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Why didn't anyone tell me this?

World Menopause Day Special – The Truth about HRT: Four Experts. Four Perspectives. What Does the Evidence Really Tell Us?

With Professor Susan Davis, Professor Annice Mukherjee, Professor Aimee Spector and Dr Juliet Balfour

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JOYCE HARPER 00:22

For World Menopause Day 2026, I wanted to do something a little bit different. Hormone replacement therapy has become one of the most talked about topics in women's health. It is also one of the most misunderstood. Social media, headlines, and personal stories can make it difficult to separate evidence from opinion, leaving many women confused about the benefits, risks, and limitations of treatment. So I've invited four internationally recognized menopause experts to discuss four areas where women need clearer, evidence-based information about hormone therapy. This includes Professor Susan Davis, Professor Annice Mukherjee, Professor Amiee Spector and Dr. Juliet Balfour, who are going to talk about the truth about HRT for experts, for perspectives. What does the evidence really tell us?

So to start, Juliet Balfour is going to explore what we know and don't know about the benefits and risks of hormone replacement therapy. Juliet is an experienced NHS GP with a long-standing interest in women's health. She is a British menopause society registered menopause specialist with the advanced certificate in menopause care and a member of the BMS Medical Advisory Council.

DR JULIET BALFOUR 01:31

Hello, so I'm going to talk a bit about HRT, hormone replacement therapy, or you might hear it being called MHT, which is menopause hormone therapy, which seems to be the preferred term now. So there's a lot of hype about HRT now, saying everyone needs it, and also there's conversely a lot of scaremongering as well, so I'm going to try and talk a bit about that. So from the hype point of view, not everybody needs it, not everybody wants to take it not everybody can have it due to their medical history and it really doesn't sort out absolutely every midlife symptom sadly. We have to really look at our lifestyle too. But from the point of view who needs it, I want to just first mention a group that really do need HRT if they as long as they don't have any medical contraindications and that's women with early menopause. So if you have POI, which is when your period stopped completely under the age of 40, you really need to try and have HRT at least to the age of 51 unless there's a contraindication and again if you have an early menopause under the age of 45 that still does apply and unfortunately that's because if you don't replace your hormones you are at increased risk of osteoporosis so thinning and fragile bones and cardiovascular disease and cognitive decline but they are a very different group to your average woman and the average age of the menopause which is from 45 to 55 although there are some women now who seem to have stopped their periods later. So, and just to mention for those who can't have HRT, you know, you've got a hormone sensitive cancer or some other condition, there are so many other things that we can give and suggest and do to help you. So please don't feel that there's nothing that can help you. So what are the indications for HRT? So the main indication are symptoms.

So I won't go through them all, I know lots of women start getting symptoms in the perimenopause when they're still having periods, they become irregular. And then some women once they've had their last period still carry on with loads of symptoms after that as well. So if you're getting awful symptoms and they're affecting your life, affecting your sleep, your work, your relationship, then absolutely HRT is a really good thing to try then I've already mentioned the really important group, the early menopause, very early menopause. And another group is those who are either at high risk or have osteoporosis. So unfortunately it's quite strongly genetic. if your mom broke her hip or has definitely had osteoporosis, you are at more increased risk of having it than your average woman. And sometimes women have a DEXA scan and know they've got osteopenia, which is the stage before osteoporosis or they have osteoporosis and those women, idea of having HRT is actually a good option to help treat or prevent that osteoporosis. But with every woman, it's looking at their individual risks and their individual benefits. So I should probably say benefits versus risks rather the other way around because we know that, Nice has said that for most women taking HRT for five years within 10 years of their last period,

For most women, the benefits really do outweigh the risks. And that's because the symptom control is better. And if you're feeling better in yourself, you're then more likely to be able to do the lifestyle things, the exercise, the healthy eating, the reducing stress. You're more likely to be able to do all that if you haven't got less symptoms. And also there is a benefit for your cardiovascular disease. Again, if you start HRT within that window of opportunity, which is within 10 years of your last period or under the age of 60, you may have a reduction in your cardiovascular disease risk and that is your heart disease and your blood vessel disease risk. But it's not reason to take HRT. We don't have enough data and enough clarity to say, every woman must take HRT to prevent cardiovascular disease. We just don't have that evidence at the moment.

We know there's lots of other things you can do to reduce your risk of cardiovascular disease. One thing that you may hear a lot about is HRT reducing the risk of dementia. Sadly, we just do not have that evidence. I did mention that people with early menopause and POI and HRT taken then can reduce their risk of cognitive decline, but they're a very different group to women midlife women and older women. We just don't have the evidence that HRT improves dementia. And in fact, there was one study that showed if you start HRT late over the age of 65, that it might actually slightly increase your risk of dementia. So that is certainly not a reason to take HRT.

