

The Body Is Also a Net

Perimenopause, the Hundred Symptoms, and a Measured Alternative to t

J.KonstapeLeiden, 1,1-9-2026

I. An Industry Built on a Missing Measurement

In September 2026, WIRED published a long investigation by Kate Knibbs into what she calls the "perimenopause industrial complex": a rapidly consolidating alliance of telehealth startups, political operatives, and clinicians that has made hormone therapy the fastest-growing consumer medical product for women in midlife. The numbers are striking. Four leading platforms saw web traffic rise 490 percent between 2023 and 2026. Estradiol patches are in de facto shortage. One company, Midi, has reached unicorn valuation and openly states its ambition to become "a national specialized primary care company for women."

The article documents the excesses one expects of any gold rush — supplements sold alongside prescriptions, an estrogen face cream a Mayo Clinic director calls "garbage," advertising claims withdrawn under regulatory pressure, "vending-machine prescriptions" issued on the strength of a questionnaire alone. These are real problems. But they are not the deep problem, and the article, to its credit, circles the deep problem several times without naming it.

The deep problem is this: **there is no measurement.**

No laboratory test can determine whether a woman is in perimenopause, because erratic hormonal fluctuation is the defining feature of the transition — a blood draw samples an oscillator that is losing its period, and a single sample of such a system is meaningless by construction. In the absence of a measurement, the industry has substituted a list. Midi's position is that there are more than one hundred possible symptoms of the transition: night sweats, insomnia, anxiety, depression, rage, forgetfulness, bloating, body odor, sensitive teeth, dry skin, recurring urinary tract infections, weight gain, fatigue. As Knibbs observes, one might be forgiven for wondering what is *not* a symptom of perimenopause. Nearly any woman over thirty-five who feels unwell can qualify. The Menopause Society's medical director warns that the field has entered "a danger zone" of attribution; a Yale gynecologist who has spent her career advocating for these treatments concedes she can neither confirm nor deny most individual attributions — "I can't say it isn't, for sure."

The result is a diagnostic vacuum filled from two sides. On one side, conventional physicians who reject the diagnosis reflexively: the article's central patient, Lisa Schrenk, was refused three times by three clinicians while she was quietly planning her own funeral. On the other side, platforms that accept the diagnosis reflexively: fill out the form, receive the prescription. Both sides fail in the same way. Both treat the individual woman as an instance of a template — the refusing physician applies the template of the standard protocol, the prescribing platform applies the template of the hundred-item list. Neither measures *her*.

What follows is an argument that the missing measurement exists, that it is cheap, and that the reason it has not been built is not technical but conceptual: the industry lacks a structural theory of

what perimenopause *is*. This essay supplies one, derived from the MAZE research programme, and then describes the instrument that follows from it.

II. What Kind of Event Is Perimenopause?

Begin with a question the WIRED article never asks: what kind of event, structurally, is the menopausal transition?

The conventional answer is chemical — declining estrogen, fluctuating progesterone — and the conventional treatment follows from it: replace the chemicals. But the chemical description is a description of the messenger substances, not of the system that uses them. Consider what the menstrual cycle has been, structurally, for the thirty-five years preceding the transition: a periodic closure. Every month the system loads, holds, discharges, and rests. It is one of the most reliable oscillators in human physiology, and it does not merely regulate reproduction — it entrains sleep, temperature, mood, appetite, and cardiovascular rhythm to its period. For three and a half decades, accumulated physiological and psychological tension has had a scheduled exit.

Perimenopause is the failure of that schedule. Before the oscillation stops, it becomes irregular: the period lengthens, shortens, skips, returns. The closure that once discharged tension on a calendar now discharges it unpredictably or not at all. Tension that was previously drained monthly remains standing in the system.

This structural reading immediately explains the three features of the transition that the chemical reading treats as inconvenient noise.

First, it explains why there is no lab test. A test measures a level; the disturbance is not a level but a rhythm. Sampling hormone concentration during perimenopause is like judging a pendulum by photographing it once — the photograph is accurate and tells you nothing, because what has changed is the period, not the position.

Second, it explains the hundred symptoms. Within the MAZE framework, every living system cycles through four states: loading, holding, discharge, rest. Map the symptom list onto these states and the heterogeneity resolves into a single pattern. Hot flashes are micro-discharges firing outside the rhythm — tension escaping through an unscheduled exit. Insomnia is a failed rest state. The rage, anxiety, and exhaustion Schrenk's fellow hiker described are prolonged holding — the state a system enters when discharge is blocked. The mood swings are the irregular closure itself, experienced from the inside. There are not one hundred disorders. There is one disturbance — the loss of periodic closure — expressed through one hundred different exits, because standing tension escapes through whatever exit each individual system offers.

