, contraception, etc.)



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Options for Endometrial Protection

FDA-approved options

- Micronized progesterone (Prometrium®)
- Medroxyprogesterone acetate (Provera®)
- Combination estrogen/progestin products (e.g., Combipatch®)

Other commonly used options

- Levonorgestrel IUD - Up to 5 Years!
- Progestin-only contraceptives (e.g., Micronor®, Slynd®) when clinically appropriate

CAUTION!!!

Topical progesterone ≠ Endometrial protection

- Most progesterone creams and compounded topical products **have not been shown** to provide reliable endometrial protection
- Avoid relying on compounded progesterone creams to oppose systemic estrogen



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Other Benefits of Progesterone



Helps with Sleep & Anxiety

Progesterone has sleep-promoting and anxiety-calming effects and can improve quality of sleep in perimenopause



Even Without a Uterus

Progesterone can be used for sleep support even when endometrial protection is not needed



Couple with IUD

Progesterone IUDs have limited systemic absorption - may add systemic progesterone for a woman with an IUD for sleep & anxiety



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Golden Rule

Estrogen + Uterus = Progesterone

Non-Negotiable



Progesterone must be added for every woman with a uterus taking systemic estrogen



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Progesterone Contraindications

Avoid Progesterone In Patients With:

- ✗ Active breast cancer*
- ✗ Undiagnosed vaginal bleeding
- ✗ Active liver disease
- ✗ Allergy to progesterone or formulation components

Use Caution

- ⚠ Significant depression or mood sensitivity
- ⚠ Excessive daytime sedation
- ⚠ Peanut allergy (older Prometrium® formulations contained peanut oil)

*Coordinate care with oncology.



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Progesterone Side Effects

Common

- Sleepiness (most common)
- Dizziness
- Mood changes
- Breast tenderness
- Bloating
- Breakthrough bleeding (early in therapy)

Management

- Take at bedtime 🌙
- Lower the dose if appropriate
- Consider switching formulations
 - Bioidentical MAY be better
 - Be aware of androgenic properties of progestones
- Reassess in 6–8 weeks



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Does She Still Need Birth Control?

If she's still ovulating...

She can still get pregnant.

- Perimenopause ≠ infertility
- Continue contraception until menopause is confirmed
- Treat symptoms **and** prevent pregnancy



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Your HRT Friendly Contraception Options

Combined Hormonal Contraceptives

- Excellent contraception
- Can improve bleeding & vasomotor symptoms
- Contains **ethinyl estradiol** (not estradiol)
 - Less effective for treating menopause symptoms

Menopausal Hormone Therapy + Progestin Contraception

- Estradiol (patch, gel, pill)
- PLUS:
 - Levonorgestrel IUD
 - Micronor®
 - Slynd®

My preferred strategy for many women



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Don't Forget!

Vasectomy!!



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My “Go-To” HRT Regimens

- **Estradiol patch 0.025–0.05 mg/day**
 - 🌙 Micronized progesterone 100 mg nightly (continuous)*
 - OR Progesterone-based IUD
- **Reassess symptoms in 6–8 weeks**
 - Use Menopause Rating Scale to Assess
- **Titrate for symptom control**
 - Hot Flashes persist - Increase Estrogen
 - Sleep remains poor? Increase Progesterone



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Genitourinary Syndrome of Menopause (GSM)

Nearly Universal

- Affects **up to 80%** of postmenopausal women
- Progressive without treatment
- Symptoms worsen over time—not better
- Yet only a minority receive treatment

It's More Than Vaginal Dryness

- Vaginal dryness
- Pain with sex
- Burning with urination
- Recurrent UTIs
- Vaginal irritation & itching
- Abnormal discharge
- Urinary urgency & frequency



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This Isn't Just About Sex

Treating GSM Prevents Disease

- Improves quality of life
- Reduces recurrent urinary tract infections
- May prevent hospitalizations for pyelonephritis & urosepsis
- Helps women stay active and independent

This is Preventive Medicine



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GUSM Treatments

★ Vaginal Estrogen (First-Line)

- **Estrace®** vaginal cream (*my favorite*)
- **Premarin®** vaginal cream (synthetic)
- **Vagifem®** vaginal tablet
- **Imvexxy®** vaginal softgel insert
- **Estring®** vaginal ring (90-day local estrogen)

