

Women's Hormone Replacement Therapy

A library document for women considering evaluation for perimenopause or menopause care: what The Menopause Society actually recommends, what “bioidentical” does and does not mean, when progesterone is required, and why testosterone in women is a narrower question than internet clinics make it.

Jupiter & Palm Beach County, FL

Physician-led · Timothy Mackey, D.O.

4.9 rating · BBB A+

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How to use this book

This is education, not a prescription. It is written so a woman — or the partner helping her decide — can read it through, then follow NovaGenix pages, society guidelines, and original research without having to reconstruct the story from ten marketing sites.

Two jobs at once: high-level patient education, and a durable internal-link resource that supports NovaGenix topical authority on women's hormone therapy in South Florida.

Companion volume. Men's testosterone care is Volume 1. The two books share a clinic and a physician; they do not share doses, indications, or monitoring rules. Do not apply a male TRT protocol to a woman.

About NovaGenix

[NovaGenix](#) is a physician-led clinic in Jupiter, Florida, directed by Timothy Mackey, D.O. Women's care is evaluated individually: history, symptoms, anatomy (uterus present or not), cancer and clot risk, goals, and — when it adds information — laboratories. Evaluation does not guarantee a prescription.

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- Women’s HT program: [Hormone replacement for women](#)
- BHRT overview: [Bioidentical hormone therapy for women](#)
- Testosterone for women: [Testosterone therapy for women](#)

1. Language first: HT, HRT, and BHRT

The Menopause Society prefers **hormone therapy (HT)** over “hormone replacement therapy.”

Menopause at the average age is a life stage, not automatically a deficiency that must be replaced in every woman. That wording is not pedantry. It stops the slide from “treat bothersome symptoms” into “optimize every midlife woman forever.”

Bioidentical means the molecule matches a hormone the human ovary or adrenal gland makes — estradiol, progesterone, testosterone. Some FDA-approved products are bioidentical (estradiol patches, gels, and some oral products; micronized progesterone such as Prometrium). Some compounded creams and capsules are also called bioidentical. The word describes structure. It does not describe regulation, dose accuracy, or safety.

BHRT is not a separate, risk-free category of medicine. A compounded cream is not safer than an FDA-approved estradiol patch because someone stamped “bioidentical” on the jar. NovaGenix says this explicitly on its women’s pages; this book follows that line.

2. Perimenopause is not menopause

Perimenopause is the menopausal transition — often four to eight years, sometimes longer — when ovarian function becomes irregular. Estrogen does not glide downward. It swings. Cycles shorten, skip, flood, or surprise. Sleep, mood, and temperature can fall apart while a woman is still menstruating.

Menopause is a point you can only name looking backward: 12 consecutive months without a period, in the absence of another explanation. The average age in the United States is about 51. After that point a woman is postmenopausal.

Premature ovarian insufficiency / early menopause (before 40, or 40–45) is a different clinical problem. Those women lose estrogen years earlier than expected and generally deserve hormone therapy at least until the average age of natural menopause, unless there is a contraindication. Bone, heart, and cognitive risk are not optional footnotes in that group.

Clinic reading: [Perimenopause vs. menopause](#) and [First signs of menopause](#).

3. What estrogen actually does

Estradiol (E2) is the dominant estrogen of reproductive life. Estrone (E1) becomes more prominent after menopause. Estriol (E3) is the pregnancy estrogen and is not a magic “safer” substitute when it is compounded into an untested cocktail.

Estrogen receptors sit in brain, bone, vessels, skin, breast, uterus, vagina, and bladder. That is why the symptom list is long and why the risk list is not imaginary.

