HRT – types, doses and regimens

Many types of Hormone Replacement Therapy (HRT) are available and there is no one type, dose or regimen that suits all women. It is important to understand which hormones are used, and why and how they are used, so that for each woman who chooses to take HRT, the treatment is individualised to best suit her needs. This should take into account symptoms, medical history, period pattern (if present) and current national and international recommendations and guidelines.

Types and regimens

The main component of HRT is estrogen. As menopausal symptoms and longer-term health consequences are due to low estrogen, HRT aims to replace this hormone.

All HRT preparations contain estrogen which can be taken as a daily tablet, a twice weekly or weekly patch, a daily gel or a daily spray. Often a daily tablet is tried first, but the route is decided by individual preference and past medical and family history. For example, if you have risk factors for venous thromboembolism (VTE) such as being overweight or a past history of VTE, then a patch, gel or spray (transdermal HRT) would be recommended.

Transdermal estrogen does not affect your risk of VTE, whereas the risk can be increased with HRT in tablet form. Tablet estrogen is absorbed by the bowel and it is then broken down by the liver before it reaches the blood stream. Transdermal estrogen acts in a way which more closely represents the way which our ovaries produce estrogen, it is picked up directly by blood vessels and then circulates around the body. However, many of the benefits of HRT shown in trials have used tablet HRT, and many women find that a daily tablet is convenient and suits them well.

If estrogen alone is given, it can stimulate the womb lining and eventually it can increase the risk of womb cancer. To prevent this, progesterone or progestogen is taken in addition to estrogen. If the womb has been removed, estrogen alone can usually be taken.

Micronised progesterone closely resembles the progesterone produced from our ovaries in the second half of a natural cycle, while progestogens are man-made. Progesterone may be associated with less risk, such as the effect on the blood clotting system and on a diagnosis of breast cancer, but the evidence, particularly regarding breast cancer risk, is not strong and many women gain many benefits with little risk from regimens using progestogens.

If you are still having periods (perimenopausal), then progestogen is taken for part of each month's pack. This cyclical progestogen leads to a withdrawal bleed in most women. Sequential HRT is available in combined tablets which provide estrogen alone for the first 14 to 16 days, followed by estrogen plus progestogen for the remaining 14 to 12 days. Sequential HRT is also available in the form of a combined patch.

Copyright © 2026 British Menopause Society. All rights reserved.
Permission granted to reproduce for personal and educational use only. Commercial copying and distribution is prohibited.

At times, it may be necessary to separate the estrogen and progestogen. An example may be an estrogen patch, gel or spray, with micronised progesterone – the progesterone being taken for 12 to 14 days per 28 day cycle, in a dose of 200 mg daily at bedtime. This is a more complicated regimen but may be required for some women.

If your periods have stopped (postmenopausal), continuous combined HRT can be taken which contains estrogen and progestogen every day and the daily progestogen provides protection of the womb lining without causing a monthly bleed (although some bleeding in the first few months is quite common). We know that you are postmenopausal by having had at least a year without periods or by being aged 54 and over, by which time 80% of women have stopped having periods.

Continuous combined HRT is available in the form of a daily tablet or a patch. The gel and spray only provide estrogen so if either of these are chosen, a separate daily progestogen is needed. An example of a continuous combined regimen using micronised progesterone would be Utrogestan 100 mg daily at bedtime along with separate estrogen.

Intrauterine progestogen

Intrauterine devices containing 52 mg levonorgestrel release progestogen directly into the womb and provide excellent protection of the womb lining and bleeding control. They can be used for the progestogen part of HRT for 5 years, and can be used even if contraception is not needed. They allow great flexibility when prescribing estrogen as they protect the womb lining with any dose of estrogen.

Doses of estrogen

Regarding the dose of estrogen, the recommendations are to start with a low dose. Symptoms often respond well to a low dose and there is no need to take more than is required. Starting with a higher dose is more likely to cause side effects.

