THE ARISING

Menopause and Hormone Therapy



NOVEMBER 2026

START WITH WHAT MATTERS

A decision about your life

A night of repeated waking can change the next day. Pain with sex can change a relationship. Hot flashes can interrupt a meeting, a walk or a quiet moment that used to belong to you. These are worthwhile reasons to seek care. You do not have to justify wanting relief by promising to live longer.

Menopausal hormone therapy can be useful, especially for bothersome hot flashes and night sweats. The central question is how its benefits and risks fit your symptoms, medical history, stage of menopause and preferences. Some people need a systemic treatment; others need a local treatment, a nonhormonal approach, or a different diagnosis. S01, S09

This issue is for women considering or revisiting that conversation. Some readers will be in perimenopause, some years beyond their last period, and some living with early or treatment-induced menopause. Trans men and nonbinary people may also experience menopause; the evidence and available guidance do not cover every treatment context equally.

Three questions that organize the choice

What are we trying to improve? Which option fits my health history? How will we decide whether it is helping?

Inside

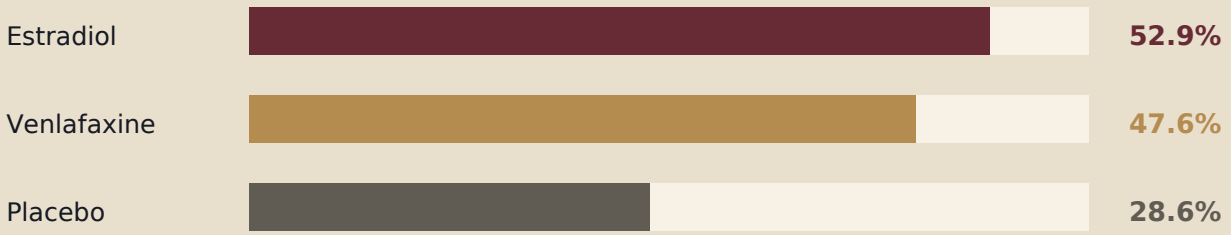
Relief and timing · Perimenopause and early menopause · Routes and uterine protection · Interpreting WHI · Breast health · Vaginal and urinary symptoms · Brain health and longevity · Metabolic health and testosterone · Alternatives · Your appointment

General education, not a prescription or a substitute for individualized care. Research checked November 9, 2026.

WHAT A SYMPTOM TRIAL CAN TELL US

Relief is a meaningful outcome

In the MsFLASH trial, 339 perimenopausal and postmenopausal women with bothersome hot flashes or night sweats were assigned low-dose oral estradiol, venlafaxine or placebo for eight weeks. The average starting frequency across participants was about eight episodes a day. Symptoms fell in all three groups, including placebo. S02



Reduction from each group's own baseline in daily symptom frequency at eight weeks. These are within-group changes, not the treatment effect versus placebo. Bars use a 0-60% scale. Source S02.

The between-group comparison matters: estradiol reduced daily symptom frequency by 2.3 more episodes than placebo, and venlafaxine by 1.8 more. The difference between the two active treatments was small and statistically uncertain. A short symptom trial cannot resolve breast cancer, clot or cardiovascular risks over years. S02

Choose an outcome you can notice

Agree on what improvement would matter: fewer awakenings, fewer disruptive hot flashes, less pain, or easier daily functioning. A lab value alone does not describe the life you are trying to regain.

Hormone therapy is the most effective treatment for vasomotor symptoms overall, but response and tolerability vary. A review after starting or changing treatment is an opportunity to adjust the plan, not a test you can fail. S01

PERIMENOPAUSE AND EARLIER LOSS OF OVARIAN FUNCTION

The stage changes the conversation

Perimenopause is not a steady decline

Symptoms, menstrual bleeding and contraceptive needs can overlap during the transition. Hormone levels fluctuate; the best plan may involve menstrual control and contraception as well as symptom relief. A 2026 clinician toolkit emphasizes this distinct physiology and the need to individualize care. It is a clinical perspective, not evidence that one hormonal strategy suits everyone. S18

Menopausal hormone therapy is not contraception. If pregnancy is possible and unwanted, ask for a contraceptive plan alongside symptom care. New or unusual bleeding should be assessed rather than automatically attributed to hormones. S11, S15

Premature ovarian insufficiency has different stakes

Loss of ovarian function before age 40 is called premature ovarian insufficiency, or POI. The joint guideline recommends hormone therapy, when appropriate, until the usual age of menopause even when symptoms are absent, followed by a new assessment. Evidence underlying some long-term recommendations is limited, but the clinical situation differs from starting hormones later in life for disease prevention. S11

An earlier transition deserves its own care

Early or surgically induced menopause may bring fertility, sexual, bone, cardiovascular and emotional concerns together. The evidence from older women in WHI should not be applied to a young person with POI without recognizing that difference.

