

Research Article

Knowledge of menopause and attitudes toward hormone replacement therapy among family physicians: A cross-sectional survey study

 Hande Kurt Güven,  Mehmet Efe Namlı,  Fatma Tunç,  Elif Yılmaz

Department of Obstetrics and Gynecology, Ankara Atatürk Sanatoryum Training and Research Hospital, Ankara, Türkiye

Abstract

Objectives: To assess family physicians' knowledge of menopause and hormone replacement therapy (HRT), their attitudes and referral behaviors, and predictors of adequate knowledge and confidence in counseling.

Methods: This cross-sectional questionnaire study included 250 family physicians. A 25-item instrument assessed demographic and practice characteristics, knowledge of menopause and HRT, attitudes, and referral preferences. A 9-item knowledge score was categorized as low (≤ 4), moderate (5–6), or adequate (≥ 7). Multivariable logistic regression was used to identify predictors of adequate knowledge and counseling confidence.

Results: Overall, 105 respondents (42.0%) were family medicine residents, and 162 (64.8%) were women. Nearly half (46.4%) had received no structured education on menopause or HRT, and only 9.6% regularly followed current guidelines. The mean knowledge score was 6.36 ± 1.74 , and 104 physicians (41.6%) had adequate knowledge. Basic menopause-related questions were answered correctly by most respondents, whereas knowledge of HRT indications (54.4%) and contraindications (43.6%) was weaker. Only 37.6% felt confident counseling patients about HRT, and 40.4% preferred to avoid HRT because of perceived risks. Adequate knowledge was associated with postgraduate training, regular guideline follow-up, and specialist status. Counseling confidence was associated with adequate knowledge and training but was inversely associated with risk-avoidant attitudes.

Conclusion: Family physicians had reasonable basic knowledge of menopause but important HRT-specific knowledge gaps, low counseling confidence, and risk-avoidant attitudes. Structured training and concise guidance may improve menopause management in primary care.

Keywords: Attitudes, Family, Health knowledge, Hormone replacement therapy, Menopause, Physicians, Practice, Primary health care

Cite This Article: Kurt Güven H, Namlı ME, Tunç F, Yılmaz E. Knowledge of menopause and attitudes toward hormone replacement therapy among family physicians: A cross-sectional survey study. EJMI 2026;10(3):378–384.

Address for correspondence: Mehmet Efe Namlı, Department of Obstetrics and Gynecology, Ankara Atatürk Sanatoryum Training and Research Hospital, Ankara, Türkiye

Phone: +90 539 328 01 67 **E-mail:** drmefenamli@gmail.com

Submitted Date: July 17, 2026 **Revised Date:** August 10, 2026 **Accepted Date:** August 14, 2026

©Copyright 2026 by Eurasian Journal of Medicine and Investigation - Available online at www.ejmi.org

OPEN ACCESS This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.



Menopause is a universal reproductive transition, defined retrospectively after 12 consecutive months of amenorrhea following the loss of ovarian follicular activity.^[1] The final years of ovarian function are characterized by increasingly erratic estrogen secretion and declining progesterone production rather than a gradual decline, which helps explain why symptoms during the menopausal transition are highly variable and often unpredictable.^[2,3] Because life expectancy now extends well beyond the age of natural menopause, most women spend approximately one-third of their lives postmenopausally, and many seek care for symptoms such as vasomotor symptoms, sleep disturbances, mood changes, and genitourinary syndrome of menopause (GSM).^[1]

Hormone replacement therapy (HRT) remains the most effective treatment for moderate-to-severe vasomotor symptoms and GSM and is effective in preventing bone loss.^[1,4] Following the initial reports from the Women's Health Initiative, HRT prescribing declined sharply, and a degree of therapeutic caution has persisted among clinicians and patients alike.^[4-6] Subsequent evidence has refined rather than overturned these findings: the balance between benefits and risks depends on a woman's age, time since menopause, formulation and route of administration, and baseline cardiovascular and thrombotic risk, with low absolute risks among symptomatic women who initiate treatment before 60 years of age or within 10 years of menopause.^[1,4] HRT is nevertheless contraindicated or requires caution in several well-defined circumstances, including a history of breast cancer, unexplained vaginal bleeding, active or previous venous thromboembolism, active liver disease, and established coronary or cerebrovascular disease.^[7,8] Two scenarios warrant particular attention in primary care: GSM, which is common yet remains persistently underdiagnosed and undertreated,^[9] and premature ovarian insufficiency, for which early recognition and adequate hormone replacement help protect bone, cardiovascular, and cognitive health.^[10]

