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Women's Midlife

Menopause • Hormones • Heart Health



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The heart belongs in the menopause conversation

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Two cardiovascular studies, a practical urinary-health trial, and why strength deserves a place beside symptom relief.

Women approaching menopause may come to a clinician for hot flashes, sleepless nights, or a sense that their bodies no longer respond as they once did. The question they bring is usually immediate: what can I do to feel better? The right answer can address that question without losing sight of the decades that follow.

This week’s reading turns to the heart. Two studies appearing in November journal issues offer different views of cardiovascular risk and menopausal hormone therapy. Both were available online earlier, and neither should be mistaken for a new trial completed this week. Their value lies in what they show together: cardiovascular context matters, and the form of evidence matters just as much.



Hormone therapy and the heart: two studies, two different answers

A new look at data from the Women's Health Initiative trials examined 27,347 postmenopausal women aged 50-79 who had been assigned by chance to hormone pills or an inactive placebo. The pills contained conjugated equine estrogens, either alone or with medroxyprogesterone acetate, a form of progestogen. In those without prior treatment for high cholesterol, cholesterol levels measured at the start were linked to different patterns of risk for disease in the arteries supplying the heart. Within each cholesterol group, researchers compared combined hormone treatment with placebo. For women with LDL cholesterol (often called "bad" cholesterol) at least 190 mg/dL, the estimated coronary heart disease hazard ratio was 2.77 (95% CI 1.42-5.40). For those with LDL below 130 mg/dL, it was 0.59 (95% CI 0.31-1.10). These are treatment-versus-placebo comparisons within the two groups, not a direct comparison between women with high and low LDL.

A hazard ratio compares how quickly events occur over follow-up: 1 means no difference, above 1 means a higher rate, and below 1 means a lower rate. The 95% confidence interval (CI) describes uncertainty around that estimate under the study's assumptions. The high-LDL estimate suggests a higher rate, but its wide interval shows considerable uncertainty about the size. For the lower-LDL group, the interval includes 1, so the result does not establish protection. These ratios do not tell an individual woman her chance of developing heart disease. [1]

The analysis was published online July 24 and appears in the November issue of Obstetrics & Gynecology. Importantly, it is an exploratory subgroup examination of older randomized trials, not a new randomization based on cholesterol. The original regimens were oral products; the findings cannot simply be transferred to today's hormone patches or gels applied through the skin. The authors also warn that multiple subgroup tests can produce chance findings. [1]

A separate JAMA Internal Medicine analysis, first released September 8 and printed in November, used observational data from the Study of Women's Health Across the Nation. Among 2,737 women with hot flashes or night sweats and no prior cardiovascular disease or hormone treatment, 755 initiated treatment over follow-up. The study recorded 224 fatal and nonfatal cardiovascular events and estimated an adjusted hazard ratio of 0.78 (95% CI 0.62-0.98) for those initiating hormone therapy versus those who did not. In plain language, the treatment group had an estimated 22% lower rate of events over follow-up after accounting for measured differences between groups. That is a relative comparison, not 22 fewer events per 100 women, and it cannot show that hormones caused the difference. [2]

That figure is an association generated by an analysis designed to imitate a clinical trial using existing records, not the result of actual random assignment. Treatment selection, timing, health-care access and unmeasured differences can influence it. The authors explicitly cautioned against prescribing hormone therapy to prevent cardiovascular disease. The older randomized trial and the younger observational

cohort also examined different formulations, populations and outcomes; their estimates are not a head-to-head disagreement about one treatment. [2]

The useful conclusion is not that every woman should take hormones, or that no one should. It is that symptom treatment and cardiovascular prevention are related clinical conversations with distinct goals. A woman who is considering treatment for disruptive symptoms deserves a review of blood pressure, lipids, metabolic health and personal risk, as well as the expected symptom benefit and possible harms. Menopause is a moment to reassess long-term cardiovascular health even for women who never need hormone therapy. [1, 2, 3]

A modest change in application could matter for recurrent urinary infections

For women with recurrent urinary tract infections after menopause, daily life can be narrowed by discomfort, disrupted plans and the anticipation of another infection. A randomized trial tested whether a less burdensome way of using vaginal estrogen cream might work comparably to the standard intravaginal approach.

