

Hormone Therapy Timing and Heart Risk

Key Talking Points · eight points for patient conversations

POINT 01

Timing is the single most consistent variable across the cardiovascular evidence.

Initiation within 10 years of menopause or before age 60 is associated with cardiovascular benefit; initiation well beyond that window is associated with increased stroke and clot risk. Time since menopause belongs in the chart.

POINT 02

Transdermal estrogen showed no significant increase in cardiovascular risk at national scale.

In a Swedish register study of 919,614 women including 77,512 initiators, transdermal delivery was not associated with a significant cardiovascular risk increase, while oral continuous combined therapy showed a modest rise in ischemic heart disease.

POINT 03

Route of delivery changes the risk profile through the liver.

Oral estrogens undergo hepatic first-pass metabolism and stimulate coagulation factor production. Transdermal delivery bypasses that step, with neutral or favorable effects on blood pressure and clot risk.

POINT 04

The trials that look contradictory align once timing is accounted for.

DOPS and ELITE enrolled recently postmenopausal women and found benefit. WHI enrolled women aged 50–79, tested one oral formulation, and found increased risk. Different populations, different formulations, different answers.

POINT 05

A 2024 meta-analysis of 44,639 women found no overall mortality benefit.

Across 33 randomized trials, hormone therapy did not significantly reduce all-cause mortality or major cardiovascular events, and stroke and venous thromboembolism risk rose. Early initiators fared better than late initiators.

POINT 06

Cardiovascular disease kills more women than all cancers combined.

This is the context that makes the conversation matter. Risk climbs through the menopause transition, in part because estrogen supports vascular tone, lipid metabolism and endothelial function.

POINT 07

Standard cardiovascular risk calculators do not account for menopause.

Widely used tools omit age at menopause, time since menopause, symptom severity and hormone therapy route, and may underestimate risk in younger postmenopausal women. The clinical conversation carries that weight.

POINT 08

Every major society has converged on individualized assessment.

NICE, the British Menopause Society and the North American Menopause Society differ on emphasis but agree on comprehensive individual evaluation and shared decision-making rather than blanket rules by age.

RESEARCH SOURCE CITATION

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