

by
**Amanda J.
Butler**



The Wellness Column

Dr Franziska Meuschel, the London longevity physician I've mentioned before in this bone series, once said something to me I haven't been able to shake. **"Bone loss,"** she told me, **"tracks oestrogen decline, and that decline can begin in the late-thirties, long before anyone is watching."**

Long before anyone is watching. That phrase has stayed with me. It's also why hormones are the most powerful lever in this whole story and the one women feel least equipped to discuss – not because the evidence is thin, but because for twenty years the subject was all but silenced.

When I was diagnosed with osteoporosis, with a T-score of -3.2, I knew almost nothing about the relationship between hormones and bone. Like most women, I associated menopause with hot flushes, poor sleep and for some, middle-aged spread. I didn't realise that one of its most significant consequences can be unfolding silently inside the skeleton. Talking to friends and reading through chat groups, I realised it wasn't just me: it seems **99% of women are in the dark. When osteoporotic fractures affect one in three women over 50, I find that both concerning and frightening.**

Oestrogen: bone's master switch

Bone is in permanent renovation – one set of cells breaking it down, another building it back up. Oestrogen is the brake on the demolition crew, restraining the cells that break bone down. When it falls at menopause, the brake comes off; breakdown outruns rebuilding, and bone is lost fastest in the first few years after your final period. This is settled cell biology, not fringe theory – and it is why the years around menopause are one of the greatest windows of risk in a woman's life.

The WHI 2002 earthquake

So why were so many women never offered this lever? You have to go back to the Women's Health Initiative, a large American trial. In 2002 the headline that reached the public was blunt: HRT causes breast cancer. Prescriptions collapsed almost overnight. An entire generation came off HRT, or were never offered it at all.

There were two problems. First, the trial population averaged around 63, some with numerous pre-conditions – many well over a decade past menopause, not the symptomatic 50-something who starts HRT today. The research into "what happens if you start HRT in your sixties?", was reported as though it applied to every woman, at every age, on every formulation.

Second, what got buried. **The same study showed roughly 33% fewer hip fractures and around 24% fewer total fractures.** HRT is one of the very few interventions ever shown to cut fractures in women not selected for high risk in the first place – and that barely made the news. Twenty years of follow-up has since refined the rest: the breast cancer signal was tied mainly to oestrogen combined with the synthetic progestin. Oes-



The Hormone Chapter: What HRT Really Does for Your Bones

Starting HRT under 60, or within ten years of menopause, generally gives a favourable balance of symptom relief, bone protection and a neutral-to-favourable heart picture. Start it much later, into arteries that have aged without oestrogen for one or two decades, and the balance can, but by no means definitively, shift the other way.

This is now the organising idea of mainstream menopause medicine, not a fringe position. The Menopause Society's 2022 statement says plainly that HRT prevents bone loss and fracture, and that benefits outweigh risks for most healthy, symptomatic women under 60 and within ten years of menopause. NICE's UK guideline adds something that deserves far wider attention: the benefit is maintained while you are taking HRT, but decreases once you stop.



trogen alone, given to women who had already had a hysterectomy, showed no increase – and in later data was actually linked to lower incidence. "HRT causes breast cancer" was always too crude a sentence. It depends enormously on the formulations and the individual.

As a result the FDA's alarming black box warning was applied even to low-dose vaginal oestrogen creams used purely for local tissue health, with a much lesser effect on the rest of the body. That warning stayed in place for roughly 25 years, and was only removed in 2025.

The window of opportunity

The field has reconciled all of this through what is now called the **timing hypothesis**.

What the specialists say

Of all the practitioners I have consulted across this series, **Dr Meuschel** remains the most carefully balanced voice. She does not take HRT herself, preferring a natural approach for her own health (covered in a future article), but she is clear that she recommends it for patients whose risk profile warrants it. Her words to me were simple: it is a decision made per woman, not per ideology. She would, she said, be a poor doctor if she let her own personal choices dictate her patients' care. Others I have drawn on are more evangelical, describing HRT as among the most powerful – and most grossly under-used – preventive tools available to post-menopausal women. One caution worth flagging honestly: their enthusiasm for tes-

tosterone in women for bone runs somewhat ahead of the guidelines, which currently license it only for low libido, not for bone.

And it is always important to remember that whilst **oestrogen is the headline, it is not the only hormone that matters. Thyroid hormone** sets the pace of bone remodelling – under-treatment harms bone, but so does over-replacement. **Cortisol is catabolic to bone**, which is why **long-term steroid medication is the single commonest cause of drug-induced bone loss.** And **parathyroid hormone**, the body's calcium thermostat, **will quietly pull calcium out of your bones when vitamin D runs low.** None of these is a headline on its own, but together they are the switchboard most of us are never told about.

Something all women want to know - oestrogen for the face, does it work?

Oestrogen receptors sit in the skin too, and falling levels contribute to reduced collagen, hydration and elasticity. Small studies of topical facial oestrogens have reported improvements in skin thickness and fine lines – but the research is short-term and inconsistent, long-term safety is not established, and products made for vaginal use were never tested or approved as skincare. Some enthusiasts swear by it; others want firmer proof – one to discuss with an appropriately qualified clinician, rather than reach for the vaginal cream and start dabbing it under your eyes.

Two more things readers ask me about deserve a brief mention. **DHEA**, the adrenal hormone popular in anti-ageing circles, has mixed bone evidence and no fracture data behind it. The **DUTCH urine test**, is also a key subject, but is too sensitive a topic to unpack here in detail. But if you are sensitive to hormones, or HRT isn't working well for you – it is worth finding a knowledgeable practitioner. I unpack both in more detail in the fuller version of this piece over on Mallorca Wellness Living.

The risks, handled like an adult

I won't close without stating the honest risk picture, because pretending there is no downside would be its own kind of dishonesty. Breast cancer risk is real, however where it exists, appears tied partly to older synthetic progestins, not so much to oestrogen alone, and does not rise appreciably with short-term use. Transdermal oestrogen – patches and gels – carries a lower blood clot and stroke signal than tablets, a distinction the guidelines now accept as fact rather than opinion. Fact is, HRT, like every intervention with real biological effect, genuinely is not suitable for every woman. It is the reason the conversation needs to happen properly, with your own risk factors on the table, rather than being shut down before it starts.

A decision, not a default

If there is one sentence I would want every woman reading this to carry into her next doctor's appointment, it is Dr Meuschel's – **"This is a decision made per woman, not per ideology."** Not a decision made by a headline from 2002. Not by a doctor's personal preference. Not by fear of a label that, in the case of vaginal oestrogen, was applied for a quarter of a century. A decision made by you – armed with your own risk factors, your own symptoms, your own bone density, and a doctor willing to have the fuller conversation.

Sources and a more expanded article are detailed online at MallorcaWellnessLiving.com