

Hormone Therapy Timing and Heart Risk

Patient Questions & Answers · written in plain language for patient-facing use

Isn't hormone therapy bad for your heart? That's what I've always heard.

That belief traces largely to trials published in the early 2000s, and the picture has become more specific since. Those studies tested one oral formulation in women who were, on average, well past menopause. More recent evidence suggests that when hormone therapy begins within about ten years of menopause, or before age 60, the cardiovascular profile looks quite different — and may be favorable. Timing turns out to matter a great deal.

What is the ten-year window I keep hearing about?

It refers to the observation, consistent across several major studies, that starting hormone therapy close to menopause is associated with lower coronary heart disease and lower overall mortality, while starting well beyond that point is associated with increased stroke and blood clot risk. It's often called the timing hypothesis, and it's now reflected in guidance from major medical societies.

Is it too late for me to start?

It depends on more than your age, which is why there's no general answer. Current guidance emphasizes looking at your symptoms, your baseline cardiovascular health, your personal and family history, how long it's been since menopause, and your own preferences together. That's a genuine conversation with someone who knows your history, not a rule that can be applied from the outside.

Does it matter whether I take a pill or use a patch?

Yes, and this is one of the more useful practical distinctions. Pills pass through the liver before reaching the bloodstream, which stimulates production of clotting factors. Patches and gels bypass that step. In a Swedish study of more than 900,000 women, transdermal estrogen was not associated with a significant increase in cardiovascular risk, while oral combined therapy showed a modest increase in ischemic heart disease.

Why do different studies say opposite things?

Mostly because they studied different women taking different things. The WHI trial enrolled women aged 50 to 79 on one oral formulation and found increased risk. The DOPS and ELITE trials enrolled recently postmenopausal women and found benefit, with ELITE finding it only in those who started within six years of menopause. Once you account for timing, formulation and population, the results are less contradictory than they first appear.

If I have a history of blood clots, is hormone therapy off the table?

Not necessarily off the table, but it does change the assessment substantially. Existing cardiovascular disease, prior clot or stroke, and uncontrolled high blood pressure move someone into a higher-risk category where systemic hormone therapy is generally avoided or approached very cautiously. Where risk factors are present but milder, transdermal delivery is often preferred. This is firmly a discussion for your provider.

Does hormone therapy reduce my risk of dying from heart disease?

The evidence doesn't support saying that. A 2024 analysis of 33 randomized trials covering 44,639 women found no significant reduction in overall mortality or major cardiovascular events, and did find increased stroke and clot risk. Women who started within ten years of menopause had better outcomes than later starters. Hormone therapy is not a heart medication, and it shouldn't be chosen as one.

Why does menopause affect the heart at all?

Estrogen plays a role in maintaining blood vessel flexibility, cholesterol handling, the lining of blood vessels, and inflammation. As it declines, several of those protective effects diminish. It's part of why heart disease appears in women roughly ten years later than in men, and why cardiovascular risk rises through the menopause transition.

Is my heart risk being assessed properly?

It's worth asking about. The standard risk calculators most clinicians use were built for the general population and don't factor in age at menopause, whether menopause was natural or surgical, how long it's been, symptom severity, or hormone therapy route. Researchers have argued these tools may underestimate risk in younger postmenopausal women. Mentioning your menopause history explicitly helps.

What should I bring to my appointment?

A few specifics make the conversation much more productive: roughly when your periods stopped, your main symptoms and how much they affect your daily life, any personal or family history of clots, stroke or heart disease, whether you smoke, and your current medications. Also bring what you're hoping to get out of treatment. Those details are exactly what shapes the recommendation.

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