

ESTROGEN REPLACEMENT THERAPY: **WHY CAN'T YOUR DOCTOR GET IT RIGHT?**

Your Weekly Newsletter

by Dr. Nick Sieveking

July 6, 2026



My original goal for this week's newsletter was straightforward: to review the safety and importance of estrogen replacement therapy in estrogen-deficient women and to explain why so many healthcare providers continue to deny appropriate hormone replacement therapy (**HRT**)—or prescribe and monitor HRT incorrectly—despite decades of evolving scientific evidence.

As I worked through the literature, it became clear that this topic simply could not be covered adequately in a brief newsletter. What began as a short review evolved into something that reads more like a chapter from a book on menopause and hormone replacement therapy.

I recognize this week's newsletter is longer than usual, but few subjects have a greater impact on the long-term health and quality of life for many millions of women. I considered dividing it into multiple installments, but the science, history, and clinical implications are so closely connected that separating them would diminish the overall message. **This is a topic that deserves to be understood in its entirety.**



Hormone replacement therapy (HRT) for women is considerably more complex and nuanced than testosterone replacement therapy for men. Treatment decisions require careful considerations of a woman's age, symptoms, medical history, cardiovascular risk, breast and gynecologic health, and the timing of menopause. Unfortunately, decades of conflicting information have left many women confused about the risks and benefits of hormone therapy, and quite frankly have robbed many decades of post-menopausal women of the health and well-being and the disease-free longevity benefits of HRT.

The Women's Health Initiative (2002): A Wrong Turn in Women's Health

Few medical studies have had a greater impact on women's health than the **Women's Health Initiative (WHI)**, published in 2002. JAMA. 2002;288(3):321–333. <https://doi.org/10.1001/jama.288.3.321>

Its findings dramatically changed the treatment of menopause and led millions of women to stop hormone therapy—or never start it at all.

Unfortunately, the study's conclusions were widely oversimplified leading physicians to deny essential mid-life and beyond therapy to a generation. The message many women heard was:

“Hormone replacement therapy causes breast cancer and heart disease.”

That was never the complete story.

The WHI primarily studied women with an **average age of 63 years**—more than a decade beyond the typical age of menopause—and evaluated **oral conjugated equine estrogen (Premarin®) and the synthetic progestin medroxyprogesterone acetate (Provera®)**, not the FDA-approved bio-identical estradiol and micronized progesterone commonly prescribed today.

(Definition of *Bio-Identical Hormones*: a hormone whose chemical and molecular structure is the same as the endogenous human hormone it is intended to replace)

Subsequent analyses have shown that the risks of menopausal hormone therapy depend on **a woman's age, time since menopause, overall health, route of administration, and the specific hormones used—bio-identical vs. synthetic and horse urine derived.**

The widespread belief that **“all hormone therapy is dangerous”** contributed to years of unnecessary menopausal symptoms and preventable conditions such as bone loss, fractures, heart disease, dementia, genitourinary syndrome of menopause, and reduced quality of life.



Although menopause science has evolved substantially over the past two decades, many physicians continue to counsel women based primarily on early interpretations of the WHI rather than current evidence and modern menopause guidelines.

Understanding Menopause

Menopause is the natural end of a woman's reproductive years and is officially diagnosed after **12** consecutive months without a menstrual period. The average age of menopause is 51–52 years.

The hormonal transition into menopause, known as **peri-menopause**, often begins during a woman's mid-40s. During this time, ovarian production of estrogen and progesterone gradually declines, affecting nearly every organ system in the body. As a result, many women experience symptoms that extend far beyond hot flashes.



Common symptoms include:

- Hot flashes and night sweats
- Sleep disturbances
- Mood changes
- Brain fog and difficulty concentrating
- Vaginal dryness and painful intercourse
- Loss of bone density ==> FRACTURES
- Loss of muscle mass and strength
- Weight gain and changes in body composition
- Reduced libido
- Increased cardiovascular risk

While menopause is a normal stage of life, prolonged estrogen deficiency can significantly affect a woman's health, function, and quality of life. Fortunately,

many lifestyle strategies—and when appropriate, bio-identical hormone replacement therapy (BHRT)—can help women navigate this transition safely and effectively.