Other FDA-Approved Options

- **Intrarosa®** (prasterone/DHEA vaginal insert)
- **Osphena®** (ospemifene oral tablet)



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Other Treatment Options

Hormonal

Vaginal DHEA (Intrarosa®)

- Converts locally to estrogen & testosterone
- Effective, but expensive

Non-Hormonal

- Silicone- or oil-based lubricants
- Vaginal moisturizers
- Hyaluronic acid
- Pelvic floor physical therapy (when appropriate)



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Take-Home on Vaginal Estrogen



Key Point

Vaginal Estrogen has Minimal Systemic Absorption

- Can be started at any age—even decades after menopause
- Can usually be used in women with history of estrogen-sensitive cancers (coordinate with oncology)
- Does NOT require progesterone for endometrial protection
- Safe for long-term use
- One of the most effective treatments for recurrent UTIs



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GUSM Advocacy



Dr. Rachel Rubin

- Urologist & Sexual Medicine Specialist

Follow on Social Media
@drrachelrubin



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When Should You Start HRT?

Start HRT before age 60 or within 10 Years of Menopause



The Timing Hypothesis

The "Golden Window"

- ✓ Before age 60

OR

- ✓ Within 10 years of menopause

Start early. Benefit more.



Why Timing Matters

Early = Protection

- Helps preserve healthy blood vessels
- Improves cardiovascular risk profile
- Supports bone health
- Most favorable benefit-risk ratio

Late = Caution

- Atherosclerosis may already be present
- Hormone therapy is **not** designed to reverse established cardiovascular disease
- Individualize treatment decisions



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Case Example

62-year-old woman

- Menopause at age **56**
- Moderate hot flashes
- Healthy, active
- No history of cardiovascular disease

Is she a candidate?



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Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: 62-year-old woman - Is She A Candidate for HRT?

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Case Example

62-year-old woman

- Menopause at age **56**
- Moderate hot flashes
- Healthy, active
- No history of cardiovascular disease

Is she a candidate?

- **YES — Consider HRT**
 - ✓ Within 10 years of menopause
 - ✓ Shared decision-making
 - ✓ Prefer transdermal estradiol if appropriate



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When Should You Stop HRT?

There Is No Expiration Date

- ✗ No mandatory age to stop
 - Continue as long as benefits outweigh risks
 - Reassess annually
 - Shared decision-making
 - Individualize care

Postmenopause Lasts Forever...

Why stop treating it?

- Vasomotor symptoms may persist for decades
- Bone protection continues while on therapy
- GSM worsens without treatment
- Continue therapy if the patient is benefiting and wishes to continue

The decision belongs to the patient—not the birthday.



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What If she Can't take - Or Doesn't Want to Take hormones?



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Non-Hormonal Therapy Options: Evidence-Based Alternatives

For women who cannot, will not, or prefer not to use hormones — not everyone needs HRT, and these options work.

Fezolinetant (Veoza)

NK3 receptor antagonist | FDA-approved 2023

Vasomotor symptoms. First non-hormonal CNS-targeted therapy. Non-inferior to low-dose HRT for hot flash frequency. 45 mg daily. Hepatotoxicity monitoring required (LFTs at baseline, 3, 6 months).

Gabapentin / Pregabalin

Alpha-2-delta ligand | Off-label

900-2400 mg/day (divided doses). Useful if nighttime hot flashes are predominant. Also helpful for comorbid pain syndromes and insomnia. Side effects: dizziness, sedation, weight gain.

Ospemifene (Osphena)

SERM | FDA-approved for GSM

60 mg daily for dyspareunia and vaginal dryness. Estrogenic on vaginal tissue, neutral or protective on breast/uterus. Oral — good option for women who won't use vaginal estrogen.

SSRIs / SNRIs

Antidepressants | Off-label (except paroxetine)

Paroxetine 7.5 mg (Brisdelle) — FDA-approved for vasomotor symptoms. Venlafaxine 37.5-75 mg, escitalopram 10-20 mg: off-label but effective. Modest vs. HRT (50-60% reduction). Consider for women with comorbid depression/anxiety.