Third, it explains why the same treatment produces such different results in different women — which brings us to the second layer of the theory.

III. The Two-Layer Law: Address and Tension

The MAZE research programme rests on a correspondence, designated C6 in its formal documents, that separates every person into two layers. The **address** is the topology of the individual: the specific configuration of connections fixed at the person's closure, which never changes. The **tension** is the dynamic state moving through that topology: it changes constantly, and it is the only

layer that treatment can reach. In compact form: *address is topology; life is tension*. You cannot treat an address. You can only treat tension — and you can only treat it accurately if you know the address through which it moves.

Applied to the menopausal transition, the law reads as follows. The transition itself is universal: every woman loses the same periodic closure. But the address is individual, and the address determines *where* the standing tension exits. Two women with identical hormonal trajectories present entirely different symptom profiles because their topologies differ — in one, the blocked discharge finds its exit through sleep; in another, through mood; in a third, through the body's thermal regulation or its immune surface. The hundred-item list is not evidence of a hundred conditions. It is one disturbance projected through millions of distinct addresses.

This is why both failure modes documented by WIRED are the *same* failure. The questionnaire platform treats all addresses as interchangeable: everyone receives the same hundred questions and, largely, the same prescription. The refusing physician commits the mirror-image error: he treats the standard protocol as if it were the patient's address. Both substitute a template for a topology. And it is why the one intervention in the article that demonstrably worked — Schrenk's five months of iterative dose adjustment with a clinician who kept listening — worked. That clinician was not practicing better chemistry than the three doctors who refused. She was, without a vocabulary for it, searching for one specific woman's closure instead of prescribing to the average of all closures.

There is a further, sharper point to be made about the questionnaire itself. A questionnaire is a context-free instrument: each item means the same thing to every respondent, by design. A living system is context-dependent: the meaning of "I sleep badly" or "I am often angry" is a function of the topology it moves through. The MAZE corpus formalizes this as the morphology prohibition — a context-dependent system cannot be parsed by a context-free instrument. This is not a complaint about badly designed questionnaires that better questionnaires could fix. It is a structural exclusion. The questionnaire fails for the same reason a keyword index fails to capture the meaning of a text: it reads form and calls it content. The perimenopause industry's diagnostic instrument is disqualified before the first answer is filled in — which is precisely why "almost anyone with aging ovaries can qualify," as the Mayo Clinic's Stephanie Faubion warns. When an instrument cannot distinguish, everything matches.

IV. What Hormone Therapy Does — and What It Cannot Do

None of this is an argument against hormone therapy. Tension is the treatable layer, and hormone therapy acts on tension: it supplies the messenger substances externally and thereby damps the amplitude of the disturbance. For many women it works, sometimes dramatically. Schrenk's account — from planning her funeral to hiking the Appalachians — deserves to be taken at face value, and the two decades in which an overread 2002 study caused this treatment to be withheld from millions of women were a genuine medical failure, now widely acknowledged.

But the structural reading exposes a distinction the industry cannot currently see, because it has no instrument that could see it. There are two ways a hormone intervention can change the four-state profile:

The rhythm can **restore**: loading, holding, discharge, and rest return in sequence, closure occurs again, tension drains on schedule. This is a system repaired.

Or the profile can **flatten**: a periodic discharge is replaced by a constant external supply, amplitude drops, symptoms recede — but no closure occurs. Tension is suppressed, not drained. The system is quieter, not restored.

Both outcomes look identical on a questionnaire. "Do you feel better?" — yes, in both cases. They are entirely different physiological states, with plausibly different long-term consequences, and every one of the growing millions of women now on these medications — an "ongoing treatment group more experimental than perhaps they know," in Knibbs's exact and troubling phrase — is in one of these two states without anyone, including her clinician, knowing which. The industry's growth chart goes up and up; its knowledge of which state its customers are in remains zero.

Distinguishing the two states requires a measurement of rhythm, taken continuously, in the individual. That measurement exists.

V. The Instrument: Blueprint Beside Sensor

The instrument combines two components that must remain strictly separate: a **blueprint**, which predicts, and a **sensor**, which scores the prediction. The architecture has four layers.

Layer one: the blueprint prediction. Within the MAZE framework, each person's address is representable as a natal coordinate — designated q_PoC — derived from the fixed data of the closure: date, time, and place of birth, mapped onto the three-sphere. From this coordinate, a single expected tension profile is computed: which of the four states is structurally weakest in this individual — where the blockage will sit when the periodic closure fails. Loading, holding, discharge, or rest: four classes. The profile is computed once, recorded, and then frozen. It is topology; it never changes. The freeze is not a convenience but a requirement — a reference that adapts to the data it is meant to test is no reference at all, a principle independently confirmed in 2026 by General Intuition's MIRA work on world-models, which found that stable networks require a frozen reference and that rest states cannot be learned from frequency data.