Natural Approaches to Managing Menopausal Symptoms

Healthy lifestyle habits remain the foundation of menopausal care and can significantly improve both symptoms and long-term health.

- Regular exercise (strength training, walking, aerobic exercise, yoga)
- Adequate protein intake (1.2–1.6 g/kg/day) to preserve muscle and bone
- Resistance training to combat bone & muscle loss



- Mediterranean-style diet rich in vegetables, fruits, legumes, fish, and healthy fats



- Omega-3 fatty acids for cardiovascular and anti-inflammatory support
- Phytoestrogens (soy, flaxseed, red clover) for mild hot flash relief in some women
- Black cohosh (may help hot flashes in some women)



- Magnesium for sleep quality and muscle relaxation
- Vitamin D and calcium to support bone health
- Vitamin K2 to support healthy bone mineralization
- Adequate fiber to support the gut microbiome and estrogen metabolism
- Stress reduction (meditation, prayer, deep breathing, mindfulness)
- Quality sleep (7–9 hours nightly)
- Limiting alcohol and avoiding smoking
- Maintaining a healthy body weight
- Pelvic floor exercises for urinary symptoms
- Vaginal moisturizers and lubricants for vaginal dryness and painful intercourse
- Cognitive behavioral therapy (CBT) for hot flashes, insomnia, and mood symptoms
- Acupuncture, which may reduce hot flashes in some women

The Most Effective Treatment

For women without contraindications, bio-identical hormone replacement therapy (**BHRT**) using FDA-approved **17 β -estradiol** (transdermal or oral-dissolving tablets) together with **micronized progesterone** (for women with an intact uterus) remains the most effective treatment for:

- Hot flashes and night sweats
- Genitourinary syndrome of menopause
- Prevention of bone loss
- Improvement in overall quality of life



When initiated in appropriate candidates—particularly women younger than 60 years of age or within 10 years of menopause—**BHRT** has a favorable benefit-risk profile and can provide substantial improvements in both symptoms and long-term health. That said, women over the age of 60 can benefit tremendously from BHRT as well.

Potential benefits of bio-identical hormone replacement therapy (BHRT) in appropriately selected women over 65 include:

- Continued relief of hot flashes and night sweats, which persist into the 60s and even 70s in many women.
- Improved sleep quality
- Improved mood, cognition, and overall quality of life
- Treatment of genitourinary syndrome of menopause (GSM), including vaginal dryness, painful intercourse, urinary urgency, recurrent urinary tract infections, and overactive bladder symptoms, improving continence
- Preservation of bone density with reduced risk of osteoporosis and fragility fractures.
- Maintenance of muscle mass and strength
- Improved skin thickness, elasticity, hydration, and collagen content, which may reduce skin fragility and bruising.
- Improvement in sexual function, including libido, arousal, and comfort with intercourse.
- Reduced joint aches and stiffness
- Potential reduction in central fat accumulation and improved insulin sensitivity ==> less diabetes

Potential Risks of Bio-identical Hormone Therapy

Like any medical treatment, BHRT carries potential risks that should be discussed with your physician.

Potential risks include:

- Breast tenderness
- Irregular bleeding
- Bloating or fluid retention
- Blood clots and stroke (primarily with oral estrogen)
- A small increase in breast cancer risk with prolonged combined estrogen-progesterone therapy
- Endometrial cancer if estrogen is used without progesterone in women who have an intact uterus
- Gallbladder disease (more common with oral estrogen)

The Biggest Concern: Breast and Gynecologic Cancer

For many women, the decision to begin hormone replacement therapy is driven by one overriding concern:

“Will hormone therapy increase my risk of cancer?”

This is an important question—and one that deserves an evidence-based answer rather than one based on outdated information or fear.