So it's all about nuance, it's all about individuality, it's about how bad your symptoms are, what your family history is, what your medical history is, what your fears are, what your worries are about your health. So just let's go onto actual HRT itself.

So the important thing is that you want is estrogen. Estrogen is the brilliant thing that will help your symptoms. And then if you still have a womb, you need to have something to protect the line of the womb. So if you just have oestrogen, it can build up the line of the womb and can develop into abnormal cells or even cancer the lining of the womb. the progesterone for the endometrial protection is very important. And there are lots of different types of progesterone. Some people don't get on with one and you have to try a different one. One brilliant option is the moraine coil that goes in the uterus. That's great because that out contraception and heavy periods and their endometrial protection for the line of the womb. You may have heard of micronized progesterone, which is one of the newer progesterones, which often people like to try because it's got the least risk of breast cancer. And it's also metabolically favorable. Some people love it. It makes them feel calm and sleepy at night. Some people hate it and gives them PMS and PMD and they want to kill everybody and they feel depressed. So again, it's so individual. And then with estrogen,

Some people get on well with a patch or a gel or a spray. Some people, younger women can have oral oestrogen. But as you get older, we prefer oestrogen through the skin because that takes away the risk of any blood clots. And certainly if you get to the age of 60, it's very important you go on transdermal oestrogen. And talking about ages, so there's no arbitrary time limit for how long you have to, you can stay on HRT. Again, it's an individual benefit versus risk decision.

But a of women are deciding to stay on it longer, particularly because of this benefit of reducing the risk of osteoporosis. But very important, it's transdermal, eastern from the age of 60 onwards. And also we often then just gradually reduce the down the dose because you only need a very small dose to protect your bones as you get older. How long to take HRT for also depends on the symptoms and

Hopefully you're feeling better on the HRT, but we don't know whether your symptoms have actually gone until you stop HRT. So that's always a question that people wonder about. And some women, if they're keen to get off HRT, you just slowly stop it, see if the symptoms have come back, and if they don't, then you can stay off it. There are various pushes nowadays. So there's a push for having progesterone when you don't need it, when you've had a hysterectomy, but there's absolutely no evidence of benefit of doing that.

There's also a big push on testosterone. think we're going to talk about test, someone else is going to talk about testosterone, but testosterone is very different to our estrogen. Our estrogen levels drop right down after menopause, whereas with testosterone, we still have reasonable levels that highest in our mid twenties, they're gradually going to go down and then they actually sometimes go up in our sixties. testosterone is not essential, but it can help someone with libido. Again, sadly we have no evidence at the moment that it helps with other things like mood, cognition, stamina, energy. But some people anecdotally do find that. So there are studies going on to look at that. A little bit about doses of estrogen. Some women go, we've got sort of recommended doses and we do gradually go up if needed, but we try not to go above the maximum recommended dose. If something's not working, we try something else rather than just pushing and pushing something that doesn't work and might not be, you might not be absorbing it.

And we don't know the safety of the really, really high doses. Occasionally, now again, I keep talking about women with POI, the really early menopause, sometimes really young women do need higher doses when they're young, but usually midlife women really don't. And that brings me on to another thing, which is starting HRT too early. So there's a great push now for women in their 30s, early 40s to come to the doctor and want to try HRT because they're having a difficult time.

Life is busy in your 30s, 40s, you've got young kids, you've got stressful jobs, you've got grandparents, parents potentially who are ill. It's a busy, busy time. And some women are coming to see us as GPs thinking HRT might help. when you, then you have to do really good history, really delve down into the symptoms and work out whether it could be hormonal or whether it's something else. But a lot of women are actually starting HRT too early. And some women actually, when you find out, they're actually got very cyclical pattern and they'll do much better on a contraceptive pill that stops ovulation rather than going on HRT. And giving HRT to young can cause all sorts of problems because in perimenopause, sometimes you've got really high levels of estrogen and sometimes they drop and things are very erratic. And if you add more estrogen on top of that, women can end up with really heavy bleeding and worse mood problems. So...

There's a lot of, there's a lot of say, nuance, individuality about this. And I just want to mention GSM, Genital Urinary Syndrome with the menopause, really important. Most of us will get it. It's all the symptoms due to lack of estrogen in our vagina, our valve on the outside, in our bladder, and our urethra, the tube that we comes out of, often get lots of symptoms, soreness, irritation, weeing all night, UTIs, painful sex, painful smears, all sorts of things.