A person who has had surgery or cancer treatment needs a plan shaped by that treatment and the reason for it. Symptoms can be real and severe even when systemic hormones are not an appropriate option.

IT DOES NOT CREATE A GUARANTEE

Timing informs risk

For otherwise healthy people with bothersome symptoms, starting systemic therapy before age 60 or within about ten years of menopause generally has a more favorable benefit-risk balance than starting later. Baseline health still matters. A history of thrombosis or an estrogen-sensitive cancer is not cancelled by a younger age. S01, S15

Earlier initiation	Later initiation	Continued use
Often a more favorable balance for symptom treatment when no contraindications are present.	Higher baseline risks make the decision more complex and call for careful individualized assessment.	A separate decision from starting for the first time. Revisit benefits, risks and goals over time.

The ELITE trial tested the timing hypothesis in 643 healthy women. Estradiol slowed progression of carotid artery wall thickness when begun less than six years after menopause, but not when begun ten or more years afterward. Coronary CT measures did not differ significantly. The trial measured a surrogate marker, not a reduction in heart attacks or deaths. S07

There is no rule that everyone must stop at 65. Continuing for persistent symptoms can be considered after review, while acknowledging the limited randomized evidence about extended treatment in older women. The aim is a reasoned decision with a follow-up plan, not an age-based deadline. S01

TWO DIFFERENT DECISIONS THAT BELONG TOGETHER

Route and uterine protection

Systemic therapy reaches the body through a pill or through the skin, such as a patch or gel. Local low-dose vaginal treatment is intended chiefly for vaginal and urinary symptoms. Some vaginal rings deliver systemic estrogen; the route alone does not tell you the exposure. These risk discussions should not be collapsed into a single category. S09, S15

Systemic estrogen + uterus present	Systemic estrogen after hysterectomy	Low-dose vaginal estrogen
Usually needs an adequate progestogen or another approved endometrial-protective regimen.	Estrogen alone may be appropriate, with exceptions considered by the clinician.	A progestogen is generally not required solely for this treatment. Report bleeding.

Unopposed systemic estrogen stimulates the uterine lining and raises endometrial cancer risk. A patch does not remove the need for protection. The October 2026 estradiol-patch label retains that boxed warning. S15

In two large UK database studies, oral therapy was associated with higher odds of venous thrombosis than no recent exposure: adjusted odds ratio 1.58 (95% CI 1.52-1.64). Transdermal therapy was not associated with a statistically detectable increase: 0.93 (0.87-1.01). These observational findings support considering route, but cannot prove that a patch has zero risk or overrides a contraindication. S06

Ask about the entire regimen

Which estrogen, which route, which uterine protection, and why? What bleeding is expected with this regimen, and what should prompt assessment?

ONE STUDIED REGIMEN, ONE STUDIED POPULATION

WHI in absolute numbers

The 2002 Women's Health Initiative report studied oral conjugated equine estrogens (CEE) plus medroxyprogesterone acetate (MPA) in 16,608 women aged 50-79 with a uterus. After an average of 5.2 years, overall risks exceeded benefits for the prevention question being tested. The trial was stopped early. S03

Reported differences per 10,000 person-years

+7	+8	+8
coronary heart disease events	strokes	pulmonary emboli
+8	-5	-6
invasive breast cancers	hip fractures	colorectal cancers

Historical estimates from S03, not a personal forecast. Person-years combine the number of people and time observed. Outcomes cannot be added as if equally important or independent.

These results still matter. They do not directly describe every modern preparation, every starting age, or low-dose vaginal estrogen. Conversely, a different formulation should not be assumed safe simply because this particular trial did not test it.

What has changed since 2002

Better separation of symptom treatment from disease prevention; more attention to age, time since menopause, route, dose, uterine status and personal priorities. None removes the obligation to discuss harms.

