Hormone Replacement is Dangerous? Or is it Dangerous to Not Replace Hormones?

People are prescribed various hormones for all kinds of reasons and of course, there is a whole medical specialty based on hormone use called endocrinology. Most conventional endocrinologists promote synthetic or patented hormone substitutes, which can cause severe problems when taken for human hormone imbalance. Because of these unnatural hormone products, conventional doctors have legitimate concerns about the safety of hormones in general and discourage their patients from taking them, even when a patient's blood test shows obvious deficiency. Even insurance and pharmaceutical companies often argue with providers over the use of preferred natural hormones, because of misinformation. Did you know some **hormones can reduce your risk of death by as much as 30-50%** according to recent research? When this research was first published in 2022, much of conventional medicine just yawned and continued to withhold life-saving medicine (hormones) to their patients out of false fears of side effects and risks. According to the research, "HRT (hormone replacement therapy) … reduces all-cause mortality as well as other age-related diseases with an excellent risk profile. Magnitude and type of HRT associated risks, including breast cancer, stroke, and venous thromboembolism (clots) are rare (<10/10,000 women), not unique to HRT and comparable with other medications." cardiovascular disease (CVD) continues to be the #1 killer of women, causing 1 in every 3.2 deaths. It is actually more prevalent in women than men, causing 64% of women to die from sudden coronary heart disease with no previous symptoms, compared to 50% of men, Also more women than men develop heart failure (22% of women versus 16% of men) and suffer more strokes (7% women vs 4% men) after their first heart attack, with higher incidence of repeat heart attack within 5 years of the first attack (21% of women versus 17% of men). So what's going on here? It turns out, women lag behind men by about 10 years for incidence of heart attacks, and sudden death in women lags behind men by 20 years. This is because pre-menopausal women are protected from cardiovascular disease by their own production of estrogen, whereas for post-menopausal women no longer protected by estrogen, the risk of cardiovascular disease is greater than the risk for men. In other words, once women lose their estrogen, their risk of atherosclerosis quickly catches up with men, and eventually overtakes a man's rate of cardiovascular disease. So why not supply women with lifesaving and quality-of-life-giving natural hormones, once their own supply gets low? **Estrogen not only prevents cardiovascular disease, but also prevents osteoporosis fractures, Alzheimer's disease, tooth loss, and**

many other disorders of aging, including death. "A woman should be fully informed of the risks and benefits of hormone therapy and play an important role in deciding whether to take hormones and which regimen to use."

Unfortunately, estrogen is better at preventing atherosclerotic lesions from forming, rather than reversing lesions once they've formed. More than 40 observational studies show consistent results: **there is a 30-50% reduction in coronary heart disease in hormone replacement therapy users, versus non-users**. Thus, to gain the benefit of using estrogen replacement, a woman should ideally start HRT within 10 years of her menopausal transition, typically before age 60, to gain long-term protection.

How does estrogen compare to statin therapy in reducing coronary artery disease? Surprisingly, estrogen is much more powerful at reducing incidence of CVD versus statin therapy alone. Comparison of hormone replacement initiated in women <60 years old and/or <10 years since menopause, with other primary prevention therapies used in women, **the results are shocking. Hormone replacement significantly reduces all cause mortality and coronary heart disease by 30-50%**, whereas lipid-lowering therapies (statins), aspirin, and ACE inhibitors have neutral effects on CHD progression in women. Yet, cardiologists, and primary care providers, fail to mention this to their recently transitioned post-menopausal women. In fact, most conventional doctors encourage post-menopausal women to go off or avoid hormone replacement, because of the "risks" involved. Here is a typical letter I often receive from my female patients who have recently visited their primary care provider or OB/GYN doctor: Dear Dr. Sherman, I need your advice. I had some lab work done recently through my gynecologist, and she told me I should stop using estrogen. My father died of a stroke and my mother died of breast cancer, and she said estrogen increases the risk of clots and stroke and can cause breast cancer. She cited a study called "The Women's Health Initiative". If I go off my hormones, I get terrible symptoms and feel awful. What would you recommend? I can't tell you how many times I've received a letter like this. It shows the misinformation and lack of understanding of the actual results of the WHI study, and what science has learned since the study results were first published in 2002. A follow-up critique of the WHI study, published soon after the WHI study was halted stated "it is our conclusion that the WHI study had major design flaws that led to adverse conclusions about the positive effects of hormone therapy." The Women's Health Initiative study concluded that the use of CEE (conjugated equine estrogens) plus progestin