And for that, most women, for the vast majority of women, it's safe to have vaginal estrogen, which is tiny doses of estrogen. It's not HRT, doesn't go anywhere else. But if you're getting any of those symptoms, talk to your doctor about vaginal estrogen. Thank you.

> **JOYCE HARPER** 12:21
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> Now let's hand over to Susan Davis, who examines the evidence for testosterone, including who may benefit and who may not. Susan is a Monash University Vice Chancellor's Distinguished Professor and Australian National Health and Medical Research Council L3 Investigator. She has many years of experience in doing the real research behind testosterone and she really knows what the evidence really says.

SUSAN 12:52

So you'd almost have to be living under a rock if you're a midlife woman today and have not heard about the whole discussion about testosterone for women, particularly in the UK and actually in many other countries. So testosterone is a normal female hormone. We make testosterone in our bodies from infancy and throughout life. Testosterone is really important for lots of things in the body, including for the production of an egg every month when a woman goes through a menstrual cycle.

But a lot of things are being attributed to testosterone therapy for postmenopausal women that aren't really substantiated. So, what am I talking about here? Well, okay, what happens to testosterone during a woman's lifespan? Testosterone levels increase at puberty. They are produced by the ovaries and the adrenal glands, and they progressively.

Increase across the menstrual cycle. So when the woman ovulates at that point, she has slightly higher testosterone than at other times in the month. We also know that between the ages of about 20 and 60 years, testosterone levels very slowly decline with age. No big blips. There's no sudden change in testosterone blood levels at menopause. So if a woman is 50, whether she's pre-peri- or post-menopause.

She is likely to have the same testosterone levels as peri and postmenopause women. There doesn't seem to be an impact of natural menopause on blood testosterone levels. Our research and other people's research suggests that women's blood testosterone levels bottom out around the age of 60 and then in some women gradually start to increase. So that by the time women in their 70s and 80s they actually have blood testosterone levels.

Similar to younger women. So a decline with age, no impact of menopause, and then a progressive increase from about the age of 60. What about testosterone therapy? Well, most of the studies have been in postmenopausal women. There's very little data for premenopausal women. Studies have consistently shown that for postmenopausal women bothered by low libido, testosterone can improve libido.

Not for everybody, not dramatically, but certainly can be highly effective for some women. So what about all the claims about testosterone and brain fog, bone health, muscle strength, preventing dementia, cardiac protection, all of these claims that are being made? Well, presently, as of right now, we don't have any evidence for the use of testosterone for anything other than low libido that's bothersome to a woman. The evidence with respect to muscle, bone, cognitive function, dementia prevention, etc., is all very uncertain and inconsistent. Similarly, evidence for mood, fatigue, vitality. Again, we don't have the evidence that women should be on testosterone for to improve mood and well-being. We need more research. There is a very big study going on in the UK at the moment looking at testosterone and well-being after menopause. Our most recent studies do not suggest a benefit of testosterone at appropriate female doses for muscle or for bone. But again, I would put the caveat that we need more research. So right now we understand that many postmenopause women may benefit from testosterone, but it's not an automatic inclusion as part of MHT.

> **JOYCE HARPER** 16:43
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> Now let's hand over to my dear friend, Annice Mukherjee, who is going to discuss menopause management after breast cancer and how women can navigate treatment decisions in this complex area. Anish is an NHS hospital physician and endocrinologist with a medical career spanning nearly 30 years. She specialises in general medicine and endocrinology with a career long interest in complex medical conditions, quality of life in endocrine disease, hormone problems and cancer survivors, and much more.

ANNICE 17:12

I've been seeing a headline recently. Breast cancer survivors should be offered HRT for their long-term health. And it's an important topic, but it's also a complicated one. Of course, women who've had breast cancer want help with menopause symptoms and their future health. They absolutely deserve excellent menopause care, but I am a bit concerned about another message spreading online that HRT after breast cancer is simply safe and that benefits outweigh the risks. The evidence is not that straightforward. Some randomized trials have found an increased risk of

new breast cancer events in women who had a previous history of breast cancer and then take systemic hormone therapy, that's hormones through the body. For example, the habits trial was stopped early because women taking HRT had more new breast cancer events than those who did not. With longer follow-up times, the risk of a new breast cancer event remained higher in the HRT group.