Perhaps no aspect of menopausal hormone therapy has generated more controversy than its relationship to breast cancer. Over the past two decades, however, the scientific literature has evolved considerably. Current evidence paints a far more nuanced picture than the one that emerged following the initial interpretation of the Women's Health Initiative (WHI).

Today, researchers recognize that the effects of hormone therapy depend on several factors, including:

- A woman's age
- Timing of treatment relative to menopause
- Duration of therapy
- Route of administration
- Most importantly, the specific hormones used

Breast Cancer

Current evidence suggests:

- **Estrogen-alone therapy** carries little to no increase in breast cancer risk and, in several studies, has been associated with a reduction in both breast cancer incidence and breast cancer mortality.
- **Combined estrogen-progestogen therapy** may be associated with a small increase in breast cancer diagnoses after several years of treatment. However, much of this evidence comes from studies using the synthetic progestin **medroxyprogesterone acetate (Provera®)** rather than bio-identical micronized progesterone.
- Observational studies suggest that **17β-estradiol combined with micronized progesterone** appears to carry a substantially lower breast cancer risk than older hormone regimens containing synthetic progestins.

Overall, multiple large cohort studies conclude that modern menopausal hormone therapy carries, at most, a **small absolute increase** in breast cancer risk. For many healthy women who begin treatment near the onset of menopause, the overall benefits of therapy usually outweigh these potential risks.

Interestingly, despite concerns regarding breast cancer incidence, several observational studies have reported **lower breast cancer mortality among systemic estrogen users** after adjustment for multiple confounding variables => even with the concern of very small increase of breast cancer diagnoses, the evidence suggests fewer deaths from breast cancer for women on HRT.

References

- Kim J, Munster PN. Estrogens and Breast Cancer. *Annals of Oncology* (2025).
<https://doi.org/10.1016/j.annonc.2024.10.824>
- Fournier A, Berrino F, Clavel-Chapelon F. Unequal Risks for Breast Cancer Associated with Different Hormone Replacement Therapies. *Breast Cancer Research and Treatment*.

- Willis DB, Calle EE, Miracle-McMahill HL, Heath CW Jr. Estrogen Replacement Therapy and Risk of Fatal Breast Cancer. Cancer Causes & Control. <https://doi.org/10.1007/BF00052671>

Endometrial Cancer

Unlike breast cancer, the relationship between estrogen therapy and endometrial cancer is well established.

Unopposed systemic estrogen (=> no progesterone) stimulates the lining of the uterus (endometrium), significantly increasing the risk of endometrial hyperplasia and endometrial cancer in women who have an intact uterus. Roughly 2 to 4 additional cases per 1000 women per year when compared to non-estrogen users.

Fortunately, this risk is largely eliminated by adding **micronized progesterone**, which protects the uterine lining by opposing estrogen's proliferative effects.

For this reason, **women with an intact uterus who receive systemic estrogen should also receive adequate progesterone unless a specific contraindication exists.**

References

- Beral V, Bull D, Reeves G, Million Women Study Collaborators. Endometrial Cancer and Hormone-Replacement Therapy in the Million Women Study. [https://doi.org/10.1016/S0140-6736\(05\)66455-0](https://doi.org/10.1016/S0140-6736(05)66455-0)
- Newcomb PA, Trentham-Dietz A. Patterns of postmenopausal progestin use with estrogen in relation to endometrial cancer (United States). Cancer Causes Control. 2003;14(2):195-201. <https://doi.org/10.1023/A:1023066304473>
- Weiderpass E, Adami HO, Baron JA, Magnusson C, Bergström R, Lindgren A, Correia N, Persson I. Risk of endometrial cancer following estrogen replacement with and without progestins. J Natl Cancer Inst. 1999;91(13):1131-1137. <https://doi.org/10.1093/jnci/91.13.1131>

Ovarian Cancer

Current evidence suggests that menopausal hormone therapy may be associated with a **slight increase in ovarian cancer diagnoses**. However, the absolute increase in risk is **very small**.