(synthetic progesterone) therapy after menopause increased risk for heart disease, stroke, blood clots, breast cancer and dementia. The study was stopped early primarily due to the so-called 'obvious' increase in breast cancer incidence through use of horse estrogen and synthetic progestin. In another post-WHI updated analysis from the National Institute of Health, they found "over an average of about 7 years of follow-up, study participants taking estrogen alone had fewer breast cancer tumors than those in the placebo group. Women in the estrogen group were diagnosed with breast cancer at a rate of 28 per 10,000 participants per year, versus a rate of 34 per 10,000 participants per year in the placebo group." By the way, not all reported estrogen is estrogen…. Most research using the label "estrogen" is actually CEE, or conjugated equine estrogens, which contains over 8 horse estrogens, and totally foreign to the human body. They're great for horses, but not so much for humans. Premarin, a CEE brand, stands for Pre(gnant) Mar(e)- in. A synthetic progestin in the form of medroxyprogesterone acetate (Provera) is also typically used in research, including the WHI study, but it still labeled as 'progesterone'. Remember, the WHI research was based on using non-bioidentical, patented, synthetic hormones, taken in oral form. But it should also be noted that 8 additional breast cancer cases per 10,000 women per year is still considered rare, and similar to, or lower, than breast cancer risk associated with obesity, low physical activity less than 2 glasses of wine daily, being a flight attendant, and commonly used high blood pressure medicines (including ACE inhibitors, beta-blockers, angiotensin receptor blockers (ARBs), calcium channel blockers, and diuretics).

What if a natural bioidentical form of estrogen was used instead of horse urine estrogens? Research in Finland on 489,105 women using only bio-identical estradiol-based regimens from 1994 to 2009 (3.3 million hormone exposure years), revealed **coronary heart disease was reduced by 18 to 54% in HRT users, and positively related to hormone exposure time. Risk of stroke death was also reduced by 18 to 39%. Risk of all-cause mortality was reduced by 12% to 38% almost in linear relationship with duration of hormone exposure.** And surprisingly, all these risk reductions were comparable in women initiating hormone therapy before age 60, as well as those initiating therapy after age 60 or older.

AS OF 2022, THE NORTH AMERICAN MENOPAUSE SOCIETY HAVE CHANGED THEIR GUIDELINES WHICH NOW SAY: "the benefits of hormone therapy outweigh the risks for most symptomatic women who

are aged younger than 60, and within 10 years of menopausal onset." "Transdermal routes of administration may decrease risk of thromboembolism (clots) and stroke." "Low dose vaginal estrogen therapy for treatment of GSM (genitourinary syndrome of menopause) appears safe and effective for select survivors of breast and endometrial cancer." "Breast cancer risk does not increase appreciably with short term use of estrogen (CEE)-progestogen therapy and may be decreased with estrogen alone." "Compounded bioidentical hormone therapy presents safety concerns and is not recommended" (Note: compounding pharmacies are now heavily regulated and considered very safe.) "For women with GSM (genitourinary syndrome of menopause), vaginal estrogen may be used at any age and or extended duration, if needed."

For all you gentlemen out there asking "What about me? How does testosterone affect all this?" This is just as controversial as female hormones, and the research is mixed but gaining clarity. I will address this in future articles but note the following expert opinion on drug safety: Available evidence (as of 2019) indicates that low T represents a risk factor of acute myocardial infarction and its related mortality. Testosterone replacement therapy in low T patients is able to improve angina symptoms in men with ischemic heart disease and exercise ability in patients with heart failure. In addition, T does not increase the risk of heart-related events.

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