Clonidine

Alpha-2 agonist | Off-label

0.1 mg BID. Modest efficacy. Primarily used when other options fail. Side effects: hypotension, dry mouth, constipation. Generally third-line.

Phytoestrogens / Supplements

Supplements | Not FDA-regulated

Black cohosh: modest evidence for vasomotor symptoms. Soy isoflavones: inconsistent data. Evening primrose oil: weak evidence. Magnesium glycinate: may improve sleep. Always discuss supplement use — interactions possible.



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What About Hormone Pellets?

✗ Not FDA-approved for menopausal hormone therapy



Challenges

- Not recommended by major menopause societies
- Limited high-quality safety and efficacy data
- May produce **supraphysiologic hormone levels**
- Cannot easily adjust the dose
- Cannot be removed once inserted
- Side effects may persist for months
- FDA-approved options are safer, adjustable, and evidence-based



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Let's Practice! Case Study

Kristen is a 42-year-old woman

- s/p hysterectomy for severe endometriosis
- Severe hot flashes & night sweats
- Brain fog & low libido
- MRS = 20
- Normal mammogram
- No migraine history
- No history of DVT
- No Cardiovascular Disease

Menopause Rating Scale Scoring

0 - 4: No or little complaints

5 - 8: Mild complaints

9 - 15: Moderate complaints

16 +: Severe complaints



How would you approach her?



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Live Content Slide

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Poll: Is this Menopause or Perimenopause?

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Question #1

Is this perimenopause or menopause?

😬 It Doesn't Matter for Management Purposes!

- She is likely in the menopausal transition (or early menopause)
- Hysterectomy makes staging difficult - This is surgical menopause
- **Treat the patient—not the calendar or the labs**



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Live Content Slide
When playing as a slideshow, this slide will display live content

Poll: Would You Offer Estrogen?

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Question #2



Would you offer estrogen?
Absolutely!!!

Any FDA-approved formulation is reasonable.

No Contraindications Here

- Transdermal estradiol (my preferred option)
- Oral estradiol
- Gel or spray
- Ring

Choose the formulation based on patient preference, convenience, cost, and shared decision-making.



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Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: Does She Need Progesterone?

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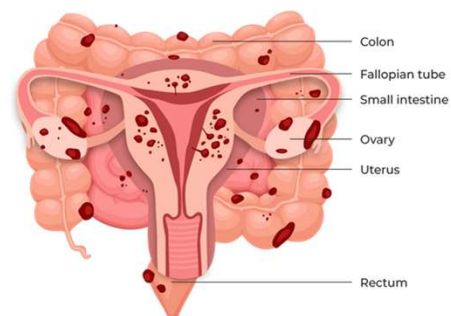
Question #3

Does she need progesterone?

Probably yes.

- Not for endometrial protection
- History of severe endometriosis
- May reduce stimulation of residual endometriosis
- Shared decision-making

Hysterectomy removes the uterus—not necessarily every endometrial implant.



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Your Menopause Toolkit: Resources & Next Steps

Clinical Guidelines

- The Menopause Society (menopause.org) — Position Statements
- ACOG Practice Bulletins (Menopause)
- British Menopause Society Guidelines
- NAMS Continuing Education modules

Patient Education

- menopause.org patient resources (free)
- "The Menopause Manifesto" — Dr. Jen Gunter
- "Estrogen Matters" — Drs. Bluming & Tavis
- Balance app — evidence-based symptom tracker

Clinical Tools

- Menopause Rating Scale (MRS) — free download
- MENQOL questionnaire
- FRAX tool for fracture risk (frax.org)
- ASCVD risk calculator (ACC/AHA)

Get Certified

- Menopause Society Certification (MSCP/NCMP)
- NAMS online courses + annual meeting
- ACOG menopause-related CME modules
- UpToDate menopause clinical overview



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Live Content Slide

When playing as a slideshow, this slide will display live content

Social Q&A for Menopause 101 for the DPC Physician: Confidently Evaluating, Supporting, and Treating Women in Transition



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QUESTIONS?

Contact Information

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Follow on Social Media!

@DrMichelleCooke



Did You Get All 6 Key Point Gold Stars??

Find Me for a Gold Star to add to your badge!!!



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References

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