Importantly, available evidence has **not consistently demonstrated that hormone therapy worsens prognosis or survival** in women who subsequently develop ovarian cancer.

Reference

- Collaborative Group on Epidemiological Studies of Ovarian Cancer. Menopausal Hormone Use and Ovarian Cancer Risk: Individual Participant Meta-analysis of 52 Epidemiological Studies. [https://doi.org/10.1016/S0140-6736\(14\)61687-1](https://doi.org/10.1016/S0140-6736(14)61687-1)

A Note on Genetics

Breast, endometrial, and ovarian cancers demonstrate various degrees of genetic inheritance: so, personal and family histories and possible genetic testing are essential before considering HRT

Key Takeaway

No medical therapy is completely free of risk—including hormone replacement therapy. However, modern evidence indicates that the relationship between menopausal hormone therapy and cancer is far more nuanced than many women have been led to believe.

The type of hormone used, the timing of therapy, the route of administration, treatment duration, and an individual's underlying cancer risk all influence the overall benefit-risk profile. For many healthy women, the benefits of appropriately prescribed bio-identical hormone therapy outweigh the potential risks.

Looking at Both Sides of the Equation

Even if hormone therapy carries a small increase in certain cancer risks for some women, an equally important question must be asked:

What are the health consequences of remaining estrogen deficient for decades?

Too often, discussions about hormone replacement focus exclusively on potential risks while overlooking the very real medical consequences of untreated estrogen deficiency.

As the saying goes: “Damned if you do, damned if you don’t.”

For many women, the decision is not between **risk and no risk**, but rather between **different types of risk**.

Estrogen **deficiency** affects virtually every organ system in the body. After menopause, declining estrogen (along with progesterone and, to a lesser extent, testosterone) contributes to widespread physiologic changes that may impact both quality of life and long-term health.

Some Breast Cancer Statistics for U.S. Women

- 7 to 8 new cases of breast cancer per 1000 women ages 50 to 70 over a 10-year period in the general population
- 2 to 3 new cases of breast cancer per 1000 ages 50 to 70 over a 10 year period in women who have never used HRT
- In appropriately selected women, ages 50 to 70, receiving estrogen-only hormone therapy, the estimated increase in breast cancer diagnoses is approximately **5 additional cases per 1,000 women over 10 years**.
- In women, ages 50 to 70, receiving combined estrogen and progesterone therapy, the estimated increase is approximately **15 additional breast cancer diagnoses per 1,000 women over 10 years**.
- Despite these small differences in breast cancer diagnoses, **breast cancer mortality remains very low**. Across major studies, the number of deaths from breast cancer among women receiving appropriately prescribed menopausal hormone therapy is estimated to range from **0 to 2**

per 1,000 women over a 10-year period => there may be more diagnoses, but no more deaths

The Health Consequences of Untreated Estrogen Deficiency:

1. Cardiovascular System



Estrogen deficiency has been associated with:

- Increased risk of coronary artery disease
- Endothelial dysfunction
- Increased arterial stiffness
- Less favorable cholesterol profile ($\uparrow$ LDL, $\downarrow$ HDL in many women)
- Increased visceral fat and metabolic syndrome
- Higher risk of hypertension

Key Point: Epidemiologic and mechanistic studies suggest that women who remain estrogen deficient have higher rates of cardiovascular disease and more rapid progression of atherosclerosis.

For **women aged 65 years and older in the United States**, the following are reasonable population-based estimates:

Condition	Approximate <u>annual</u> incidence (per 1,000 women ≥ 65 years)
Cardiovascular disease (first major cardiovascular event*)	20–30 per 1,000
Myocardial infarction (heart attack)	5–8 per 1,000
Stroke (ischemic + hemorrhagic)	4–7 per 1,000

*Properly managed non-oral HRT in hormone deficient women likely reduces the lifetime incidences of these cardiovascular events by 30 to 50%.