In most health care systems, the family physician is the first, and often the only, clinician whom a midlife woman consults regarding menopause.^[11] Primary care therefore carries much of the responsibility for symptom assessment, risk stratification, initial counseling, and timely referral. However, clinician surveys from several countries have repeatedly demonstrated inconsistent knowledge of HRT indications and contraindications, limited confidence in counseling, and reluctance to prescribe HRT driven more by concerns about harm than by individualized risk assessment.^[11-13] Structured education improves both knowledge and preparedness, but such training is inconsistently available during and after residency.^[14] Patients themselves of-

ten hold inaccurate beliefs about menopause and HRT and rely on their physicians to correct them, sometimes in the context of poor-quality information obtained from social media and other lay sources.^[15,16]

Data on menopause-related knowledge and attitudes toward HRT among family physicians in Türkiye are limited, and few studies have examined which characteristics predict adequate knowledge or counseling confidence in this group. We therefore conducted a cross-sectional survey of family physicians to assess their knowledge of menopause and HRT, describe their attitudes and referral behaviors, and identify factors associated with adequate knowledge and confidence in counseling.

Methods

Study Design and Participants

We conducted a cross-sectional, questionnaire-based study among family physicians practicing in Türkiye and reported the study in accordance with the STROBE statement for cross-sectional studies. Eligible participants were family medicine residents, family medicine specialists, and general practitioners providing primary care to adult patients. The questionnaire was distributed electronically through professional networks, and responses were collected online over a one-month period in 2026. Participation was voluntary and anonymous. Physicians who did not provide consent or who did not provide care to adult female patients were excluded. A total of 250 physicians completed the survey and comprised the analytic sample.

Survey Instrument

The instrument was developed by the investigators after reviewing current menopause and HRT guidelines.^[1,4,7] It comprised 25 items organized into four sections. Section A (seven items) addressed demographic and practice characteristics, including age, sex, years in practice, type of institution, monthly volume of peri- and postmenopausal patients, previous menopause/HRT education, and guideline follow-up. Section B (four items) assessed core knowledge of menopause, including the definition of menopause, recognition of menopausal symptoms, the approach to abnormal perimenopausal bleeding, and the domains that should be evaluated during a menopause consultation. Section C (five items) assessed HRT-related knowledge, including the principal purpose of treatment, appropriate indications, contraindications and conditions requiring caution, the need for progestogen for endometrial protection in women with an intact uterus, and the relevance of age and time since menopause to the risk-benefit assessment. Section D (nine items) examined attitudes, clinical

approaches, referral preferences, perceived educational needs, and self-reported difficulties using five-point Likert-scale items, multiple-response items, and single-choice questions.

No previously validated scale was used in this study. Instead, the questionnaire was developed by the investigators to assess clinically relevant domains of menopause knowledge, HRT-related knowledge, counseling confidence, referral behavior, and educational needs among family physicians. The questionnaire content was derived from contemporary menopause and HRT guidance, and the items were reviewed by the investigator team for face and content relevance before distribution.

Scoring and Definitions

A total knowledge score was calculated from the nine knowledge items in Sections B and C. Each item was scored as correct (1) or incorrect (0), yielding a possible score of 0–9. For multiple-response items, a response was considered correct only if the participant selected all appropriate options and no incorrect options. Reference answers were defined a priori according to contemporary guideline recommendations.^[1,4,7] Knowledge was categorized as low (≤ 4 correct responses), moderate (5–6), or adequate (≥ 7). The threshold of ≥ 7 of 9 was defined before the analysis as the operational criterion for adequate knowledge. For Likert-scale items, responses of “agree” and “strongly agree” were combined and categorized as agreement in dichotomous analyses. Confidence in HRT counseling was defined as agreement with the corresponding attitude statement.

This score was developed for descriptive and analytical purposes in the present study and should not be interpreted as a validated knowledge scale.

