Advancing Menopause Care: The Practical Framework for Hormone Therapy

Jessica Chandler, DO, FACOOG, MSCP

Essentials of Clinical Medicine

CME Conference

June 14, 2026

LEGACY
Education Group

DISCLOSURE

I HAVE NO FINANCIAL DISCLOSURES

LEGACY
Education Group

OBJECTIVES

01 Differentiate Key Indicators And Contraindications For Menopause Hormone Therapy

02 Evaluate Patient Factors That Guide Safe And Appropriate Hormone Therapy Use

03 Select Optimal Hormone Therapy Formulations, Doses, And Delivery Routes

04 Apply A Patient-centered framework To Initiate And manage Hormone Therapy

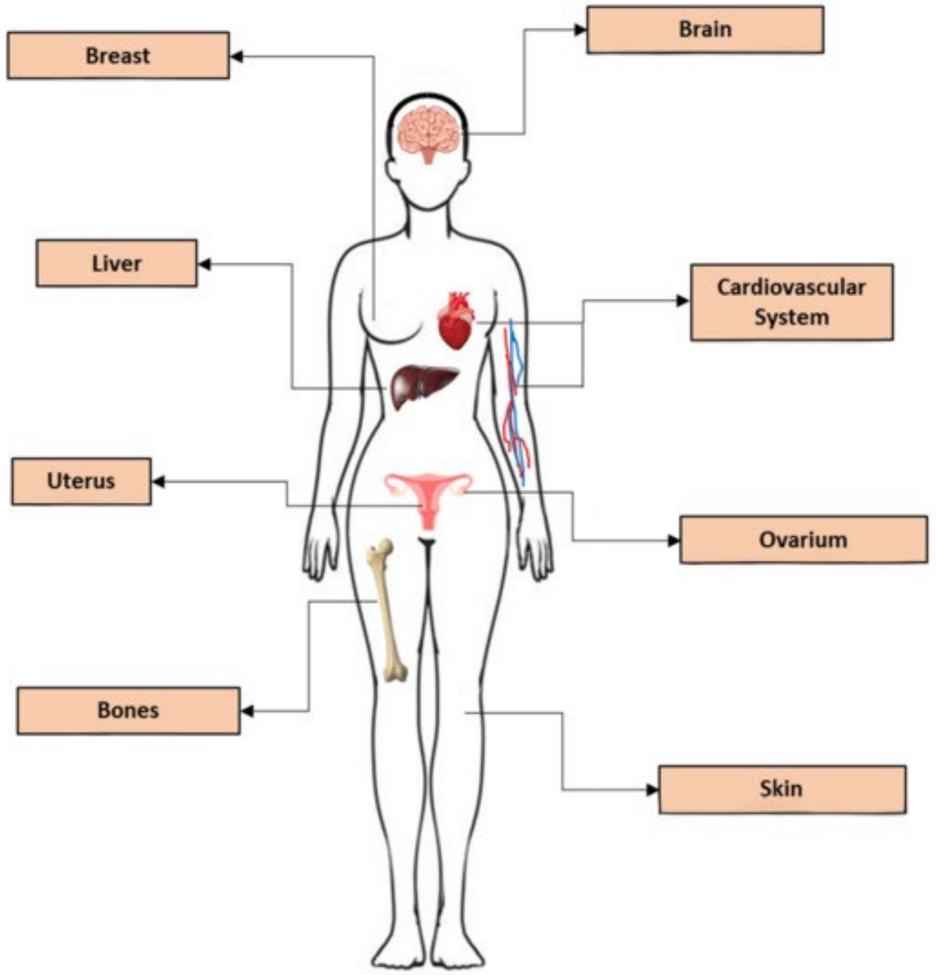
LEGACY
Education Group

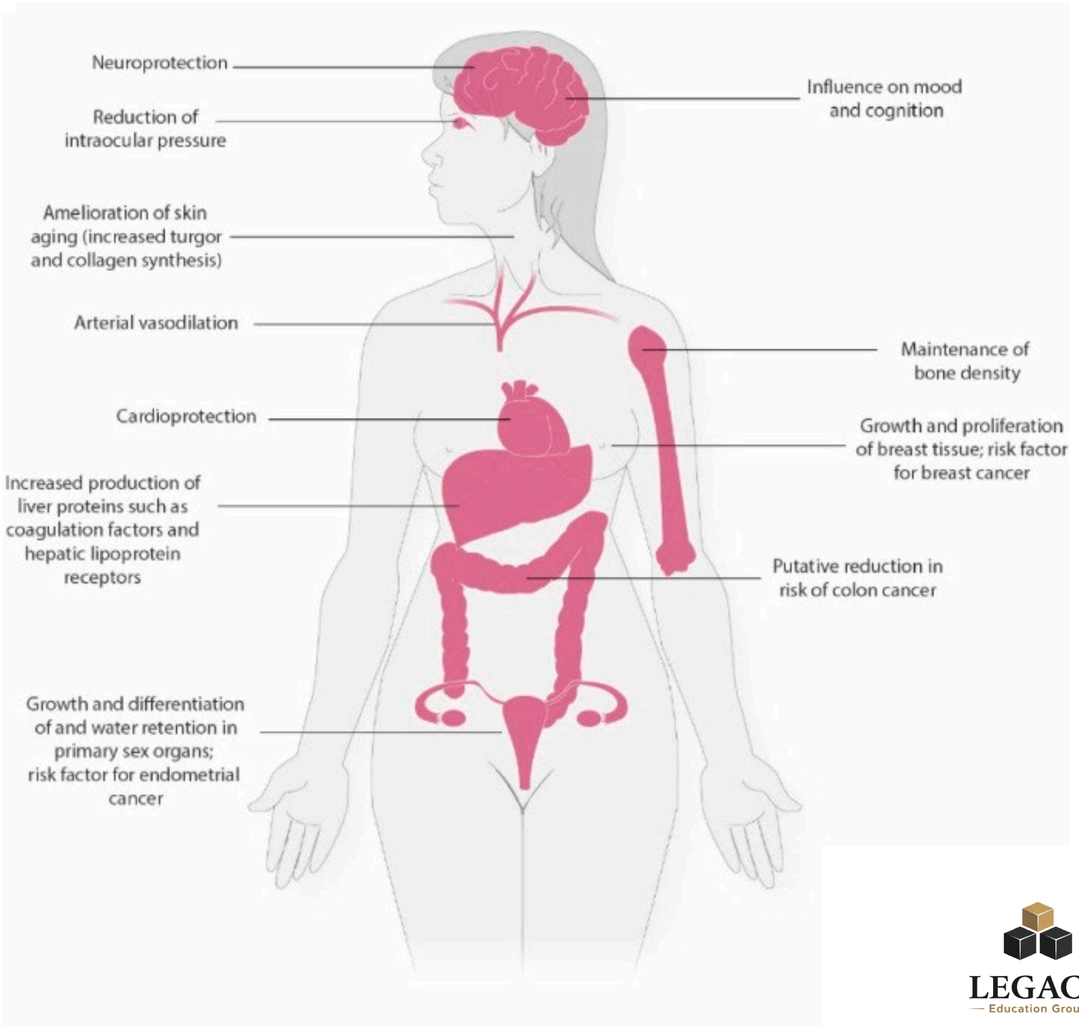
Abbreviations

CEE = Conjugated Equine Estrogen
FDA = Food and Drug Administration
GSM = Genitourinary Syndrome of Menopause
LNG = Levonorgestrel
MHT = Menopause Hormone Therapy
MP = Micronized progesterone
MPA = Medroxyprogesterone Acetate
SXS = Signs and symptoms
VMS = Vasomotor Symptoms
WHI = Women's Health Initiative