References

- Effect of hormone replacement therapy on cardiovascular events in recently postmenopausal women: randomised trial. BMJ. 2012;345 <https://www.bmj.com/content/345/bmj.e6409>
- Cardioprotective Effects of Ovarian Hormones and the HERS in Perspective [https://doi.org/10.1016/S0378-5122\(00\)00106-7](https://doi.org/10.1016/S0378-5122(00)00106-7)

2. Brain & Nervous System



Estrogen deficiency may contribute to:

- Hot flashes
- Night sweats
- Sleep disturbances
- Brain fog
- Memory decline
- Difficulty concentrating
- Increased anxiety
- Depression
- Increased risk of dementia in women with untreated early menopause

Key Point: Declining estrogen levels have been associated with cognitive changes and an increased risk of Alzheimer's disease and other neurodegenerative disorders, particularly following early or abrupt menopause.

Every year, approximately 2 out of every 100 women over age 65 will develop a major neurodegenerative disease, most commonly Alzheimer's disease or another form of dementia.

Disorder	<u>Annual</u> incidence (per 1,000 women ≥65)
Alzheimer's disease and other dementias	15–25 per 1,000
Parkinson's disease	1–2 per 1,000
Lewy body dementia	0.5–1 per 1,000
Frontotemporal dementia	<0.5 per 1,000
ALS	0.1–0.3 per 1,000

Multiple meta-analysis studies suggest initiation of HRT in midlife (40s–50s) around menopausal symptom onset is associated with a 23–32% reduction in dementia of all types.

References

- Influence of the Onset of Menopause on the Risk of Developing Alzheimer's Disease
<https://doi.org/10.7759/cureus.69124>
- Systematic review and meta-analysis of the effects of menopause hormone therapy on risk of Alzheimer's disease and dementia. Front Aging Neurosci. 2023;15
<https://pmc.ncbi.nlm.nih.gov/articles/PMC10625913/>

3. Bone & Musculoskeletal System



Estrogen deficiency accelerates:

- Osteopenia
- Osteoporosis
- Increased fracture risk
- Sarcopenia (loss of muscle mass)
- Joint pain and stiffness
- Tendon and ligament weakness
- Reduced exercise capacity

Key Point: Untreated estrogen deficiency accelerates bone loss, muscle loss, connective tissue degeneration, and physical decline, increasing the risk of falls, fractures, disability, and loss of independence.

For **U.S. women aged ≥ 65 years**, the annual incidence of hip fracture is approximately:

Age	<u>Annual</u> hip fractures
65–69 years	2–3 per 1,000 women
70–74 years	4–6 per 1,000 women
75–79 years	8–12 per 1,000 women
80–84 years	15–25 per 1,000 women
≥85 years	30–50 per 1,000 women

Properly managed menopausal hormone therapy (MHT/HRT) in estrogen-deficient women typically reduces overall fracture risk on the order of about 25–35%, with some studies showing ~30–40% reductions

References

- Osteoarthritis Associated with Estrogen Deficiency <https://doi.org/10.1186/ar2791>
- Estrogen and the Skeleton <https://doi.org/10.1016/j.tem.2012.03.008>

4. Genitourinary System

- Vaginal dryness
- Painful intercourse
- Vaginal atrophy
- Recurrent urinary tract infections
- Urinary urgency
- Urinary frequency
- Stress urinary incontinence
- Overactive bladder symptoms

For **women aged 65 years and older**, the best estimate is:

- **Approximately 0.3–0.8 deaths per 1,000 women per year** from urinary tract infections or their complications (primarily urosepsis), depending on age and overall health.
- **HRT, especially older women, reduces the risk of severe urinary infections that can lead to urosepsis and death**

Age	<u>Annual</u> UTI-related deaths (per 1,000 women/year)
65–74 years	0.1–0.3
75–84 years	0.3–0.8
≥85 years	1–3

HRT roughly confers 60–80% lower odds of death across age groups from urinary tract infections