Statistical Analysis

Categorical variables are presented as counts and percentages, and continuous variables as mean $\pm$ standard deviation. Group comparisons were performed using the chi-square test or Fisher’s exact test for categorical variables and the independent-samples t test for continuous variables, as appropriate. Two multivariable binary logistic regression models were constructed. The first examined predictors of adequate knowledge ($\geq 7/9$), and the second examined predictors of confidence in HRT counseling. Candidate variables were selected on clinical grounds and included professional status, previous postgraduate menopause/HRT education, guideline follow-up, monthly volume of menopausal patients, sex, and, in the confidence model, adequate knowledge. Results are reported as adjusted odds ratios (aORs) with 95% confidence intervals (CIs). A two-sided p value < 0.05 was considered statistically

significant. Statistical analyses were performed using SPSS version 25.

Ethics

The study was approved by the Ethics Committee of Ankara Atatürk Sanatorium Training and Research Hospital (approval no. 2024-BÇEK/619) and was conducted in accordance with the principles of the Declaration of Helsinki. Completion of the questionnaire followed presentation of an electronic informed consent statement, and no identifying information was collected.

Results

A total of 250 family physicians completed the survey and were included in the analysis. Most respondents were early-career physicians: 105 participants were family medicine residents (42.0%), and 77 were family medicine specialists within five years of specialist qualification (30.8%). Overall, 147 physicians (58.8%) were aged ≤ 35 years, and 162 participants (64.8%) were women. More than half of the respondents worked in family health centers (54.8%), while 26.4% were employed in training and research hospitals. Nearly half of the physicians reported no previous structured education on menopause management or hormone replacement therapy (HRT) (46.4%), and only 9.6% reported regularly following current menopause or HRT guidelines (Table 1).

The mean total knowledge score was 6.36 ± 1.74 out of 9. Adequate knowledge, defined as ≥ 7 correct responses, was observed in 104 physicians (41.6%), whereas 94 physicians (37.6%) had moderate knowledge and 52 (20.8%) had low knowledge. Basic menopause-related knowledge was relatively high: 88.0% correctly defined menopause, and 85.2% selected an appropriate risk-based approach to abnormal bleeding during the perimenopausal period. However, knowledge gaps were more evident in HRT-specific domains. Although 78.8% correctly identified the primary purpose of HRT, only 54.4% correctly identified appropriate HRT indications, and 43.6% correctly recognized the major contraindications or conditions requiring caution with systemic HRT. Most respondents knew that progestogen should generally be added for endometrial protection in women with an intact uterus receiving systemic estrogen therapy (82.8%), and 76.8% recognized the importance of age and time since menopause in HRT decision-making (Table 2).

Attitudes toward HRT were mixed. Although 153 physicians (61.2%) agreed or strongly agreed that HRT may be an effective and safe option in appropriately selected patients, only 94 physicians (37.6%) reported feeling confident counseling patients about HRT. A substantial proportion

Table 1. Baseline characteristics of respondents

Variable	n (%)
Total	250 (100)
Age group	
25–30 years	64 (25.6)
31–35 years	83 (33.2)
36–40 years	48 (19.2)
41–45 years	27 (10.8)
46–50 years	18 (7.2)
≥51 years	10 (4.0)
Professional status	
Family medicine resident	105 (42.0)
Recently qualified family medicine specialist, ≤5 years	77 (30.8)
Family medicine specialist, >5 years	48 (19.2)
General practitioner / other primary care physician	20 (8.0)
Previous menopause/HRT education	
Undergraduate only	48 (19.2)
Postgraduate only	54 (21.6)
Both undergraduate and postgraduate	32 (12.8)
None	116 (46.4)
Guideline follow-up	
Regularly	24 (9.6)
Occasionally	73 (29.2)
Rarely	89 (35.6)
Never	64 (25.6)

of respondents, 101 physicians (40.4%), agreed that they generally preferred to avoid HRT because of its perceived risks. Most participants supported an individualized approach that included lifestyle counseling before treatment decisions (91.2%), and 72.4% reported a low threshold for referral to obstetrics and gynecology specialists for menopause management (Table 3).

Referral patterns were strongly influenced by perceived risk. The most commonly selected indications for referral were unexplained vaginal bleeding (95.2%), a history of breast cancer or venous thromboembolism (89.6%), suspected contraindications to HRT (82.8%), and suspected early menopause or premature ovarian insufficiency (73.6%). In contrast, fewer physicians selected treatment-resistant genitourinary symptoms as an indication for referral (59.6%), suggesting a relative knowledge gap in the management of genitourinary syndrome of menopause.