LEGACY
Education Group

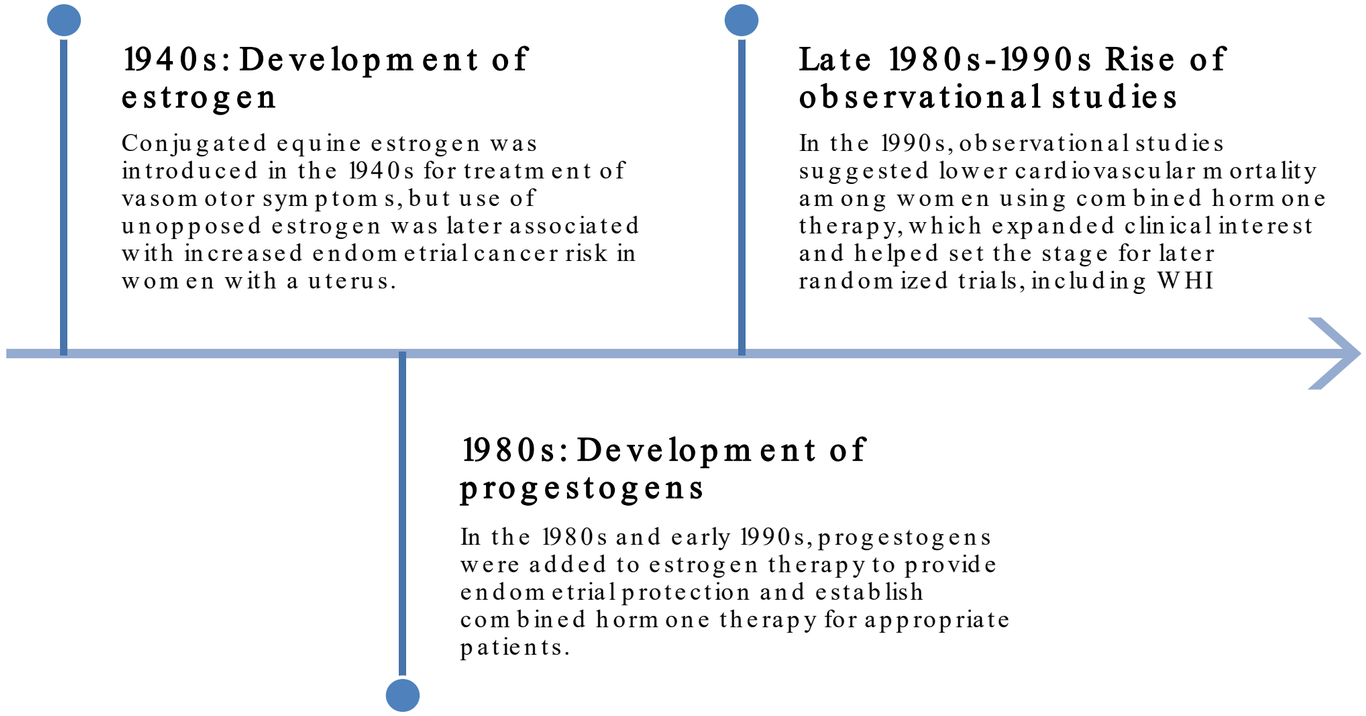
Estrogen Receptors





LEGACY
Education Group

History Of Menopause Hormone Therapy



- **1942** – Conjugated equine estrogen first introduced. *Approximately 20 million HT prescriptions prescribed*
- **1975 -** Endometrial cancer risk recognized. *60 million+ HT prescriptions.*
- **1980 -** Combined estrogen + progestin introduced. *Less than 40 million HT prescriptions.*
- **1990s -** Nurses Health Study (1991) + PEPI (1995) published + HERS Trial Published (1998). *Between 80-100+ million HT prescriptions*
- **2002 -** WHI Trial published. *Less than 80 million HT prescriptions.*

LEGACY
Education Group

OBJECTIVE

01 Differentiate Key Indicators And Contraindications For Menopause Hormone Therapy

LEGACY
Education Group

Indications For Hormone Therapy

Women with natural and surgical menopause having distressing vasomotor and/or vulvovaginal symptoms.

