

Perimenopause, Bone Health, and Hormone Replacement Strategy

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CLIENT REFERENCE

Ms. C.L. · Age 52

ENGAGEMENT TYPE

Sonnet · Comprehensive Strategy

PRIMARY CONCERN

Perimenopause symptoms, family history of osteoporosis, evaluation of HRT options and long-term bone health strategy

REPORT DATE

May 2026 · Illustrative

CLINICAL SITUATION

Ms. C.L. is a 52-year-old female executive in good general health who has been experiencing perimenopausal symptoms for approximately 18 months. She reports moderate vasomotor symptoms (hot flashes 4–6 times daily, night sweats), sleep disturbance, and reduced concentration affecting her professional performance. FSH and oestradiol results confirm perimenopausal status; last menstrual period 8 months ago.

Her mother sustained a hip fracture at age 68 secondary to osteoporosis. Ms. C.L. has not had a DEXA bone density scan. She is a former light smoker (stopped age 38), drinks alcohol moderately, BMI 23, exercises 3 times weekly. No personal history of breast cancer, DVT, or cardiovascular disease. She is nulliparous.

Her GP has suggested a low-dose combined oral contraceptive as a bridging strategy. Ms. C.L. seeks a more comprehensive, evidence-based approach — including a definitive view on HRT, bone health monitoring, and a restorative preventive medicine framework.

ADVISOR'S FRAMING NOTE

The management of perimenopause has undergone significant evidence-based revision since the Women's Health Initiative data was initially misinterpreted. For healthy women under 60 within 10 years of menopause onset, the benefits of HRT substantially outweigh risks. Ms. C.L.'s profile — no contraindications, significant family history of osteoporosis, active career, early perimenopausal window — makes her an excellent candidate for a considered HRT strategy combined with a proactive bone health programme.

HORMONE REPLACEMENT THERAPY — EVIDENCE AND OPTIONS

Re-analysis of WHI data and subsequent large observational studies have substantially rehabilitated HRT for women in the perimenopausal and early post-menopausal window. The current consensus position of the British Menopause Society, International Menopause Society, and NICE (updated 2023) is that HRT is safe and effective for the majority of symptomatic women under 60.

Oestrogen — Route of Administration

Transdermal (gel, patch, spray) — preferred. Avoids first-pass hepatic metabolism, no increased VTE risk unlike oral. First-line per NICE and BMS.

Oral — remains an option; small increased VTE risk (~2-fold, absolute risk low). Not first-line with cardiovascular risk factors.

Local (vaginal) — addresses genitourinary symptoms; can be used alongside systemic HRT.

Progestogen — Uterine Protection

Micronised progesterone (Utrogestan/Prometrium) — most physiological. Lowest breast cancer risk signal. Favourable effects on sleep. Preferred first-line.

Levonorgestrel IUS (Mirena) — local uterine delivery; minimal systemic absorption. Suitable for women preferring not to take oral medication.

Synthetic progestogens — effective but associated with higher breast cancer risk signal. Avoided where possible.

Recommended Starting Regimen: Transdermal oestradiol gel (0.5–1mg oestradiol daily, titrated to symptom control) + Micronised progesterone 200mg for 12 days per month (sequential regimen, appropriate for perimenopause). Review at 3 months; transition to continuous combined regimen at 12 months post-menopause.

BONE HEALTH — RISK ASSESSMENT AND STRATEGY

Ms. C.L.'s family history of hip fracture represents a significant risk factor. Her FRAX score (10-year fracture risk) should be formally calculated. A DEXA scan is the priority first step. HRT itself is a proven first-line treatment for osteoporosis prevention — oestrogen preserves bone mineral density and reduces fracture risk.

IMMEDIATE ACTIONS

DEXA scan (lumbar spine and hip). FRAX calculation. Vitamin D and calcium levels. Bone turnover markers (CTX, P1NP).

HRT AS BONE PROTECTION

Dual benefit of HRT: symptom control and bone protection. Most physiological intervention available at this life stage.

NUTRITIONAL STRATEGY

Calcium 1,000–1,200mg daily. Vitamin D 1,000–2,000 IU daily. Magnesium 300–400mg. Vitamin K2 (MK-7) 90–180mcg.

EXERCISE PROGRAMME

Weight-bearing exercise 150min/week. Resistance training 2–3×/week. Balance training (yoga, Pilates, tai chi). Ms. C.L.'s existing routine is an excellent foundation.

RECOMMENDED CARE PATHWAY — NEXT STEPS

- 1 WITHIN 4 WEEKS — SPECIALIST MENOPAUSE CLINIC REFERRAL**
Request referral to a specialist menopause clinic or gynaecological endocrinologist. BMS directory (thebms.org.uk) for UK; EMAS directory for Europe.
- 2 WITHIN 6 WEEKS — DEXA SCAN AND BASELINE BLOODS**
DEXA of lumbar spine and hip. Bloods: FSH, oestradiol, testosterone, SHBG, vitamin D, calcium, bone turnover markers. Results guide HRT dosing and additional bone-protective therapy.
- 3 AT 3 MONTHS — HRT REVIEW**
Symptom control assessment, side effect review, dose adjustment if needed. Breast awareness and mammography scheduling. Blood pressure check.
- 4 AT 12 MONTHS — COMPREHENSIVE REVIEW**
Repeat DEXA if baseline showed osteopenia. Reassess menstrual pattern for transition to continuous combined HRT. Review bone turnover markers. Annual mammography.

QUESTIONS TO BRING TO YOUR SPECIALIST APPOINTMENT

- 1** Given my family history of hip fracture, what is my FRAX score and should I start HRT specifically for bone protection, independent of symptoms?
- 2** Would you recommend transdermal oestradiol gel with micronised progesterone as a starting regimen, and what dose would you suggest given my symptom severity?
- 3** At what point would you consider adding a bisphosphonate if my DEXA shows significant osteopenia, and how does HRT interact with bisphosphonate therapy?
- 4** What are your recommendations regarding testosterone supplementation for libido and energy, given that testosterone declines significantly in perimenopause?

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