In multivariable logistic regression analysis, adequate knowledge was independently associated with previous

Table 2. Knowledge items and knowledge score distribution

Knowledge domain / item	Correct response, n (%)
Correct definition of menopause	220 (88.0)
Recognition of common menopausal symptoms	166 (66.4)
Risk-based approach to perimenopausal abnormal bleeding	213 (85.2)
Recognition of key assessment domains in menopause	152 (60.8)
Correct identification of the main purpose of HRT	197 (78.8)
Correct identification of HRT indications	136 (54.4)
Correct recognition of systemic HRT contraindications/cautions	109 (43.6)
Knowledge of progestogen requirement in women with uterus	207 (82.8)
Recognition of age/time-since-menopause effect on risk-benefit assessment	192 (76.8)
Total knowledge score, mean ± SD	6.36 ± 1.74
Low knowledge, ≤4/9	52 (20.8)
Moderate knowledge, 5–6/9	94 (37.6)
Adequate knowledge, ≥7/9	104 (41.6)

Table 3. Attitudes and referral preferences of respondents

Variable	n (%)
Attitude items	
Agreed HRT may be effective and safe in selected patients	153 (61.2)
Felt confident counselling patients about HRT	94 (37.6)
Preferred to avoid HRT because of risks	101 (40.4)
Supported lifestyle advice and individualised assessment	228 (91.2)
Reported low threshold for gynaecology referral	181 (72.4)
Needed a concise practical menopause/HRT guide	231 (92.4)
Wanted further menopause/HRT education	220 (88.0)
Referral indications selected	
Unexplained vaginal bleeding	238 (95.2)
Breast cancer or venous thromboembolism history	224 (89.6)
Suspected HRT contraindication	207 (82.8)
Severe/treatment-resistant vasomotor symptoms	174 (69.6)
Early menopause/premature ovarian insufficiency suspicion	184 (73.6)
Treatment-resistant genitourinary symptoms	149 (59.6)

postgraduate menopause/HRT training (adjusted odds ratio [aOR] 2.31, 95% confidence interval [CI] 1.29–4.16; $p=0.005$), regular or occasional guideline follow-up (aOR 2.76, 95% CI 1.56–4.90; $p<0.001$), and specialist status compared with resident/non-specialist status (aOR 1.78, 95% CI 1.02–3.10; $p=0.041$). Monthly exposure to ≥ 11 peri- or postmenopausal patients showed a borderline association with adequate knowledge (aOR 1.69, 95% CI 0.98–2.91; $p=0.059$). In a separate model, confidence in HRT counseling was independently associated with adequate knowledge (aOR 3.48, 95% CI 1.91–6.34; $p<0.001$), postgraduate menopause/HRT training (aOR 2.12, 95% CI 1.15–3.91; $p=0.016$), and regular or occasional guideline follow-up (aOR 2.30, 95% CI 1.25–4.22; $p=0.007$). Conversely, a risk-avoidant attitude toward HRT was negatively associated with counseling confidence (aOR 0.46, 95% CI 0.24–0.88; $p=0.020$) (Table 4).

Overall, 231 respondents (92.4%) stated that they needed a concise, up-to-date, and practical clinical guide for menopause and HRT management, and 220 respondents (88.0%) reported willingness to receive further education. The most frequently reported challenges were risk–benefit counseling (24.8%), recognizing HRT contraindications (20.4%), and identifying appropriate HRT indications (15.6%)

Discussion

In this survey of 250 family physicians, basic knowledge of menopause was reasonably sound, but understanding of HRT was uneven, and attitudes were cautious rather than confident. Most respondents could define menopause and recognized the need for a risk-based approach to abnormal perimenopausal bleeding, yet fewer than half correctly identified contraindications to systemic HRT, and only about half recognized its appropriate indications. This distinction between solid general knowledge and weaker treatment-specific knowledge is the central finding and

has direct clinical implications: a physician who is comfortable explaining menopause but uncertain about who can safely receive HRT may be more likely to default to non-treatment. The overall proportion of respondents with adequate knowledge (41.6%) falls within the moderate range reported in clinician surveys elsewhere, which have similarly identified specific weaknesses in eligibility and safety rather than in basic concepts.^[11–13]