LEGACY
Education Group

FDA-Approved Indications For Hormone Therapy

- **Moderate to severe VMS**
- Hypoestrogenism due to hypogonadism
- Bilateral oophorectomy
- Primary ovarian insufficiency
- Vulvovaginal symptoms
- **PREVENTION of osteoporosis**

LEGACY
Education Group

Contraindications to Estrogen Hormone Therapy

- A history of estrogen-sensitive cancer
- A history of liver disease
- A history of thromboembolic strokes
- Unexplained vaginal bleeding*

LEGACY
Education Group

OBJECTIVE

02 Evaluate Patient Factors That Guide Safe and Appropriate Hormone Therapy Use

LEGACY
Education Group

Importance Of Patient-specific Assessment

- Past Medical history
- Medications
- Social history
- Obstetrical history
- Gynecologic history

LEGACY
Education Group

Key Elements of Patient History

- History of VTE
- History of Stroke
- History of Liver Disease
- History of Estrogen-Sensitive Cancer
- Cardiovascular Risk Score

LEGACY
Education Group

Obstetrical and Gynecologic History

- Obstetrical History
  - History of preeclampsia
  - History of gestational diabetes?
- Gynecologic History
  - Do they have a diagnosis of Polyendocrine Metabolic Ovarian Syndrome?
  - Age of final menstrual period?
  - Does the patient still have their ovaries?
    - If not, her age when they were removed?

LEGACY
Education Group

Assessing Cardiovascular Risk

LEGACY
Education Group

Menopausal Hormone Therapy

Low Risk HT
- Recent menopause
- Normal weight
- Normal blood pressure
- Physically active
- 10 year ASCVD risk <5%
- Low risk for breast cancer

Intermediate Risk HT
- Diabetes
- Smoking
- HTN
- Obesity
- Sedentary/ Limited mobility
- Autoimmune disease
- Hyperlipidemia
- Metabolic syndrome
- 10 years ASCVD risk ≥ 5 - 10%
- High risk for breast cancer

High Risk HT*
- Congenital heart disease
- ASCVD/CAD/PAD
- Venous thrombosis or pulmonary embolism
- Stroke/TIA or MI
- Breast cancer
- 10 year ASCVD risk ≥10%*

LEGACY
Education Group

OBJECTIVE

03 Select Optimal Hormone Therapy Formulations, Dosing, and Delivery Routes

LEGACY
Education Group

Formulations

- Estrogen
  - Oral
  - Transdermal
  - Vaginal formulations

- Progestogen
  - Oral
  - Vaginal
  - Transdermal*
  - Intrauterine

LEGACY
Education Group

Formulations

- Hormone therapy is metabolized by our liver - *the location of clotting factor production.*

- CVD risk will influence *oral* route vs *transdermal* route.

LEGACY
Education Group

Delivery Options

- Progestogens in oral, transdermal patch, and intrauterine delivery*
- Giving unopposed estrogen will increase the development of hyperplasia within the uterine cavity

LEGACY
Education Group

Delivery options & Cancer risk

- Estrogen-only therapy is not associated with an increased risk of breast cancer.
- Micronized progesterone is associated with fewer rates of breast cancer.

LEGACY
Education Group

Dosing – How Much Is Enough

Bone protection and VMS relief is noted in:

- 1-2 mg of oral estradiol
- 25-50 micrograms of transdermal.

LEGACY
Education Group

How Long Do I Treat?

The thought of "lowest dose for shortest time" is not based upon validate research. Now the decision to discontinue is based upon patient preference and risk factors. Even beyond the age of 65, the route of delivery may need to change, but there is no need to discontinue unless contraindications develop.

LEGACY
Education Group

Progestogen Dose

Drug	Cyclical Dose	Continuous Dosing
Micronized Progesterone	200 mg Orally – 12 days/cycle	100mg PO daily
Medroxyprogesterone acetate (MPA)	10mg – 12 days a month	*Minimum* 2.5mg daily
Norethinedrone Acetate (NETA)	5mg – 12 days a month	
Drospirenone 4 mg (Slynd) *		One 4mg *active hormone* tablet daily
		*Omit the 4 *hormone-free* pills