Goal	Estrogen’s usual role	Limit
Vasomotor symptoms (hot flashes, night sweats)	Systemic HT is the most effective treatment	Not every woman needs or wants it
Genitourinary syndrome of menopause	Local vaginal estrogen is often enough	Systemic therapy is not required for GSM alone
Bone	Systemic estrogen prevents bone loss while used	Not first-line osteoporosis drug for every older woman
Sleep and mood	May improve when VMS and night sweats settle	Not an antidepressant and not a guarantee
Weight	May help sleep and comfort	HT is not a weight-loss medication

Clinic reading: [Estrogen levels in women](#).

4. Progesterone exists to protect the uterus — and sometimes to help sleep

If a woman still has a uterus and she takes *systemic* estrogen, she generally needs an adequate progestogen. Unopposed estrogen can drive endometrial hyperplasia and raise endometrial-cancer risk. That is not optional folklore. It is the reason combined regimens exist.

Micronized progesterone is bioidentical and FDA-approved. It is often chosen because it protects the endometrium and, in some women, helps sleep through GABA-receptor effects. Synthetic progestins (used in many studied combinations, including the original WHI regimen) are not identical molecules; they are not automatically “worse,” but they are not interchangeable in conversation or in risk tables.

Low-dose *local* vaginal estrogen is different. Many women using only low-dose vaginal products do not need a systemic progestogen. Product labeling and anatomy still decide that — some vaginal rings are systemic.

Clinic reading: [Progesterone and HRT](#).

5. Symptoms that start the conversation

Classic menopausal

- Hot flashes and night sweats
- Vaginal dryness, pain with sex, recurrent UTIs, urgency
- Cycle chaos in perimenopause
- Sleep fragmentation

Common and multifactorial

- Mood changes, anxiety, “brain fog”
- Joint stiffness
- Weight redistribution
- Lower desire

Desire deserves its own workup. Pain, sleep loss, depression, relationship strain, SSRI effects, and thyroid disease can look like “low hormones.” See [low sex drive in women](#).

6. Who may benefit — the timing window

The 2022 Hormone Therapy Position Statement of The Menopause Society (formerly NAMS) is the spine of modern U.S. counseling:

- HT remains the most effective treatment for vasomotor symptoms and genitourinary syndrome of menopause, and it prevents bone loss and fracture while used.
- For most healthy symptomatic women **younger than 60, or within 10 years of menopause onset**, with no contraindication, the benefit–risk ratio is favorable for bothersome VMS and for prevention of bone loss.

- Starting HT after 60, or more than 10 years after menopause, looks less favorable because absolute risks of coronary disease, stroke, VTE, and dementia are higher.
- HT does not need to be stopped automatically at 60 or 65. Continuation is a shared decision for persistent VMS, quality of life, or bone indications after re-counseling.
- HT is not indicated for primary prevention of heart disease or dementia in women who reach menopause at the average age, and it is not an anti-aging program.

Transdermal estradiol at lower doses may carry less venous-thrombosis and stroke risk than oral estrogen. That is a route decision, not a personality preference.

7. Routes and formulations

Approach	Typical job	Notes
Transdermal estradiol (patch, gel, spray)	Systemic VMS, bone	Avoids first-pass hepatic effect; often preferred when clot risk is a concern
Oral estradiol or conjugated estrogens	Systemic VMS, bone	More first-pass effect; VTE signal higher in many datasets
Micronized progesterone or a progestin	Endometrial protection	Required with systemic estrogen if uterus is present
Low-dose vaginal estrogen, vaginal DHEA, ospemifene	GSM	Local therapy can be used long-term for GSM; not the same as systemic HT
Female-range transdermal testosterone	Selected postmenopausal HSDD	Off-label in the U.S.; physiologic female levels only

Pellets that produce high, unmodifiable levels are a poor fit for the evidence on testosterone in women and are viewed skeptically by ACOG and menopause societies when used as a default “wellness” implant.

8. “Bioidentical” versus compounded — say the quiet part

The Menopause Society’s 2022 statement is blunt about custom-compounded HT: safety concerns include minimal government regulation and monitoring, over- and under-dosing, impurities, lack of

sterility, lack of scientific efficacy and safety data, and lack of a label that outlines risks.