The HRT-specific knowledge gap is clinically important because of the broader context in which treatment decisions are made. Vasomotor symptoms are not only among the most common reasons women seek care but are increasingly associated with adverse autonomic and cardiovascular profiles, making accurate symptom assessment relevant beyond symptom relief alone.^[17] The perimenopausal period in particular, during which irregular cycles, abnormal bleeding, and early menopausal symptoms may overlap, requires clinical judgment that our respondents demonstrated only in part.^[18] The finding that two in five physicians preferred to steer patients away from HRT because of perceived risks echoes the post-Women's Health Initiative pattern of risk-averse prescribing, in which concerns about breast cancer and thrombosis may outweigh individualized risk assessment.^[4,12,13] Such caution is understandable but is not fully aligned with current evidence, which supports treatment for symptomatic women without contraindications, particularly when HRT is initiated before 60 years of age or within 10 years of menopause.^[14] At the same time, genuine contraindications, including thrombophilic states, active smoking in the presence of additional vascular risk factors, and estrogen-sensitive disease, may appropriately preclude systemic therapy even in highly symptomatic women, and recognizing these conditions is essential to safe practice.^[7,19] Reassuringly, most respondents knew that progestogen is required for endometrial protection in women with an intact uterus and recognized the impor-

Table 4. Multivariable logistic regression analyses for adequate knowledge and confidence in HRT counselling

Outcome	Predictor	aOR (95% CI)	p
Adequate knowledge ($\geq 7/9$)	Postgraduate menopause/HRT training	2.31 (1.29–4.16)	0.005
	Regular/occasional guideline follow-up	2.76 (1.56–4.90)	<0.001
	Specialist status vs resident/non-specialist	1.78 (1.02–3.10)	0.041
	≥ 11 menopausal patients/month	1.69 (0.98–2.91)	0.059
	Female sex	1.24 (0.69–2.22)	0.469
Confidence in HRT counselling	Adequate knowledge ($\geq 7/9$)	3.48 (1.91–6.34)	<0.001
	Postgraduate menopause/HRT training	2.12 (1.15–3.91)	0.016
	Regular/occasional guideline follow-up	2.30 (1.25–4.22)	0.007
	Risk-avoidant attitude toward HRT	0.46 (0.24–0.88)	0.020

tance of age and time since menopause, suggesting that the “timing” concept has reached primary care even where more detailed safety knowledge remains limited.^[1,4]

Confidence closely paralleled knowledge. Only 37.6% of respondents felt confident counseling patients about HRT, and confidence was strongly associated with adequate knowledge (aOR 3.48) and previous postgraduate training, whereas a risk-avoidant attitude was associated with lower confidence. Taken together, these associations suggest a potentially modifiable pathway: targeted education may improve knowledge, greater knowledge may support counseling confidence, and greater confidence may reduce reflexive avoidance of an otherwise appropriate therapy. The independent associations of postgraduate training and guideline follow-up with both outcomes further support this interpretation and are consistent with curriculum studies reporting measurable improvements after structured menopause education.^[14] The finding that nearly half of respondents had received no structured education on menopause or HRT and that fewer than one in ten regularly followed guidelines identifies a clear and potentially addressable deficit.

Referral behavior was driven primarily by perceived risk. Physicians readily referred patients with unexplained vaginal bleeding, a history of breast cancer or venous thromboembolism, and suspected contraindications. These are appropriate referral triggers and also underscore the importance of excluding serious gynecological pathology in midlife and postmenopausal women, as presentations such as adnexal masses may mimic malignancy and require specialist evaluation.^[20] Referral for suspected premature ovarian insufficiency was also common, which is appropriate given the importance of prompt diagnosis and adequate hormone replacement in this population.^[10] The weakest referral signal involved treatment-resistant genitourinary symptoms, selected by only 59.6% of respondents. This finding is consistent with the well-documented tendency for GSM to be underrecognized, insufficiently discussed, and undertreated and raises the possibility that some women with manageable but quality-of-life-limiting symptoms may neither receive treatment in primary care nor be referred for further management.^[9] The comparatively modest rates of correctly recognizing menopausal symptoms (66.4%) and relevant assessment domains (60.8%) point in the same direction.