LEGACY
Education Group

Estrogen Dose

Method of Delivery	Composition	Product Name	Dosage, mg/d
Oral	Conjugated Estrogen		0.3, 0.625, 1.25
	17β-estradiol		0.5, 1.0, 2.0
Transdermal	17β-estradiol matrix patch		0.025, 0.0375, 0.05, 0.075, 0.1 once/week
		Vivelle	0.025, 0.0375, 0.05, 0.075, 0.1 twice/week
		Vivelle-Dot	0.025, 0.0375, 0.05, 0.075, 0.1 twice/week
	17β-estradiol transdermal gel	Divigel	0.25, 0.5, and 1.0 g/d

LEGACY
Education Group

Approximate Equivalent Estrogen Dose

Method of Delivery	Composition	Dosage
Oral	Conjugated Estrogen (CE)	0.625 mg
	Ethinylestradiol	0.005 – 0.015 mg
	17β-estradiol	1.0 mg
Transdermal/Topical	Estradiol patch	0.05 mg
	Estradiol gel	1.5 mg/2 metered doses *Divige1* 0.1 mg/day
Vaginal	17β-estradiol	0.5 mg

LEGACY
Education Group

When To Start?

As soon as possible as long as the patient:

- Has no contraindications to use
- Is not beyond 10 years of post-menopause
- Is not over the age of 65

LEGACY
Education Group

Vaginal estrogen

Low-dose vaginal estrogen is indicated to treat GSM.

Safe for breast cancer patients*.

LEGACY
Education Group

Vaginal estrogen

Trade Name	Hormone	FDA-Approved	Dose
Premarin vaginal 0.625 gm	Conjugated equine estrogens	Yes	0.5–2 gm qd × 2–3 week ➢ off 1 week ➢ repeat prn
Estrace vaginal 0.01% cream	Estradiol	Yes	1gm qd x 14 days, then biweekly to triweekly
Estring 2 mg	Estradiol	Yes	One ring every 3 months
Estradiol Tablet 4 mcg, 10 mcg	Estradiol	Yes	1 tablet per vagina for 14 days, then insert twice weekly

LEGACY
Education Group

OBJECTIVES

04 Apply A Patient-Centered Framework to Initiate and Manage Hormone Therapy

LEGACY
Education Group

Brenda

Brenda is a 52-year-old. She has a history of thyroid disease, and she reports her final menstrual cycle was over one year ago. She's not had spotting since that time. She does, however, report hot flashes that are keeping her awake at night and interrupting her sleep. She finds that she also sweats profusely throughout the day and it impacts her work. She is in inquiring about starting hormone-based therapy.

What are her options?

What information do you need to know?

LEGACY
Education Group

Br e n d a

Age:

SXS:

Uterus Present:

PMHx:

Formulation Options:

LEGACY
Education Group

Joanna

Joanna is 50 and presents for follow-up and she wasn't so initiation hormone therapy. She had undergone a hysterectomy with uterine fibroids at the age of 49. Both ovaries remain, and prior to her hysterectomy, she began having hot flashes at age 48. She would like to discuss initiating estrogen-based therapy to help with her hot flashes. Her PMx is significant for HTN as well as preeclampsia during her last delivery. Her blood pressure in the office today is 125/84. She takes amlodipine once per day. You reviewed her labs and her lipid profile was within normal limits.

What are her options for estrogen therapy?

Does she need progesterone?

LEGACY
Education Group

Joanna

Age:

SXS:

Uterus Present:

PMHx:

Formulation Options:

LEGACY
Education Group

Gail

Gail is a 68-year-old female who presents to your office to inquire about treatment options for her vaginal dryness. She has tried lubricants and moisturizers, none of which were helpful. She is hesitant to try hormone therapy because she was diagnosed with breast cancer when she was 47 years old. At the time it was stage one, it was treated with a lumpectomy, and no additional treatments were required. She continues to get appropriate breast screenings. She's also continuing to get her recommended breast screenings and so far she's had no signs of recurrence.

What are her options?