ACOG's 2023 clinical consensus on compounded bioidentical menopausal hormone therapy is in the same key: FDA-approved products first; compounding when there is a documented clinical need (allergy, missing strength or route) rather than a marketing preference; caution on pellets and on salivary "hormone mapping" as a dosing method.

NovaGenix may still use a compounded product when a physician decides an approved option does not meet a specific need. That is ordinary compounding logic. It is not a claim that compounded equals personalized-and-therefore-safer.

9. Testosterone in women is not female TRT

Women make testosterone. Levels are roughly one-tenth to one-twentieth of male concentrations. They decline with age and fall sharply after bilateral oophorectomy. None of that, by itself, creates an indication to treat.

The 2019 Global Consensus Position Statement (Davis et al.), endorsed by the Endocrine Society, The Menopause Society, ISSWSH, IMS and others, is the governing sentence:

The only evidence-based indication for testosterone in women is treatment of postmenopausal women diagnosed with hypoactive sexual desire disorder (HSDD) after a formal biopsychosocial assessment. Doses should approximate physiologic premenopausal female concentrations — not male replacement ranges.

Pooled randomized-trial data (Islam et al., *Lancet Diabetes & Endocrinology*, 2019) show a modest average gain — on the order of one additional satisfying sexual event per month above placebo — plus improvements in desire, arousal, orgasm, pleasure, and sexual distress. Trials do *not* support testosterone for mood, cognition, bone, muscle, hot flashes, energy, or weight loss. A small average weight *increase* appeared in pooled data.

There is no blood-level cutoff that identifies which women have HSDD. Diagnosis is clinical. Direct immunoassays are often unreliable in the female range; LC-MS/MS is preferred when a level is used to keep the dose inside the female physiologic window.

In the United States, as of 2026, no testosterone product is FDA-approved specifically for women. Off-label prescribing is legal and common. It still requires female-strength dosing, transfer precautions, and a stop rule: if there is no meaningful benefit by about six months, stop and rethink the diagnosis.

Virilization (voice deepening, clitoromegaly) can be irreversible. That is why “a little extra for muscle” is not a harmless tweak.

Clinic pages: [Testosterone therapy for women](#) and [Why women take testosterone](#).

10. Risks, the Women’s Health Initiative, and how to talk about breast cancer

WHI (estrogen + medroxyprogesterone acetate in older postmenopausal women, started on average well after menopause) changed the world in 2002. It also got flattened into “HRT causes breast cancer and heart attacks.” The later story is more precise:

- Risks differ by estrogen alone vs estrogen-plus-progestogen, by age and years since menopause, by dose and route, and by baseline risk.
- Estrogen-alone (women without a uterus) and combined regimens do not have identical breast-cancer curves.
- Absolute risk increases, when present, are often small in younger newly menopausal women and larger when therapy is started late.
- VTE and stroke risk are more clearly associated with oral estrogen than with transdermal estradiol in observational and some trial data.
- Systemic HT is generally not recommended in breast-cancer survivors; rare exceptions belong to oncology plus menopause specialists, not a wellness protocol.

The Menopause Society’s later misinformation statement is useful: you cannot honestly say combined estrogen-containing HT has zero breast-cancer association. You also cannot honestly treat WHI as a ban on treating a healthy 52-year-old with severe night sweats.

New postmenopausal bleeding is never “just hormones.” It needs evaluation.

11. Testing and monitoring

Menopause after 45 is usually diagnosed from cycle history and symptoms, not from a single estradiol draw. Hormones lurch in perimenopause; one afternoon number can lie.

Labs still matter when menopause is early or surgical, when the diagnosis is uncertain, when thyroid or other disease is on the table, and when treatment needs a baseline.