Sequential preparations in both tablet and patch form are available in low and medium doses of estrogen, with appropriate doses of progestogen.

Tablet form continuous combined preparations are available in a range of estrogen doses: low, medium and high, all with appropriate progestogen included.

Continuous combined patches are available in low and medium doses, offering convenience and reliably proportionate progestogen. You could also use a low dose patch, gel or spay and a separate progestogen, e.g. micronised progesterone 100 mg, taken daily.

Current recommendations advise that the lowest effective dose of estrogen be used, which applies to all therapy areas. For some women, the dose of estrogen may need to be increased to adequately control symptoms and a gradual increase (no sooner than 3 monthly) is in line with recommendations. The lowest effective dose for one woman may be very different to the appropriate effective dose for another. Any need for a change in dose is assessed by the presence, or not, of menopausal symptoms and any side effects. Blood tests to measure hormone levels are rarely needed, nor are they helpful.

Copyright © 2026 British Menopause Society. All rights reserved.
Permission granted to reproduce for personal and educational use only. Commercial copying and distribution is prohibited.

While dose adjustment may be needed, it is also important to address any other factors which may be contributing to symptoms, such as diet and lifestyle. All factors should be considered, rather than solely increasing the dose of estrogen.

In situations when a higher estrogen dose is needed and progesterone is taken separately, great care must be taken to ensure that the progesterone dose is adequate for protection of the womb lining. It should be noted that no data is available for the effect on the womb lining of varying doses of transdermal estrogen and micronised progesterone.

Approximate equivalent doses of estradiol products for those of average menopause age with symptoms (45-55 yrs)

Product	Low	Medium	High†
Oestrogel (gel pump)	1 pump	2-3 pumps	4 pumps
Sandrena (gel sachet)	0.5 mg	1 mg 2 mg*	2.5-3 mg* *See note 2*
Lenzetto (spray)	1-2 sprays	3 sprays 4 sprays*	5-6 sprays* *See note 3*
Patch	25/30/37.5 mcg	40/50/75 mcg	100 mcg
Oral estradiol	0.5 mg	1-2 mg	3 mg* *See note 4*

** Outside of Summary of Product Characteristic licensing.*

† High doses and doses outside of product license should only be considered in exceptional individualised cases and after full discussion about the relative lack of evidence of additional benefit and risks with these doses. If response has not been assessed with other options, consider offering a change of estrogen preparation before increasing the dose above license.

Notes

1. The table has been drawn up as a practical guide based on a combination of pharmacokinetics, clinical trials and clinical experience. The dose equivalents are subject to significant individual variations in absorption and metabolism, so cannot be precise.
2. Sandrena: high doses have been extrapolated from other gel preparations.
3. Lenzetto has a unique mode of action so data cannot be extrapolated: the excipient pushes estradiol through the skin into a reservoir from which it slowly releases. If going above 3 sprays, advise applying these additional sprays to the contralateral side.
4. Oral estradiol: high doses are rarely used in this age group.
5. Doses for those with premature ovarian insufficiency (POI) are not included in this table.

Copyright © 2026 British Menopause Society. All rights reserved.
Permission granted to reproduce for personal and educational use only. Commercial copying and distribution is prohibited.

It should be noted that response to any preparation is unique to each woman, some women responding well to a low dose of one preparation while not responding well to a high dose of another.

You can see different types of HRT at www.menopausematters.co.uk/tree.php.

REVIEWED: MAY 2026

This Women's Health Concern fact sheet provides information and guidance, to be used in consultation with your own healthcare professional. It has been developed by the medical advisory council of the British Menopause Society and it will be updated when guidance changes and/or new data becomes available.

Copyright © 2026 British Menopause Society. All rights reserved.
Permission granted to reproduce for personal and educational use only. Commercial copying and distribution is prohibited.

Reg Charity No: 1015144 Company Reg No: 02759439