The TAPER study randomized 114 postmenopausal participants with laboratory-confirmed recurrent infections to twice-weekly cream placed inside the vagina (intravaginal) or applied around the opening through which urine leaves the body (periurethral). At six months, 52.6% in the intravaginal group and 50.9% in the periurethral group had remained free of urinary tract infections (UTIs). The risk difference was -1.75 percentage points, with a 95% confidence interval from -20.0 to +17.0 points. The uncertainty range allows for the around-the-opening method to leave about 20 fewer or 17 more women infection-free per 100 treated, compared with application inside the vagina. The study therefore leaves room for a meaningful difference in either direction. Intravaginal treatment caused more reported vaginal itching at three months (24.0% versus 2.4%). [4]

The investigators had agreed in advance on how much worse the simpler method could be and still count as an acceptable alternative. The study met that “noninferiority” rule, but the rule allowed a large gap of 25 percentage points, or 25 women per 100. Participants and researchers knew which method was used. The trial took place at one center, and participants were on average 71 years old and predominantly White. It informs a practical discussion for some older postmenopausal women; it is not evidence that techniques are identical or that the results apply universally. The paper was first available July 27, and appears in the November journal issue. [4]

Strength is a health outcome, not an aesthetic project

A Stanford-led study plan published online October 8 offers a useful example of the questions women's health research is beginning to ask. Ninety participants in the transition leading up to menopause were assigned among several remote strength-training formats or a waitlist. The comparison includes small exercise "snacks" spread through the day versus longer sessions, as well as simpler versus more detailed progress tracking. [5]

The study's main question is whether people stick with the exercise plan, not whether short exercise sessions extend life. Data collection ended in February 2026, but the paper describing the plan reports no intervention results: analysis was ongoing. It would be premature to declare either format superior. The practical advance is the focus on making strength training fit real lives rather than prescribing a plan that cannot be maintained. [5]

After breast cancer, function is part of survivorship

A small randomized trial released September 7 followed 42 breast cancer survivors assigned to one of three groups for 16 weeks: a home-based program combining aerobic exercise (activity that raises breathing and heart rate) and strength training, aerobic exercise alone, or a comparison group. Both exercise groups improved measures of fitness and flexibility; the combined program produced larger gains in upper- and lower-body strength than aerobic work alone. Investigators also reported changes in blood or other biological measurements related to inflammation. [6]

The study did not show that exercise prevents recurrence or increases survival: it was small, short, and relied partly on body measurements used as clues to health rather than direct evidence of longer life or less cancer. But its measures of physical ability are important in their own right. For someone completing cancer treatment, being able to carry groceries, climb stairs or resume a beloved activity is not a secondary concern. It is part of returning to life.

Across these studies, a pattern emerges. Women's midlife care improves when it begins with the life a person is trying to live. Addressing symptoms matters. So do a healthy heart, the strength to move freely, relief from recurrent infection, and the capacity to work, love and participate without giving up those years to avoidable limitations.

An especially useful question for the next visit is: "What are we treating now, what long-term risks should we assess separately, and how will we know this plan is helping?"

Read the research

1. Rossouw et al. WHI oral hormone therapy and cardiometabolic status. Online July 24, 2026; Nov journal issue. PMID 42492078. Open full text.
Evidence note: Exploratory comparison within an earlier trial; women were assigned treatments by chance, not assigned to cholesterol groups.

2. Wang et al. SWAN target-trial emulation and CVD. Online Sept 8, 2026; Nov journal issue. PMID 42709460.
Evidence note: Observed existing treatment choices; unmeasured differences between women may affect the results, and nonfatal events were self-reported.

3. El Khoudary et al. Perimenopause and cardiometabolic risk. Published Nov 2, 2026. PMID 42969289.
Evidence note: An overview of research, not a new test showing a treatment works.

4. Zuo et al. TAPER vaginal estrogen application noninferiority trial. Online July 27; Nov issue, 2026. PMID 42492951.
Evidence note: 114 participants randomly assigned; the rule for an acceptable alternative allowed a broad 25-percentage-point difference.

5. Rovzar et al. Stronger remote exercise study plan. Online Oct 8; Nov issue, 2026. PMID 42849707.
Evidence note: Study plan only; no results showing which exercise format worked better.

6. Jamali et al. Home-based exercise in breast cancer survivors. Sept 7, 2026. PMID 42705049.
Evidence note: 42 participants randomly assigned, with short follow-up; measured physical ability and biological clues, not cancer recurrence or survival.

Connected reading

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