Bone protection is a real benefit of hormone therapy. If fracture prevention is the main goal, compare it with osteoporosis-specific options and the person's fracture risk. The current estradiol-patch label advises considering non-estrogen medicines first when prescribing solely for osteoporosis prevention. S15

ESTROGEN ALONE IS NOT THE SAME TRIAL AS COMBINED THERAPY

Breast risk needs precise language

Long-term WHI follow-up found different breast cancer results in its two trials. Among women with a uterus, prior assignment to oral conjugated equine estrogens (CEE) plus medroxyprogesterone acetate (MPA) was associated with more breast cancers than placebo. Among women with a prior hysterectomy, assignment to CEE alone was associated with fewer. S04

Annualized breast cancer incidence in long-term follow-up

Trial population	Assigned hormones	Placebo
Uterus present CEE + MPA	0.45%	0.36%
Prior hysterectomy CEE alone	0.30%	0.37%

More than 20-year median cumulative follow-up. Trial treatment lasted a median 5.6 or 7.2 years, respectively. The rows represent different populations, not a head-to-head comparison. Source S04.

For combined therapy the hazard ratio was 1.28 (95% CI 1.13-1.45); for estrogen alone it was 0.78 (0.65-0.93). Breast cancer mortality was lower in the estrogen-alone trial and not statistically different in the combined trial. These findings should not be turned into a recommendation to use estrogen to prevent breast cancer. S04

Personal and family history, prior biopsies, age, duration and the specific regimen belong in the discussion. Evidence about newer estrogen-progesterone combinations is not identical to WHI evidence. "Bioidentical" does not mean no breast risk.

A useful request

Ask for the best estimate of your baseline risk and how the proposed regimen might change it, using the same time horizon and denominator. A relative percentage without context is incomplete.

LOCAL SYMPTOMS CAN NEED A LOCAL TREATMENT

Vaginal and urinary health deserve care

Dryness, burning, pain with penetration and some urinary symptoms can accompany the genitourinary syndrome of menopause, or GSM. They can affect comfort, intimacy and ordinary activities. Similar symptoms can also come from infections, skin conditions, pelvic-floor problems or other causes, so an assessment matters. S10

Comfort	Targeted treatment	Reassessment
Lubricants and moisturizers can help mild symptoms and can be used alongside other care.	Low-dose vaginal estrogen is one well-supported option; vaginal DHEA and oral ospemifene are alternatives for selected patients.	Persistent pain, bleeding or urinary symptoms may need a different explanation or additional treatment.

The 2025 AUA/SUFU/AUGS guideline identifies local low-dose vaginal estrogen as having the most robust evidence base. The 2020 NAMS statement also supports several hormonal options for moderate to severe GSM. Systemic therapy may not fully relieve local symptoms. S09, S10, S11

A progestogen is generally not required with low-dose vaginal estrogen. Long-term endometrial safety evidence from clinical trials is limited, and postmenopausal bleeding needs evaluation. If there is a history of breast cancer, involve the treating team in the decision, especially during endocrine therapy; do not transfer safety claims from the general population without qualification. S09

No obligation to endure pain

The conversation can begin simply: "This is affecting my comfort or intimacy. Can we evaluate it and discuss treatment?" There is no need to wait until symptoms become severe.

KEEP PROMISING HYPOTHESES SEPARATE FROM PROVEN OUTCOMES

Brain health and a longer life

Difficulty concentrating can be distressing. Improved sleep and relief from night sweats may make daily life easier, but that does not establish hormone therapy as a treatment to prevent dementia. New cognitive symptoms also deserve consideration of sleep, mood, medicines and other health problems.

In WHIMS, 4,532 women aged at least 65 were assigned oral CEE plus MPA or placebo. Probable dementia occurred at rates of 45 versus 22 cases per 10,000 person-years, with a hazard ratio of 2.05 (95% CI 1.21-3.48). This is evidence of harm for that older population and regimen, not a direct estimate for starting treatment near menopause. S08

In the pooled WHI trials, all-cause mortality over 18 years was 27.1% after assignment to hormone therapy and 27.6% after placebo, HR 0.99 (0.94-1.03). That long follow-up included many years after trial treatment ended. Age-related patterns do not turn the overall study into proof that menopausal hormones extend everyone's life. S05

The prevention distinction

The USPSTF recommends against hormone therapy solely for primary prevention of chronic conditions in asymptomatic postmenopausal people. That recommendation does not address treatment of menopausal symptoms or premature or surgical menopause. S17

A future study may sharpen these distinctions. Today, a sound reason to treat symptoms is enough; it need not carry an unsupported promise of preventing Alzheimer disease or reversing aging.