Importantly, most women in the habits trial were taking estradiol combined with the progestogen norothysterone. So this trial tells us something important about systemic HRT after breast cancer, but it does not tell us exactly what the risk would be with every modern HRT preparation. And that distinction does matter. Then there's the liberate trial, which looked at Tibolone, which is a synthetic steroid hormone treatment in women who had had a previous history of breast cancer and that trial was stopped early because tibilone was associated with a higher rate of breast cancer recurrence. That's particularly interesting because in women who had not had breast cancer, some observational studies suggested that tibulone may have a different breast cancer risk profile compared with some other forms of combined HRT. But we can't take reassuring findings in healthy women and assume that they apply to women who have already had breast cancer.

The liberate trial is a good example of why we need to study these questions in women who are we're actually treating. And there's another important point. Some modern HRTs contain modern hormones that are chemically identical to the hormones naturally produced by our bodies, but chemically identical doesn't mean biologically risk free. Taking a hormone as a tablet, patch, or gel is not the same physiological situation as the body producing hormones by itself The dose, the route, the duration of treatment and the tissues exposed all matter. And we still have very limited randomized trial information about systemic hormone therapy with modern preparations. And we've got virtually no information about combinations containing estradiol and micronized progesterone in women who have had a previous history of breast cancer. So we shouldn't pretend that we have evidence that we simply don't have.

It's also important to remember why this is such a difficult decision. Many women who have had breast cancer are treated with tamoxifen or an aromatase inhibitor to reduce the effects of available estrogen. Temoxifen blocks oestrogen receptors, aromatase inhibitors reduce the body's production of estrogen. So adding systemic hormones back into the picture is not a completely natural decision.

Now, some studies have suggested that although systemic HRT may increase the risk of breast cancer events in survivors, this has not clearly translated into an increase in breast cancer mortality in clinical trials. But as someone who has had breast cancer myself, I want to be really honest about this. Any recurrence is a really big deal. Even when a study doesn't demonstrate an increase in mortality, that doesn't make a new breast cancer event any less significant.

And so I think we need to resist two extremes. I don't think we should be told HRT is dangerous, you can never have it, because we don't have that evidence. But I also don't think women should be simply told HRT has more benefits than risks after breast cancer because both statements are too simplistic. And the real conversation is what do we actually know? What don't we know? What are the potential benefits and what are the potential risks for this particular woman?

Because the balance will be different for different women. It also depends on the type and biology of the original breast cancer, the treatment you've had, your risk of recurrence, how severe your menopause symptoms are, and how much they're affecting your life. And also what other treatments you've tried and what alternatives are available. We also need to remember that some estrogen receptor-positive breast cancers can unfortunately recur many years, if not decades, later after the original diagnosis.

And the current studies we have simply cannot tell us everything about the longer-term risks. So, lack of evidence isn't the same as evidence of safety, but equally, uncertainty isn't proof that a treatment can never be used. It means we need to look carefully at the whole picture. I saw a woman in my clinic recently who faced exactly this dilemma. She had severe menopausal symptoms that had not responded to comprehensive trials of non-hormone treatments. She has a busy job.

And an active life and her quality of life was being devastated after she was told to stop her HRT following a breast cancer diagnosis. In her circumstances, after considering her history, her symptoms, and the alternatives that she tried, and the uncertainties, we had a detailed discussion about potential benefits and risks. And we decided together to restart systemic hormone therapy with a plan to review her regularly and minimise her future risks as much as possible.

This was an individual specialist decision, and it's not the right decision for every woman who's had breast cancer. And that's an important point. Not every symptom after breast cancer necessarily is caused by menopause. Some symptoms respond very well to non-hormone treatments, and there are many ways to protect things like your long-term bone health and cardiovascular health without systemic HRT. And for some women, HRT may not be needed or wanted at all.

For others, it may be a reasonable option after a careful specialist discussion, and those needs might change over time. There's also an important distinction between systemic HRT that goes through your whole body and local vaginal estrogen. For women with severe or disruptive vaginal or urinary symptoms who haven't responded to non-hormone treatments, low dose vaginal estrogen can be a really important option because systemic absorption is very low.

But even here there are important considerations after breast cancer, particularly in women taking aromatase inhibitors, and this should be discussed with an appropriate healthcare professional so that a the right decision for that woman is made. So please don't let social media reduce this conversation to HRT is dangerous or HRT is safe. Neither tells you enough. We can't make an informed choice without the full picture.

Without the full picture, we risk making decisions that we might not have otherwise made if we'd known all the relevant information. I'm a medical expert who has specialised in hormone health and the complications of breast cancer throughout my career. And I've had breast cancer myself. My mantra has always been and always will be: women with a history of breast cancer deserve excellent menopause care. We should not be forgotten, but we also deserve the whole story.

