Highlights from the NAMS 2022 Hormone Therapy Position Statement include:

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- Hormone therapy remains the gold standard for relieving bothersome hot flashes, night sweats (vasomotor symptoms), and the genital/urinary symptoms tied to menopause (GSM). It also shows clear benefit in preventing bone loss and reducing fracture risk.

- But — one size does not fit all. You've got to individualize care. Use shared decision-making: regularly reassess each woman's risk vs benefit and tailor the dose, duration, delivery method, and regimen to her specific symptom burden and goals.

- We should stratify risk by both age and how far out she is from menopause onset. These influence how favorably the benefit:risk ratio stacks up.

- For most healthy, symptomatic women under age 60 (or within about 10 years from menopause), the benefits of hormone therapy tend to outweigh the risks.

- Using lower doses and transdermal delivery (patch, gel, etc.) may reduce the risks of venous blood clots (VTE) and stroke compared to higher doses and some oral formulations.

- In women who experience primary ovarian insufficiency or have premature/early menopause, they face elevated risks (bone loss, cardiac issues, mood/cognitive impacts). For them, hormone therapy is often recommended at least until the average age of menopause (unless there's a contraindication).

- Beyond age 60 or 65, we don't have robust randomized controlled trial data about long-term hormone therapy. Observational studies hint at a possible (but rare) increase in breast cancer risk with longer durations, so caution and ongoing evaluation are key.

- For women who've survived breast or endometrial cancer and haven't gotten relief from nonhormonal options, research shows that low-dose vaginal estrogen can be a safe and effective next step. It can make a huge difference in comfort and quality of life for those struggling with genitourinary symptoms of menopause (GSM).

- Short-term estrogen-progestogen therapy doesn't appear to raise breast-cancer risk in any meaningful way — and estrogen alone may even lower that risk slightly in certain women.

- Hormone therapy isn't a "stop at 65" situation. For some women, staying on it beyond that age is perfectly reasonable — especially if it's helping manage ongoing hot flashes, improving daily quality of life, or protecting bone density. The key is regular check-ins and individualized risk-benefit discussions.

- When it comes to vaginal or urinary symptoms, local estrogen (and systemic therapy if needed) — or even non-estrogen options — can be used safely at any age and for as long as needed to maintain comfort and tissue health.

- FDA-approved bioidentical options include 17β-estradiol (in patches, gels, sprays, and vaginal forms) and micronized progesterone (Prometrium).

- Synthetic options like conjugated equine estrogens (Premarin) and medroxyprogesterone acetate (Provera) are notidentical to human hormones and have different receptor activity and metabolic profiles.

- The Women's Health Initiative (WHI) used synthetic conjugated equine estrogens + medroxyprogesterone acetate, which is a huge reason the results were so different (and so overgeneralized) compared to bioidentical options.

"The 2022 Hormone Therapy Position Statement of The North American Menopause Society" has been endorsed by more than 20 well-respected international organizations. It can be viewed on the NAMS website: https://menopause.org/wp-content/uploads/professional/nams-2022-hormone-therapy-position-statement.pdf

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