Reference

- Update on Genitourinary Syndrome of Menopause: A Tailored Treatment-Based Approach
<https://doi.org/10.3390/life14111504>

5. Sexual Health

- Decreased libido
- Reduced arousal
- Decreased orgasm intensity
- Delayed orgasm
- Reduced genital blood flow

Reference

- Identifying and Treating Sexual Dysfunction in Postmenopausal Women: The Role of Estrogen
<https://doi.org/10.1089/jwh.2010.2151>

6. Skin, Hair & Connective Tissue



Estrogen deficiency contributes to:

- Loss of collagen
- Thinning skin
- Wrinkles
- Poor wound healing
- Dry skin
- Hair thinning
- Brittle nails
- Reduced skin elasticity

Reference

- Managing Menopausal Skin Changes: A Narrative Review <https://doi.org/10.1111/jocd.70393>

7. Eyes

- Dry eye syndrome
- Reduced tear production

Reference

- Dry Eye in Postmenopausal Women: A Hormonal Disorder
<https://doi.org/10.1097/GME.0000000000000530>

8. Oral Health

- Dry mouth
- Burning mouth syndrome
- Increased periodontal disease
- Increased risk of tooth loss

Reference

- Menopause, Skin and Common Dermatoses: Part 4 – Oral Disorders <https://doi.org/10.1111/ced.15341>

9. Metabolic Health

Estrogen deficiency is associated with:

- Increased insulin resistance
- Diabetes
- Weight gain (particularly abdominal fat)
- Increased risk of fatty liver disease
- Increased systemic inflammation

For **women over age 65**, a reasonable population estimate is:

- **Approximately 2–4 deaths per 1,000 women per year** are attributable to diabetes or its complications (including cardiovascular disease, kidney failure, infections, and hyperglycemic crises).

Age	Diabetes-related deaths (per 1,000 women/ <u>year</u>)
65–74 years	1–2
75–84 years	2–4
≥85 years	4–8

Properly chosen and monitored HRT in hormone deficient women can lower diabetes incidence, with relative risk reductions in the 30–60% range reported.

Reference

- Metabolic Disorders in Menopause <https://doi.org/10.5114/pm.2015.50000>
- Hormone therapy protects from diabetes: the Kuopio Osteoporosis Risk Factor and Prevention Study. Eur. J. Endocrinol. 160, 979–983 (2009). <https://doi.org/10.1038/nrendo.2009.92>

10. Immune System

- Altered immune regulation
- Increased pro-inflammatory cytokines
- Potential worsening of autoimmune diseases in susceptible women

Reference

- The Impact of Menopause on Autoimmune and Rheumatic Diseases <https://doi.org/10.1007/s12016-025-09031-8>

11. Gastrointestinal System

- Changes in the gut microbiome
- Increased visceral adiposity affecting gastrointestinal function
- Constipation in some women

Reference

- The Gut Microbiota in Menopause: Is There a Role for Prebiotic and Probiotic Solutions?
<https://doi.org/10.1177/20533691251340491>

12. Sleep



- Insomnia
- Frequent awakenings
- Reduced sleep quality
- Fatigue

Reference

- Insomnia in Postmenopausal Women: How to Approach and Treat It?
<https://doi.org/10.3390/jcm13020428>

13. Quality of Life



Untreated estrogen deficiency may lead to:

- Reduced energy
- Reduced productivity
- Lower physical function
- Reduced overall well-being
- Reduced quality of intimate relationships

Reference

- Quality of Life Among Menopausal Women: Menopause-Specific Quality of Life Questionnaire
https://doi.org/10.4103/jmh.jmh_109_25

PICK YOUR POISON

The choice is not between “risk” and “no risk.”
It is between different risks.

OPTION A



- A possible small increase in **breast cancer diagnoses** in some women, with **minimal to no increase in breast cancer deaths**.