NovaGenix Comprehensive Hormone and Wellness Panel for women typically includes:

- CBC and comprehensive metabolic panel
- Testosterone (free and total)
- Estradiol
- TSH
- Progesterone
- Optional when indicated: FSH, IGF-1, cortisol

On treatment, follow symptoms first. Confirm that systemic estrogen users with a uterus have an adequate progestogen plan. Recheck female testosterone if it is prescribed, with an assay that can read the female range. Revisit blood pressure, bleeding pattern, breast-screening schedule, and whether the original goal is still the goal.

12. Nonhormone options belong in the same book

Not every woman wants HT. Not every woman can take it. Reasonable companions include:

- SSRI/SNRI or other nonhormonal prescriptions studied for VMS (including newer neurokinin-targeted agents where labeled)
- Cognitive behavioral therapy for hot flashes and sleep
- Vaginal moisturizers and lubricants before or instead of local estrogen
- Weight-bearing activity and protein for bone and muscle — separately from any peptide or testosterone conversation
- Treatment of sleep apnea, iron deficiency, and depression when those are the actual drivers

Hormone therapy is not the only competent answer to midlife distress. It is the most effective answer to VMS and GSM when it is appropriate.

13. How physician-led women's HT is structured at NovaGenix

1. Listen to what changed, what is intolerable, and what “better” would mean.
2. History: bleeding pattern, surgeries, migraines with aura, clots, cancer, heart disease, medications, prior hormone use.
3. Labs when they add information — not as a ritual that manufactures a prescription.

4. Match tool to goal: systemic HT for VMS, local therapy for GSM, progestogen if the uterus and systemic estrogen share the plan, testosterone only after an HSDD-level assessment.
5. Telehealth for eligible Florida patients when appropriate; some evaluations still need in-person care.
6. Follow-up on bleeding, breasts, mood, blood pressure, symptom score, and whether to continue.

HT is not used as a weight-loss program. Compounded products are not marketed as inherently safer. Testosterone is not dosed like male TRT.

NovaGenix library — pages and posts on this topic

Service pages

[BHRT / women's hormone therapy hub](#)

[Menopause hormone therapy program](#)

[Testosterone therapy for women](#)

[Low sex drive in women](#)

[Contact / consult](#)

[Dr. Timothy Mackey](#)

Educational posts

[Perimenopause vs. menopause](#)

[First signs of menopause](#)

[Estrogen levels in women](#)

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[Why women take testosterone](#)

[Full blog index](#)

More women's hormone pages

[Estrogen therapy for women](#)

[Progesterone therapy for women](#)

[Hormone therapy in Jupiter, FL](#)

[Hormone therapy — practice overview](#)

[Estrogen's role in female health](#)

When weight and thyroid are part of it

[Medically supervised weight loss](#)

[Semaglutide](#)

[Thyroid evaluation and treatment](#)

[All NovaGenix articles](#)

[About the practice](#)

Guidelines, landmark studies, and scholarly articles

Society statements

- [The 2022 Hormone Therapy Position Statement of The North American Menopause Society. Menopause. 2022;29:767-794. Journal: LWW full text. PDF via society: NAMS 2022 PDF.](#)
- [The Menopause Society patient page on hormone therapy.](#)
- [The Menopause Society statement on HT misinformation](#)
- [ACOG: Hormone therapy for menopause \(patient FAQ\)](#)
- ACOG Clinical Consensus No. 6 (2023): Compounded Bioidentical Menopausal Hormone Therapy
- [Davis SR, et al. Global Consensus Position Statement on Testosterone Therapy for Women. JCEM 2019;104:4660-4666. PubMed 31498871](#)
- [Endocrine Society announcement of the 2019 global consensus](#)
- ISSWSH 2021 clinical practice guideline on systemic testosterone for HSDD in women
- Wierman ME, et al. Androgen Therapy in Women: A Reappraisal. JCEM 2014.