A BROADER ASSESSMENT, WITHOUT BLAME

Metabolic health and testosterone

The menopause transition can coincide with changes in body composition, lipids and vascular health. It is a useful time to review blood pressure, smoking, movement, sleep and cardiometabolic risk. These concerns deserve attention whether or not hormone therapy is chosen. S20

A larger waist does not diagnose an "aromatase problem," and an estradiol or testosterone result alone does not explain fatigue, weight change or low desire. For women, the evidence in this issue does not support suppressing estrogen production as a general metabolic strategy. Aromatase inhibitors have specific medical uses; they should not be repurposed into a self-directed menopause plan.

What about testosterone?

The 2019 international consensus identifies a narrow evidence-based use: postmenopausal hypoactive sexual desire disorder, persistently low desire that causes personal distress, after a formal assessment of biological, psychological and relationship factors. That is different from treating a laboratory value, general tiredness, cognition or longevity. The consensus notes a lack of safety data beyond 24 months. S12

A careful sexual-health conversation

Low desire may involve pain, medications, sleep, mood, relationship context or changing priorities. Ask what is contributing and what outcome matters to you before assuming a hormone is the answer.

Building a healthier metabolic environment and treating disruptive menopausal symptoms can proceed together. Neither requires framing a person's body as a failure. The companion men's issue examines the different evidence about testosterone, adiposity and aromatase; those findings should not be transferred wholesale to women.

NONHORMONAL OPTIONS AND THE LANGUAGE OF "NATURAL"

More than one route to relief

If systemic hormones are not suitable or not wanted, there are evidence-based alternatives for hot flashes. Options include certain SSRIs or SNRIs, gabapentin, and menopause-specific cognitive behavioral therapy. The right choice depends on other symptoms, drug interactions and side effects. S14

Newer nonhormonal medicines target neurokinin signaling. Fezolinetant carries an FDA boxed warning for rare serious liver injury and requires liver blood-test monitoring. Elinzanetant was approved by the FDA on October 24, 2025. Its label requires liver tests before treatment and at three months, warns of daytime impairment and sleepiness, contraindicates use in pregnancy, and advises caution with a seizure history. Approval does not establish that it is best for every patient or directly equivalent to hormone therapy. S21, S22, S23

Bioidentical describes a molecule, not a guarantee

FDA-approved estradiol and progesterone products are available. Compounded preparations do not acquire proven safety because they are marketed as "natural" or individualized. ACOG recommends approved menopausal therapies over routinely using compounded alternatives when approved formulations exist. S13

Questions before buying a plan

What is the active ingredient? Is this an approved product? Which outcome has been demonstrated? What are the monitoring requirements, side effects and total costs? What happens if I want to stop?

Exercise, nourishing food and sleep support broader health and can be worth pursuing for their own benefits. They should not be sold as guaranteed replacements for effective symptom treatment. Nor should supplements be assumed to treat hot flashes reliably because they are sold without a prescription. S14

A CONVERSATION GUIDE TO BRING WITH YOU

Make the appointment useful

1. The problem I want to improve

Which symptoms disrupt sleep, work, comfort, relationships or activities? How often?

2. The history that changes the choice

Last menstrual period, bleeding pattern, uterus and ovary surgery, pregnancy possibility, cancer history, clotting or cardiovascular history, liver disease, medications and family history.

3. The proposed plan

Why this formulation and route? Do I need uterine protection? Are local treatment or nonhormonal options a better fit?

4. How we will review it

What improvement should I expect? Which adverse effects matter? When do we reassess? How do we change or discontinue the plan if it is not helping?

Safety comes before a routine start

Unexplained genital bleeding, current or prior breast cancer, estrogen-dependent cancer, prior clots, stroke or heart attack, liver disease and certain thrombophilias are listed contraindications for systemic estrogen products such as the estradiol patch reviewed here. Specialist evaluation may help identify other options. A transdermal route does not erase these concerns. This is not a complete product-specific checklist. S15

Seek urgent medical care for sudden chest pain or shortness of breath, stroke-like symptoms or a painful swollen leg. Arrange prompt assessment for postmenopausal bleeding rather than assuming it is harmless.