LEGACY
Education Group

Gail

Age:

SXS:

Uterus Present:

PMHx:

Formulation Options:

LEGACY
Education Group

Leslie

Leslie is a 75-year-old who presents to your office to inquire about the initiation of hormone therapy. She saw on the news that the FDA recently lifted the black box warning, and she is coming in now because she's hearing about all the benefits of estrogen. She is disappointed she was not started on the therapy sooner and hopes it will 'revive her lost youth".

What are her options?

LEGACY
Education Group

Leslie

Age:

SXS:

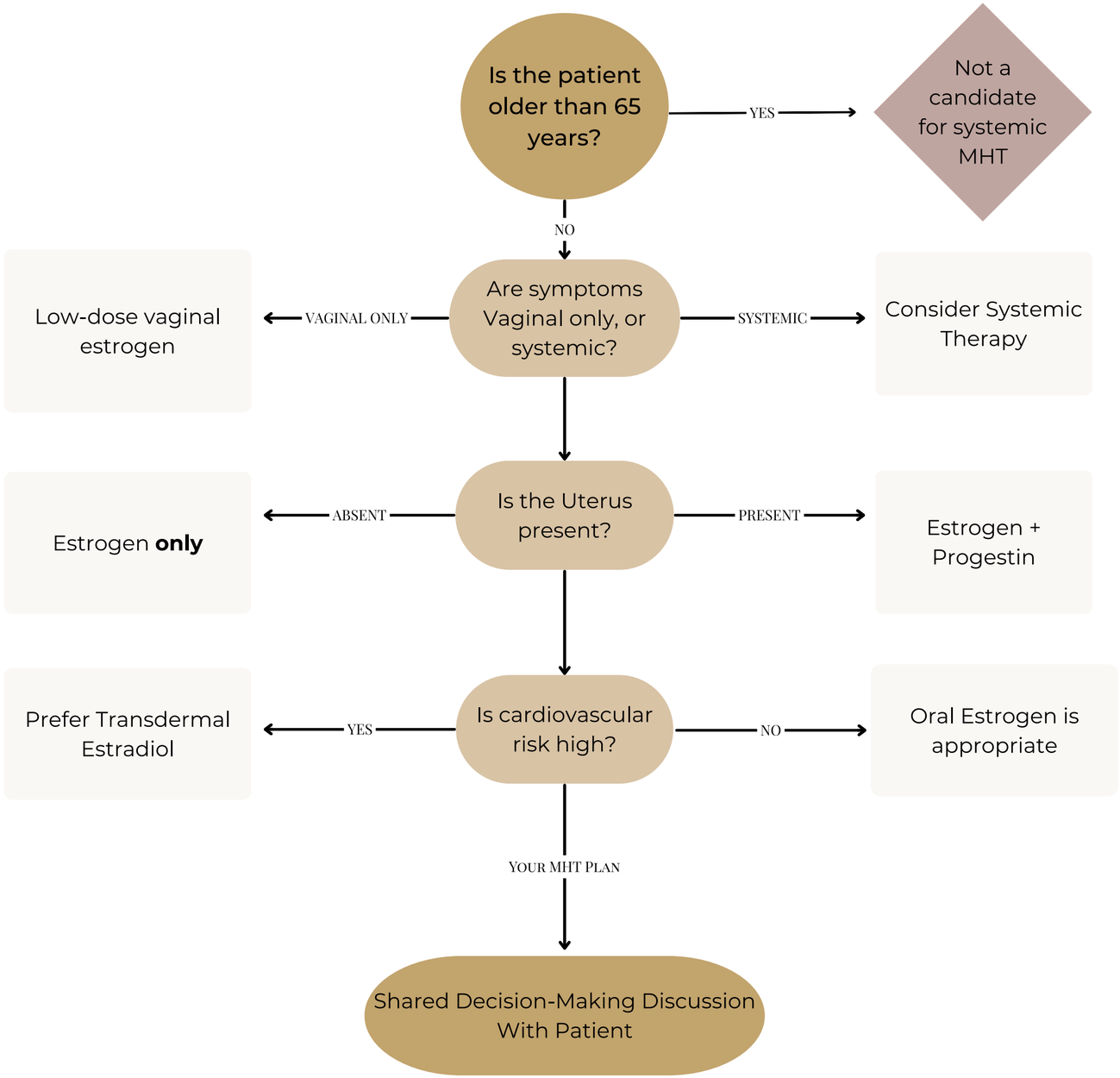
Uterus Present:

PMHx:

Formulation Options:

LEGACY
Education Group

MHT Decision Tree



Key Take Aways

✓ Treat the patient, not the age alone.

