Hormone Therapy: Vasomotor Relief, Bone Health and Risk

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

How well does hormone therapy actually work for hot flashes?

Very well — it's the most effective treatment available. Across randomized trials, it reduces hot flash frequency by roughly 70 to 80% versus baseline, with NAMS estimating a 75% reduction compared with placebo. Relief typically starts within 2 to 4 weeks and is at its best by 8 to 12 weeks.

Does hormone therapy protect my heart?

No — and this is worth being clear about. Cardiovascular prevention is explicitly not an indication for hormone therapy. Major trials, including the Women's Health Initiative, did not show cardiovascular protection and instead raised concerns about stroke risk. It shouldn't be started or continued for heart protection specifically.

What does hormone therapy actually do for bone health?

It's genuinely effective here. Bone loss accelerates in the first 2 to 3 years after menopause, and hormone therapy is the only anti-osteoporotic treatment with proven efficacy regardless of your baseline fracture risk, including in women considered low-risk.

Is a patch safer than a pill?

For stroke and blood clot risk specifically, yes, based on current evidence. A recent large study found transdermal estrogen wasn't linked to increased stroke risk, while oral estrogen carried risk similar to older trials. Clot risk follows a similar pattern — transdermal estradiol has the lowest risk among the options studied.

Does the type of oral estrogen matter for safety?

Yes, meaningfully. A UK study found conjugated equine estrogen carried higher clot risk than oral estradiol, with risk increasing at higher doses. If you're taking an oral formulation, it's worth knowing specifically which one and discussing whether a different option might carry less risk for you.

Can hormone therapy help with anything besides hot flashes?

Modestly, yes. Research points to improvements in sleep quality, some benefit for mood, and better sexual function — particularly when vaginal symptoms are treated at the same time. These effects are real but described as modest rather than dramatic, so it's worth having realistic expectations.

I keep hearing about a new hormone called estetrol. What is it?

It's a newer type of estrogen showing good results for hot flashes with a favorable safety profile so far. The honest caveat: long-term data on its cardiovascular, blood clot, and breast safety is still being gathered, so it's an option worth knowing about but not yet as established as older, well-studied formulations.

Is hormone therapy still considered risky, like I remember hearing years ago?

The evidence has moved on considerably since then. Much of the original concern came from a single large trial testing one oral formulation in an older population. Current research distinguishes risk much more precisely by route, formulation, and timing — and several of today's options show a more favorable safety profile than what was studied decades ago.

How do I know if hormone therapy is right for me specifically?

It depends on four things working together: when you'd start relative to your menopause, which route and formulation you'd use, your dose, and your individual health history and risk factors. There's genuinely no single answer that applies to everyone — that's exactly why this is worth a real conversation rather than a quick decision.

How often should I revisit this decision once I start?

Regularly. Current guidance recommends using the lowest effective dose and reassessing periodically as your circumstances and the evidence itself continue to evolve — this isn't meant to be a one-time decision made and never revisited.

RESEARCH SOURCE CITATION

TITLE	Menopausal Hormone Therapy—Risks, Benefits and Emerging Options: A Narrative Review
AUTHORS	Arnautu AM, Nimigean VR, Nacea-Radu CA, Tilici DM, Paun DL
SOURCE	International Journal of Molecular Sciences
PUBLISHED	November 2025
URL	https://doi.org/10.3390/ijms262211098