The goal is a plan you understand, with benefits that matter to you and risks discussed honestly. Choosing treatment, declining it or changing course can each be a reasonable decision.

SOURCE NOTES 1 OF 4

Read the evidence

S01 · The 2022 hormone therapy position statement

The North American Menopause Society, 2022

https://pubmed.ncbi.nlm.nih.gov/35797481/

Consensus guideline; PubMed abstract and society highlights reviewed. Individualized symptom treatment; age and timing; continued reassessment. Full guideline could not be retrieved in this run.

S02 · Low-dose estradiol and venlafaxine for vasomotor symptoms

Joffe et al., JAMA Internal Medicine, 2014

https://pubmed.ncbi.nlm.nih.gov/24861828/

Randomized trial; full PubMed abstract reviewed. 339 participants, 8 weeks. Symptom frequency endpoint; not a long-term safety comparison.

S03 · WHI estrogen plus progestin principal results

Rossouw et al., JAMA, 2002

https://pubmed.ncbi.nlm.nih.gov/12117397/

Randomized trial; full PubMed abstract reviewed. 16,608 women aged 50-79; oral CEE plus MPA. Mean 5.2-year report; regimen and population limits retained.

S04 · WHI breast cancer incidence and mortality during long-term follow-up

Chlebowski et al., JAMA, 2020

https://pubmed.ncbi.nlm.nih.gov/32721007/

Follow-up of two randomized trials; full PubMed abstract reviewed. 27,347 participants; more than 20-year median cumulative follow-up. Different uterine-status populations, not a direct comparison of regimens.

S05 · WHI long-term all-cause and cause-specific mortality

Manson et al., JAMA, 2017

https://pubmed.ncbi.nlm.nih.gov/28898378/

Follow-up of randomized trials; full PubMed abstract reviewed. 27,347 participants; 18-year cumulative follow-up, not 18 years of assigned treatment.

S06 · Hormone therapy and venous thromboembolism in QResearch and CPRD

Vinogradova et al., BMJ, 2019

https://pubmed.ncbi.nlm.nih.gov/30626577/

Nested case-control studies; full PubMed abstract reviewed. 80,396 VTE cases and 391,494 controls. Associations, not randomized route comparisons.

SOURCE NOTES 2 OF 4

Read the evidence

S07 · Vascular Effects of Early versus Late Postmenopausal Treatment with Estradiol

Hodis et al., New England Journal of Medicine, 2016

https://pubmed.ncbi.nlm.nih.gov/27028912/

Randomized trial; full PubMed abstract reviewed. 643 healthy women; median 5 years. Carotid-wall thickness was the primary endpoint, not heart attacks or survival.

S08 · WHIMS estrogen plus progestin and dementia

Shumaker et al., JAMA, 2003

https://pubmed.ncbi.nlm.nih.gov/12771112/

Randomized trial; full PubMed abstract reviewed. 4,532 women aged 65 or older; oral CEE plus MPA. Do not extrapolate directly to treatment at age 50.

S09 · The 2020 genitourinary syndrome of menopause position statement

The North American Menopause Society, 2020

https://pubmed.ncbi.nlm.nih.gov/32852449/

Consensus guideline; full PubMed abstract reviewed. Local treatments and uterine-protection distinction. Long-term endometrial trial data limited.

S10 · AUA SUFU AUGS Guideline on Genitourinary Syndrome of Menopause

American Urological Association and partner societies, 2025

https://pubmed.ncbi.nlm.nih.gov/40298120/

Guideline; full PubMed abstract reviewed. Local low-dose vaginal estrogen has the most robust evidence base; diagnosis excludes other causes. Full guideline PDF returned access error.

S11 · Evidence-based guideline on premature ovarian insufficiency

ESHRE, ASRM, CREWHIRL and IMS, 2024/2025

https://www.asrm.org/practice-guidance/practice-committee-documents/evidence-based-guideline-premature-ovarian-insufficiency--2024/

Official full guideline webpage; relevant recommendations reviewed. POI differs from usual-age menopause; replacement generally recommended until usual menopause age, followed by individual reassessment.