✓ Determine whether symptoms are systemic or vaginal only.

✓ Confirm medical history and contraindications.

✓ Assess cardiovascular risk before selecting a route of therapy.

✓ Match the formulation, dose, and duration to the patient's symptoms, goals, and risk profile.

✓ Shared decision-making remains the foundation of successful menopause care.

Scan to access Key Takeaways PDF

LEGACY
Education Group

References

Abenhaim, H. A., Suissa, S., Azoulay, L., Spence, A. R., Czuzoj-Shulman, N., & Tulandi, T. (2022). Menopausal hormone therapy formulation and breast cancer risk. Obstetrics & Gynecology, 139(6), 1103–1110. https://doi.org/10.1097/AOG.0000000000004723

Biason-Lauber, A., & Lang-Muritano, M. (2022). Estrogens: Two nuclear receptors, multiple possibilities. Molecular and Cellular Endocrinology, 554, 111710. https://doi.org/10.1016/j.mce.2022.111710

British Menopause Society. (2026). Progestogens and endometrial protection (BMS Tool for Clinicians). https://thebms.org.uk/wp-content/uploads/2026/05/Progestogens-and-endometrial-protection.pdf

Cho, L., Kaunitz, A. M., Faubion, S. S., Hayes, S. N., Lau, E. S., Pristera, N., Scott, N., Shifren, J. L., Shufelt, C. L., Stuenkel, C. A., & Lindley, K. J. (2023). Rethinking menopausal hormone therapy: For whom, what, when, and how long? Circulation, 147(7), 597–610. https://doi.org/10.1161/CIRCULATIONAHA.122.061559

Depypere, H., & Inki, P. (2015). The levonorgestrel-releasing intrauterine system for endom protection during estrogen replacement therapy: a clinical review. Climacteric, 18(4), 470- https://doi.org/10.3109/13697137.2014.991302

LEGACY
Education Group

References

Faubion, S. S., Crandall, C. J., Davis, L., El Khoudary, S. R., Hodis, H. N., Maki, P. M., Manson, J. E., Pinkerton, J. V., Santoro, N. F., Shifren, J. L., Shufelt, C. L., Thurston, R. C., Wolfman, W. (2022). The 2022 hormone therapy position statement of The North American Menopause Society. Menopause, 29, 767–794. https://doi.org/10.1097/GME.0000000000002028

Panay, N., Ang, S. B., Cheshire, R., Goldstein, S. R., Maki, P., & Nappi, R. E. (2024). Menopause and MHT in 2024: addressing the key controversies – an International Menopause Society White Paper. Climacteric, 27(5), 441–457. https://doi.org/10.1080/13697137.2024.2394950

Panay, N., Fenton, A., Hamoda, H., Hillard, T., Islam, R., ...Pedder, H. (2025). International Menopause Society (IMS) recommendations and key messages on women's midlife health and menopause. Climacteric, 28(6), 634–656. https://doi.org/10.1080/13697137.2025.2585487

Santoro, N., Epperson, C. N., & Mathews, S. B. (2015). Menopausal Symptoms and Their Management. Endocrinology and metabolism clinics of North America, 44(3), 497–515. https://doi.org/10.1016/j.ecl.2015.05.001

Farkas, S., Szabó, A., Hegyi, A. E., Török, B., Fazekas, C. L., Ernszt, D., Kovács, T., & Zelena, D. (2022). Estradiol and Estrogen-like Alternative Therapies in Use: The Importance of the Selective and Non-Classical Actions. Biomedicines, 10(4), 861. https://doi.org/10.3390/biomedicines10040861

LEGACY
Education Group