Key research

- Women's Health Initiative estrogen-plus-progestin and estrogen-alone trial publications (JAMA 2002 and subsequent long-term follow-up papers)
- NHLBI WHI overview: nhlbi.nih.gov/science/womens-health-initiative-ghi
- Islam RM, et al. Safety and efficacy of testosterone for women: systematic review and meta-analysis. Lancet Diabetes Endocrinol. 2019;7:754-766.

Regulatory

- [FDA: Menopause](#)

- FDA, August 2026 workshop/comment docket noting no FDA-approved testosterone indication specifically for menopausal women

Research institutes and public-education destinations

Societies and government

[The Menopause Society](#)

[American College of Obstetricians and Gynecologists](#)

[Endocrine Society](#)

[International Menopause Society](#)

[ISSWSH](#)

[NIH](#)

[National Institute on Aging — menopause](#)

Health-system explainers

[Mayo Clinic: menopause](#)

[Cleveland Clinic: menopause](#)

[Johns Hopkins: menopause](#)

[Harvard Health: menopause](#)

[MedlinePlus: menopause](#)

Other clinics — comparison, not endorsement

Patients comparison-shop. These organizations are not affiliated with NovaGenix. Use them to compare physician involvement, whether “BHRT” is being sold as risk-free, and whether testosterone is dosed like a male protocol.

National / consumer hormone brands

[Hone Health](#)

[Winona](#)

[Evernow](#)

Academic women's health

For complex cancer history, premature ovarian insufficiency, or unexplained bleeding, a menopause clinic inside a health system or a board-certified gynecologist remains an appropriate second opinion alongside — or instead of — a wellness practice.

Frequently asked questions

▼ Can a blood test diagnose perimenopause?

Usually no. After 45, cycle pattern and symptoms do more work than a single estradiol. Testing helps when menopause is early, surgical, or the story is unclear, and it helps as a treatment baseline.

▼ Is bioidentical HRT safer?

Not as a class. Some FDA-approved products are bioidentical. Compounded products can be appropriate for a specific gap. They are not automatically safer, cleaner, or more effective.

▼ Do I need progesterone?

If you have a uterus and you take systemic estrogen, generally yes. Local low-dose vaginal estrogen is a different product class.

▼ Will hormone therapy make me lose weight?

That is not its job. NovaGenix states this on the women's program page. Sleep and comfort may improve; the scale is a separate medical question (see the forthcoming Volume 3 on medical weight loss).

▼ Should every menopausal woman take testosterone?

No. The evidence-based indication is postmenopausal HSDD after a real sexual-health assessment, at female physiologic levels, with a six-month stop rule if nothing useful happens.

▼ Does HRT cause breast cancer?

It depends on the regimen, duration, and your baseline risk. Combined therapy has a more discussed breast-cancer signal than estrogen-alone in WHI-era data. It is not honest to say “zero,” and it is not honest to say “everyone will get cancer.” Bring your family history and screening record to the visit.

▼ Can this be done by telehealth in Florida?

Often, for eligible patients. Some problems still need an exam. Start at [contact](#).

Glossary

- **VMS** — vasomotor symptoms: hot flashes and night sweats.
- **GSM** — genitourinary syndrome of menopause.
- **HT / MHT** — (menopausal) hormone therapy.
- **POI** — primary ovarian insufficiency.
- **HSDD** — hypoactive sexual desire disorder.
- **Micronized progesterone** — bioidentical oral (or vaginal) progesterone; FDA-approved products exist.
- **WHI** — Women’s Health Initiative.

Medical disclaimer

This educational book is general information. It is not medical advice, a diagnosis, or a promise of outcome. Hormone products are prescription medications. Decisions belong to a licensed clinician who knows the patient. Call 911 for emergencies.

Full clinic disclaimer: novagenix.org/medical-disclaimer.

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Volume 1: [Testosterone Replacement Therapy](#) · Planned: Medical Weight Loss · Regenerative Medicine · Peptides.

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