S12 · Global Consensus Position Statement on Testosterone Therapy for Women

Davis et al., Journal of Clinical Endocrinology and Metabolism, 2019

https://pubmed.ncbi.nlm.nih.gov/31498871/

PubMed identity and official journal indexed recommendations reviewed. Limited to postmenopausal HSDD after assessment; long-term safety uncertain. Full text unavailable during this run.

SOURCE NOTES 3 OF 4

Read the evidence

S13 · Compounded Bioidentical Menopausal Hormone Therapy

ACOG Clinical Consensus No. 6, 2023

https://pubmed.ncbi.nlm.nih.gov/37856860/

Consensus; full PubMed abstract reviewed. FDA-approved products preferred when available; marketing does not establish safety or effectiveness.

S14 · The 2023 nonhormone therapy position statement

The North American Menopause Society, 2023

https://pubmed.ncbi.nlm.nih.gov/37252752/

Consensus guideline; full PubMed abstract reviewed. Several evidence-based options for vasomotor symptoms. Later regulatory updates checked separately.

S15 · Vivelle-Dot prescribing information revised October 2026

U.S. Food and Drug Administration

https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/020538s047lbl.pdf

Official label; boxed warning, indications and contraindications reviewed. Endometrial cancer boxed warning retained; systemic contraindications remain despite other labeling changes. One product example, not a class-wide label audit.

S16 · FDA approves labeling changes to menopausal hormone therapy products

U.S. Food and Drug Administration, February 12, 2026

https://www.fda.gov/news-events/press-announcements/fda-approves-labeling-changes-menopausal-hormone-therapy-products

Official regulatory announcement reviewed. Initial six-product approval; do not imply every product changed that day or infer risk-free treatment.

S17 · Hormone therapy for primary prevention of chronic conditions

U.S. Preventive Services Task Force, 2022

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/menopausal-hormone-therapy-preventive-medication

Official recommendation and population scope reviewed. Against use solely for primary prevention in asymptomatic postmenopausal people; excludes symptom treatment and premature/surgical menopause.

S18 · Hormonal Options for Perimenopause A Clinician Toolkit

Piasta and Zewail, Obstetrics and Gynecology, 2026

https://pubmed.ncbi.nlm.nih.gov/42743436/

Clinical perspective; PubMed abstract reviewed. Different physiology, bleeding and contraception needs; not a formal guideline or dosing basis here.

SOURCE NOTES 4 OF 4

Read the evidence

S19 · Management of menopause-related vasomotor sleep and mood symptoms

ACOG Clinical Practice Guideline, 2026

https://pubmed.ncbi.nlm.nih.gov/42878500/

Identity and full PubMed abstract reviewed. Current guideline exists; exact recommendation text and evidence tables not retrieved. Detailed recommendation claims held.

S20 · Menopause transition and cardiovascular disease risk

El Khoudary et al., American Heart Association scientific statement, 2020

https://pubmed.ncbi.nlm.nih.gov/33251828/

Scientific statement; full PubMed abstract reviewed. Midlife is an opportunity for cardiovascular risk assessment; does not establish hormone therapy as cardiovascular prevention.

S21 · FDA adds boxed warning about serious liver injury with fezolinetant

U.S. Food and Drug Administration, December 16, 2024 update

https://www.fda.gov/drugs/drug-safety-communications/fda-adds-warning-about-rare-occurrence-serious-liver-injury-use-veozah-fezolinetant-hot-flashes-due

Official drug safety update, relevant text reviewed. Rare serious liver injury and required laboratory monitoring.

S22 · Drug Trials Snapshot LYNKUET

U.S. Food and Drug Administration

https://www.fda.gov/drugs/drug-trials-snapshots/drug-trials-snapshots-lynkuet

Official approval record, relevant text reviewed. Elinzanetant approval October 24, 2025; not a head-to-head comparison with hormone therapy.

S23 · Lynkuet prescribing information at approval

U.S. Food and Drug Administration, October 2025

https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/219469s000lbl.pdf

Official label; safety provisions independently reviewed. Baseline and 3-month liver tests; daytime impairment, pregnancy contraindication and seizure-history caution.

What this edition does and does not claim

Targeted review, not an exhaustive systematic search. Most trial checks used complete PubMed abstracts, not full-text methods or supplements. New 2026 ACOG guideline details are held pending full-text review.

This guide complements the November 7 Renaissance issue without reprinting its heart-risk, urinary-health and exercise coverage.