Layer two: the sensor measurement. A consumer-grade chest or arm sensor (thirty dollars, standard Bluetooth heart-rate profile) streams RR intervals — the beat-to-beat timing of the heart, from which heart-rate variability is computed. HRV is the most direct non-invasive window onto the autonomic nervous system, standardized in the clinical literature since 1996. The four states are legible in it without any interpretive layer: loading appears as declining variability under rising heart rate; holding as sustained low variability without recovery; discharge as the abrupt transition; rest as restored high variability. Each measurement session is classified by its state trajectory. No words, no self-report, no hundred-item list — only the rhythm itself. And, following the MAZE storage law, a session becomes a record only at period closure: when a complete cycle, or its demonstrable absence, has been observed. Frequency never determines placement; closure does.

Layer three: the score. Here the governing rule of the entire design: *the blueprint stands beside the measured data, never inside it*. The two streams are never merged. Each classified session is compared against the frozen prediction. If the blueprint predicts a holding-blockage and the sensor shows prolonged holding without discharge, the prediction scores a hit; if not, a miss. Every measurement is thereby a scored prediction — the instrument is falsifiable at the level of the individual session, which is precisely what the questionnaire can never be. And the score series itself carries a second signal: a woman whose measurements drift progressively away from her blueprint is a system in transition. The instrument thus measures perimenopause not as a symptom

checklist but as the growing distance between address and state — which is, structurally, what perimenopause is.

Layer four: the treatment test. This is what converts the instrument from a research tool into something immediately usable — a product, not a calibration exercise. A woman who begins hormone therapy simply keeps measuring. Within days, the sensor distinguishes the two outcomes that the questionnaire conflates: either the four states return in sequence and closure reappears (rhythm restored), or variability rises while the cycle stays absent (profile flattened). Her clinician sees, per dose adjustment, whether closure is approaching — Schrenk's five months of tearful trial-and-error, compressed and made visible. The woman herself sees which of the two states she is in. No one currently on these medications has access to that fact. Every one of them could, for the price of a chest strap.

VI. What This Is Not, and What Remains Unproven

The claim is deliberately bounded. This essay does not claim that the natal coordinate's predictive power is established — that is exactly what the scoring layer exists to test, and a systematically low hit rate would falsify the blueprint layer while leaving the sensor layer intact and useful on its own. It does not claim that hormone therapy is harmful, or that flattening is worse than restoration — only that the two are different states and that no one is currently distinguishing them. It does not replace clinical care; it instruments it.

Three things remain open, and are named here as the next experiments rather than buried as caveats. The thresholds separating the four states in RR data must be established empirically, in particular the boundary of the holding state. The mapping from natal coordinate to dominant blockage class must be formally derived from the theory and frozen before any scoring begins — calibration and validation strictly separated, parameters estimated on one population and tested blind on another, exactly the standard the MAZE programme already applies to its market instruments. And the retrospective question is worth asking first: whether existing datasets linking symptom profiles to birth data permit the blueprint prediction to be scored before a single new sensor is strapped on.

VII. Conclusion: From the List to the Rhythm

The WIRED investigation ends on an image of unbounded growth: an industry "zeroed in on its growth chart going up, and up, and up," selling a treatment to millions of women on the strength of a questionnaire, in the absence of any test. The standard critique of this situation — more regulation, more caution, more studies — is correct and insufficient, because it accepts the industry's own framing: that the problem is how carefully the list is administered. The problem is the list.

Perimenopause is not a hundred symptoms. It is one structural event — the loss of a periodic closure that has organized a woman's physiology for thirty-five years — expressed through one individual topology. The symptoms are where her particular address lets the standing tension out. That event is invisible to a blood test, invisible to a questionnaire, and directly visible in the rhythm of her own heart, measured continuously by a thirty-dollar sensor and scored against a prediction fixed at her birth.

The industry has built a distribution system without a measurement. The measurement is buildable now. A woman entering the transition deserves better than to be the average of a hundred questions:

she deserves an instrument that knows her address, watches her rhythm, and tells her — and her clinician — not merely *whether* she feels better, but *whether her system has closed*.