VS

OPTION B



- Remaining estrogen deficient, with a **substantially higher risk of:**
 - Cardiovascular disease
 - Osteoporosis and fragility fractures
 - Dementia
 - Genitourinary syndrome of menopause
 - Reduced quality of life
 - Increased risks of several other chronic diseases

The goal is not to eliminate risk—it is to choose the risk profile that offers the greatest overall health and longevity based on the best available evidence.

The Bottom Line

Menopause is a natural stage of life—but prolonged estrogen deficiency has measurable effects on nearly every organ system. While hormone therapy is not appropriate for every woman, the risks of remaining hormone deficient should be considered alongside the potential risks of treatment.

Every woman deserves an individualized discussion based on her symptoms, medical history, risk factors, and personal health goals—not outdated misconceptions or one-size-fits-all recommendations.

Advice on Choosing a Menopause Hormone Therapy (HRT) Clinician



Consider finding a new doctor if your clinician:

- 1  Dismisses hormone therapy solely because of cancer concerns without discussing your individual risks, benefits, and current evidence.
- 2  Relies primarily on the 2002 WHI study without acknowledging the extensive research published over the past two decades.
- 3  Routinely prescribes conjugated equine estrogens (Premarin®) instead of FDA-approved bioidentical 17β-estradiol without explaining why.
- 4  Routinely prescribes medroxyprogesterone acetate (Provera®) instead of FDA-approved bioidentical micronized progesterone without discussing the differences.
- 5  Recommends oral estrogen as the default without discussing transdermal estrogen and its potential advantages for many women.
- 6  Prescribes systemic estrogen to a woman with an intact uterus without addressing the need for endometrial protection with progesterone.
- 7  States that hormone therapy must automatically be stopped at age 60 or 65, regardless of your health status or preferences.
- 8  Does not assess your cardiovascular risk before initiating hormone therapy.
- 9  Does not obtain an appropriate personal and family history, including breast, endometrial, ovarian cancers, and venous thromboembolism, before recommending treatment.
- 10  Does not safely check hormone levels at appropriately scheduled intervals.

The 10 Most Dangerous Inaccuracies

Women Are Still Told About Menopause

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"Hormone replacement therapy causes breast cancer."
The risk depends on the type of hormone, duration of use, timing of initiation, and the individual woman.
 - 

"The Women's Health Initiative proved hormone therapy is dangerous for all women."
The WHI has been widely overgeneralized and does not apply equally to symptomatic women of all ages using modern hormone therapy.
 - 

"All hormones are the same."
Bioidentical 17 β -estradiol and micronized progesterone differ significantly from older synthetic hormones in their pharmacology and risk profiles.
 - 

"Menopause only causes hot flashes."
Estrogen deficiency affects nearly every organ system, including the heart, brain, bones, muscles, skin, urinary tract, and sexual function.
 - 

"Women should simply learn to live with menopause."
Effective lifestyle interventions and medical treatments are available that can significantly improve symptoms and quality of life.
 - 

"Hormone therapy should never be started after menopause."
Many healthy women older than 60 years of age or over 10 years past menopause are appropriate candidates.
 - 

"You must stop hormone therapy at age 60 or 65."
There is no mandatory age to discontinue therapy. Treatment benefits are apparent into the 70's and 80's. Our society is living longer and desires more vitality with age.
 - 

"Vaginal estrogen is as risky as systemic estrogen."
Low-dose vaginal estrogen has minimal systemic absorption and is considered safe for many women.
 - 

"Weight gain is simply part of aging."
Estrogen deficiency contributes to changes in body composition, visceral fat accumulation, insulin resistance, and loss of lean muscle mass.
 - 

"Hormone therapy is only for symptom relief."
Restoring and balancing hormones has a positive longevity effect on almost every system in the body.
-   **The truth matters.** Accurate information empowers women to make informed decisions about their health. 

SPECIAL PROMO:

--Free Estrogen Panel for Women--

Offer expires 7/16/26.

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Be on the lookout for next week's newsletter, "*Game-Changing Testosterone Replacement Has Arrived...No Needles!*"

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