The demand for additional support was notably high: 92.4% of respondents wanted a concise, practical menopause/HRT guide, and 88.0% were willing to undergo further training. This appears to reflect a need not simply for more information but for accessible, point-of-care guid-

ance and is consistent with evidence that the quality and accessibility of menopause-related information, including lay material brought by patients into consultations, are variable and often poor.^[15,16] A brief, locally adapted decision aid addressing indications, contraindications, the need for progestogen, the timing principle, and clear referral thresholds would align closely with the gaps identified in this study.

This study has several limitations. The cross-sectional design precludes causal inference, and the regression findings indicate associations rather than causal relationships. Recruitment through professional networks and use of an online questionnaire may have resulted in overrepresentation of physicians with an interest in the topic and introduced nonresponse and self-selection bias; therefore, a true response rate could not be calculated. Self-reported attitudes and practices are subject to social desirability bias and may not reflect actual prescribing or referral behavior. The questionnaire was developed specifically for this study and was not a previously validated scale. Although its content was based on contemporary menopause and HRT guidance and reviewed by the investigator team for clinical relevance, formal psychometric validation, reliability testing, and external validation were not performed. Accordingly, the knowledge score should be interpreted as an operational measure of guideline-based knowledge rather than as a validated measurement scale. Finally, the study was conducted in a single country, and the cohort was relatively young and weighted toward residents and recently qualified specialists, which may itself be associated with the observed levels of knowledge and confidence.

The overall implication of these findings is that gaps in HRT-specific knowledge and counseling confidence among family physicians may contribute to unnecessarily risk-averse management and greater reliance on specialist referral. The associations of both knowledge and counseling confidence with postgraduate training and guideline follow-up suggest that focused, practice-oriented education and concise clinical decision support may help improve menopause management in primary care.

Conclusion

Family physicians demonstrated adequate basic knowledge of menopause but important gaps in HRT-specific knowledge, particularly regarding indications and contraindications, together with low counseling confidence and a risk-avoidant approach to treatment. Adequate knowledge and confidence were independently associated with postgraduate education and regular guideline use. Given the high demand for practical guidance and further training,

a concise, locally adapted clinical aid combined with structured menopause education embedded in residency training and continuing professional development may help improve menopause care in primary care.

Disclosure

Ethics Committee Approval: The study was conducted according to the guidelines of the Declaration of, Helsinki and approved by the Ethics Committee of Ankara Atatürk Sanatorium Training and Research Hospital (Approval No:2024-BÇEK/619).

Informed Consent: Completion of the questionnaire followed presentation of an electronic informed consent statement, and no identifying information was collected.

Conflict of Interest: The authors declare no conflict of interest.

Funding: This research received no external funding.

Use of AI for Writing Assistance: No generative artificial intelligence tool was used to produce the scientific content, analysis or conclusions of this manuscript.

Author Contribution: Concept: Concept – HKG, MEN; Design – HKG, MEN, FT; Supervision – EY; Fundings – Not stated; Materials – HKG, FT; Data Collection and/or Processing – HKG, MEN, FT; Analysis and/or Interpretation – MEN; Literature Review – MEN; Writing – MEN; Critical Review – EY.

Peer-review: Externally peer-reviewed.