Annotated References

- 1. Knibbs, K., "Inside the Perimenopause Industrial Complex," WIRED, 1 September 2026.** The problem statement of this essay. Documents the 490 percent traffic surge across four telehealth platforms, the absence of any laboratory test for perimenopause, the hundred-plus-item symptom lists, questionnaire-only "vending-machine" prescribing, the estradiol supply shortage, and the internal criticism from the Menopause Society and Mayo Clinic. Its most important sentence — that women on these medications form "an ongoing treatment group more experimental than perhaps they know" — identifies, without naming it, the measurement gap this essay's instrument is designed to close.
- 2. Writing Group for the Women's Health Initiative Investigators, "Risks and Benefits of Estrogen Plus Progestin in Healthy Postmenopausal Women," JAMA 288(3), 2002.** The study whose overread cancer-risk findings triggered two decades of hormone-therapy avoidance and the FDA black-box warnings. Cited here as the origin of the pendulum whose 2025–2026 reverse swing the WIRED article documents. The lesson relevant to this essay: population-level statistics applied without individual measurement caused harm in the restrictive direction then; the same absence of individual measurement now risks harm in the permissive direction.
- 3. Konstapel, J., "The Height of the Tower," second edition, Constable Research B.V. / constable.blog, 16 August 2026.** The theoretical foundation of the MAZE programme: derivation of ternary structure, the Bronze Mean recursion, the four-floor dimensional ladder, and nilpotency from a single self-crossing strand. The two-layer law used throughout this essay — address as topology fixed at closure, life as treatable tension — is grounded here. The derived growth law appears in §5 of the second edition.
- 4. Konstapel, J., "Positional Psychiatry" (MAZE-08), Constable Research B.V., 2026.** The formal statement of correspondence C6 applied to persons: a person is a closure in the net; the address is fixed, the tension is dynamic and treatable. This essay is, in effect, C6 applied to endocrinology — the argument that perimenopausal symptomatology is tension read through an address, and that treatment which ignores the address can only prescribe to an average.
- 5. Konstapel, J., "MAZE Space Weather: From Market Tension to a Multi-Layer Early-Warning System" (MAZE-06), constable.blog, 12 August 2026.** Source of the four-state model — tension (what the system does now), loading (what has accumulated), holding (how long the elevated state persists), discharge (the release transition) — and of the calibration discipline adopted wholesale in this essay's instrument: parameters frozen after calibration, blind out-of-sample validation, every added sensor tested against the baseline for incremental predictive power, failed components removed. The essay transfers this methodology unchanged from financial markets to the physiology of one woman.
- 6. The morphology prohibition (Goethe–Turing–Chomsky argument, 2009; as formalized in the MAZE corpus, constable.blog).** The structural exclusion of questionnaire input: a context-dependent system cannot be parsed by a context-free instrument. Invoked in this essay to establish that the hundred-item symptom list fails not by poor design but by category — the same failure

mode, at the diagnostic level, that produced the MAZE encoder's historical collapse when it addressed texts by structural form rather than content.

7. Task Force of the European Society of Cardiology and the North American Society of Pacing and Electrophysiology, "Heart Rate Variability: Standards of Measurement, Physiological Interpretation, and Clinical Use," *Circulation* 93(5), 1996. The clinical standardization of HRV measurement from RR intervals. Establishes that the sensor layer of the proposed instrument rests on thirty years of settled measurement methodology; nothing in the acquisition or computation of the signal is novel. What is novel is what the signal is scored against.

8. Bluetooth SIG, Heart Rate Profile specification (service 0x180D, characteristic 0x2A37). The open standard by which consumer sensors (e.g., Kyo KETO2935/2936-class chest and arm bands, ~\$30) stream RR intervals. Cited to fix the cost and availability claim: the sensor layer requires no proprietary hardware, no subscription, and no platform — a deliberate contrast with the \$200-per-month subscription model documented in reference 1.

9. General Intuition, MIRA world-model results, 2026. Independent external confirmation of four principles load-bearing in this essay's design: stable networks require a frozen reference (the blueprint freeze); rest and zero states cannot be learned from frequency data (why closure, not frequency, triggers storage); multiple closures remain consistent over one net (C6); and the action alphabet is the trit. Cited as convergent evidence from an unrelated research programme, not as authority.

10. Gunter, J., *The Menopause Manifesto* (Citadel Press, 2021) and subsequent public criticism of telehealth hormone platforms. The strongest inside-medicine critique of the industry documented in reference 1: that selling inadequately studied products "under the guise of closing the gaps in health care" strips women of agency. This essay agrees with the diagnosis and extends it — the restoration of agency requires not only honest products but an individual measurement, since agency over an unmeasured process is nominal.

Correspondence: het MAZE-project, maze.swarp.nl — Constable Research B.V., Leiden.