Hormone Therapy: Vasomotor Relief, Bone Health and Risk

Key Talking Points · eight points for patient conversations

POINT 01

Hormone therapy reduces hot flash frequency by 70 to 80% versus baseline.

Across randomized trials, with NAMS estimating a 75% reduction versus placebo specifically. Relief typically begins within 2 to 4 weeks and is maximal by 8 to 12 weeks — the most well-established benefit of MHT.

POINT 02

Bone loss peaks in the first 2 to 3 years after menopause — exactly when MHT protects best.

MHT is the only anti-osteoporotic therapy with proven efficacy regardless of a woman's baseline fracture risk, including in women considered low-risk.

POINT 03

Cardiovascular prevention is explicitly not an indication for MHT.

Major trials, including the WHI, did not demonstrate cardiovascular protection and instead raised stroke concerns. This is a distinct question from bone protection, where the evidence is well-established and positive.

POINT 04

Route of administration changes stroke and clot risk meaningfully.

A recent nationwide cohort found transdermal estrogen was not associated with excess stroke risk, while oral estrogen carried risk consistent with older trials. Low-dose vaginal estrogen was associated with lower risk than either.

POINT 05

VTE risk varies clearly by formulation, not just by route.

Transdermal estradiol carries the lowest risk; oral estradiol is lower risk than conjugated equine estrogen; ethinyl estradiol carries the highest. A clear dose-response relationship exists for oral formulations.

POINT 06

Benefits extend modestly beyond vasomotor relief — sleep, mood, and sexual function.

A 2024 Korean study found meaningful sleep quality improvement within 1 to 3 months. A 2025 Cochrane meta-analysis found estrogen therapy slightly improves sexual function, more so when GSM is treated concurrently.

POINT 07

Estetrol (E4) is a newer option worth knowing about — with caveats.

It shows anti-vasomotor efficacy and favorable pharmacology, but long-term cardiovascular, thrombotic, and breast safety data are still pending. Worth mentioning to patients as emerging, not yet fully established.

POINT 08

The core principle: individualize based on timing, route, dose, and progestogen choice.

No single rule fits every patient. The lowest effective dose, reassessed periodically as new evidence emerges, is the guiding approach — consistent with NAMS, EMAS, and BMS consensus statements.

RESEARCH SOURCE CITATION

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