References

1. "The 2022 Hormone Therapy Position Statement of The North American Menopause Society" Advisory Panel. The 2022 hormone therapy position statement of The North American Menopause Society. *Menopause* 2022;29(7):767–94. [\[CrossRef\]](#)
2. Yang JL, Hodara E, Sriprasert I, Shoupe D, Stanczyk FZ. Estrogen deficiency in the menopause and the role of hormone therapy: integrating the findings of basic science research with clinical trials. *Menopause* 2024;31(10):926–39. [\[CrossRef\]](#)
3. Bochynska S, García-Pérez MÁ, Tarín JJ, Szeliga A, Meczekalski B, Cano A. The final phases of ovarian aging: a tale of diverging functional trajectories. *J Clin Med* 2025;14(16):5834. [\[CrossRef\]](#)
4. Cho L, Kaunitz AM, Faubion SS, Hayes SN, Lau ES, Pristera N, et al; ACC CVD in Women Committee. Rethinking menopausal hormone therapy: for whom, what, when, and how long? *Circulation* 2023;147(7):597–610. [\[CrossRef\]](#)
5. Xia W, Khalil RA. Hormone replacement therapy and cardiovascular health in postmenopausal women. *Int J Mol Sci* 2025;26(11):5078. [\[CrossRef\]](#)
6. Yanachkova V, Vasileva-Slaveva M, Kostov S, Yordanov A. Reconsidering hormone replacement therapy: current insights on utilisation in premenopausal and menopausal women: an overview. *J Clin Med* 2025;14:7156. [\[CrossRef\]](#)
7. Kapoor E, Kling JM, Lobo AS, Faubion SS. Menopausal hormone therapy in women with medical conditions. *Best Pract Res Clin Endocrinol Metab* 2021;35:101578. [\[CrossRef\]](#)
8. Goel N, Ranjan M, Sharma JB, Srivastava R, Vardhan S. Use of hormone replacement therapy in special circumstances. *J Midlife Health* 2025;16:6–13. [\[CrossRef\]](#)
9. Danan ER, Sowerby C, Ullman KE, Ensrud K, Forte ML, Zerzan N, et al. Hormonal Treatments and Vaginal Moisturizers for Genitourinary Syndrome of Menopause : A Systematic Review. *Ann Intern Med* 2024;177(10):1400–14. [\[CrossRef\]](#)
10. Panay N, Anderson RA, Bennie A, Cedars M, Davies M, Ee C, et al. Evidence-based guideline: premature ovarian insufficiency. *Hum Reprod Open* 2024;2024(4):hoae065. [\[CrossRef\]](#)
11. Low TL, Cheong AT, Devaraj NK, Ismail R. Prevalence of offering menopause hormone therapy among primary care doctors and its associated factors: a cross-sectional study. *PLoS One* 2024;19(9):e0310994. [\[CrossRef\]](#)
12. Zhu Y, Yang X, Wang Y, Zhu X. Assessment of knowledge, understanding and awareness of Chinese women clinical staff towards menopause hormone therapy: a survey study. *J Obstet Gynaecol* 2023;43:2171779. [\[CrossRef\]](#)
13. Qutob RA, Alaryni A, Alsolamy EN, Al Harbi K, Alammari Y, Al-anazi A, et al. Attitude, practices, and barriers to menopausal hormone therapy among physicians in Saudi Arabia. *Cureus* 2024;16(1):e52049. [\[CrossRef\]](#)
14. Vesco KK, Brooks NB, Francisco MC, Leo MC, Anderson TM, Kalter M, et al. Resident training to optimize patient-focused menopause management: a multispecialty menopause curriculum to enhance knowledge and preparedness. *Menopause* 2024;31(2):93–100. [\[CrossRef\]](#)
15. Rodrigues MAH, Reis ZSN, Verona APA, Teixeira MC, Pappa GL, Soares Junior JM, et al. Climacteric women's perspectives on menopause and hormone therapy: knowledge gaps, fears, and the role of healthcare advice. *PLoS One* 2025;20(5):e0316873. [\[CrossRef\]](#)
16. Ateş Ç. Quality and reliability assessment of Turkish YouTube videos related to polycystic ovary syndrome: a cross-sectional study. *Anatol J Obstet Gynecol Res* 2025;2(3):124–8. [\[CrossRef\]](#)
17. Lee E, Anselmo M, Tahsin CT, Vanden Noven M, Stokes W, Carter JR, et al. Vasomotor symptoms of menopause, autonomic dysfunction, and cardiovascular disease. *Am J Physiol Heart Circ Physiol* 2022;323(6):H1270–80. [\[CrossRef\]](#)
18. Troia L, Martone S, Morgante G, Luisi S. Management of perimenopause disorders: hormonal treatment. *Gynecol Endocrinol* 2021;37(3):195–200. [\[CrossRef\]](#)
19. Kara SS. Asystolic vasovagal syncope temporally associated with perimenopausal hormonal instability: a case report. *Anatol J Obstet Gynecol Res* 2026;3(1):56–61. [\[CrossRef\]](#)
20. Salem AEMA, Abdelrahman NRH, Alboughdadi M, Hosni W. Giant ovarian fibrothecoma in a postmenopausal woman mimicking malignancy with bilateral hydronephrosis: a case report. *Anatol J Obstet Gynecol Res* 2025;2(2):90–3. [\[CrossRef\]](#)