> **JOYCE HARPER** 24:51
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> Finally, my colleague from University College London, Amiee Spector, who is going to update us on the latest evidence of whether HRT can reduce the risk of dementia. Amiee is Professor of Clinical Psychology of Aging and Director of the University College London International Cognitive Stimulation Therapy Centre and the Menopause Mind Lab. She's been doing lots of fantastic work on menopause and she is going to tell us what we really know about HRT and dementia.

AIMEE SPECTOR 25:20

So I'm going to talk briefly about the work that we did with the World Health Organisation and this is looking at the link between HRT and later risk of dementia. The reason they asked us to do it, there's so much controversy about HRT and dementia risk. Does it increase our risk of dementia? Can it reduce the risk of dementia? Does it prevent dementia? People want to know and there's lots and lots of mixed messages in the media.

The WHO, the World Health Organisation, had never published guidelines on it before and what they wanted was a really, really robust, up-to-date review of the existing research and evidence so that they could make the right kind of guidelines. And they asked our group to do this and the work was published last year in the Lancet, Healthy Aging and Longevity. And just a quick bit of background as well. We know that dementia is much higher in women and that's why we ask this question, even when we account for age, dementia is higher in women. Could it be due to hormones? Could it be due to taking HRT? And mixed messages. So there are some studies suggesting that women who have dementia are less likely to have taken HRT. These are the observational studies that we look at. So we sometimes see these patterns, but they're very, hard to interpret because what we know is that when people have been taking HRT, they're also more likely to be women who are taking other medication, who have more access to healthcare, who

have better general health conditions and fewer comorbidities. So these patterns don't mean that HRT is reducing dementia, but just that maybe they're more likely to be on HRT because they have a lot of other positive access to healthcare.

And there was also another really big study that was published at the early part of this century, which actually found that HRT doubled the risk of dementia. This was the only randomized controlled trial that we could use. But the problem with that study was that they gave HRT to women who were too old. So they gave it to women over 65, which we think is probably the missing, the kind of window of opportunity. And they also used a version of HRT that we don't use anymore, something called conjugated equine estrogen.

So there's lots and lots of confusion which led them to ask us to do an up-to-date review looking at the best evidence available. So we did a huge search, we got loads and loads of studies and we ended up with 10 studies that we looked at and these were what we thought were the best evidence. So the best quality observational studies and also one randomized controlled trial. And they included data from over 1 million women. And what we found by combining the data looking really closely was that there was no association between taking HRT and later risk of dementia or general cognitive and mild cognitive impairment in older age. So it neither increased nor reduced that risk. What we also concluded was that the studies were not good quality, there was a high risk of bias. So lots of problems with the studies, which meant that if there was any evidence, if there was an association, perhaps the studies hadn't pick them up. We also wanted to look at the types of HRT, the doses of HRT, length of time people have been on it, but we weren't able to look that closely because the data wasn't there. And we also weren't able to look at testosterone. We wanted to see whether testosterone might link to reduced dementia, but there were no trials that looked at that.

So as a result of this study, the WHO guidelines came out in July, and what they've said in their guidelines is that there's insufficient evidence for the recommendation of HRT for reducing cognitive impairment and dementia in people under 65. But they also said that they do not recommend HRT as a way of reducing dementia and cognitive risk for people over 65.

So looking at that study that we mentioned, we think that maybe giving HRT to people over 65 actually comes with a slightly increased risk, albeit a poor quality study. And overall, I think the conclusion is that we really need more research in this space. So we concluded that no association in the research doesn't mean that it doesn't exist, but we certainly don't have the evidence base yet.

> **JOYCE HARPER** 29:55
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> I'd like to thank Juliet, Susan, Annice and Amiee for their brilliant summaries of what we really understand about hormone replacement therapy. And I know you're going to see different things on social media and in the press. These are who I consider the experts. They practice evidence-based medicine and they follow the recommendations of the International European and British Menopause Society. So this, in my view, is what we really know right now about hormone therapy. I know there's going to be some of you out there who do not agree with what they've said. I'd love to hear your comments and we'd have more discussions. Now next year on my podcast, I really want to run some debates. It's causing a little bit of a stir when I'm discussing this with people and they're like, how are you going to do that? I would love to get two people, for example, who have very different differing views on hormone replacement therapy. I can think of two people that really spring to mind on this and I'd love to get them to debate this on this podcast. So watch this space. I'm going to do what I can to get these controversial topics in women's health discussed on my podcast next year. Thank you.

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