

Systemic Menopause Hormone Therapy (MHT) Equivalency Table

General Guidance and Intended Use: This equivalency table is intended as a general clinical guide to assist healthcare providers in initiating or switching between various estrogen and progestogen formulations commonly used in menopause management. It is **not intended to replace individualized clinical judgment** or account for all patient-specific factors.

Basis of Equivalency The dose equivalencies provided are approximate and based on expert consensus from members of the Canadian Menopause Society (CMS), drawing on international guidelines including the British Menopause Society (BMS) and International Menopause Society (IMS). Where evidence is limited or conflicting, ranges are presented to reflect variability in clinical practice and interpretation of available data. **Dose comparisons are rough equivalencies, as absorption varies both between products and between individuals.**

Trade Name (Active Ingredient)	Ultra Low	Low	Standard Dose	Moderate-High	High (POI/Early Menopause)
ORAL Estrogen					
Estrace (estradiol), tablet	-	0.5 mg	1 mg	2 mg	3-4 mg
Premarin (conjugated estrogen), tablet	-	0.3 mg	0.625 mg	-	1.25 mg
TRANSDERMAL Estrogen					
Estrogel (0.06% estradiol), gel 1 pump = 0.75 mg		1 pump	1 - 2 pumps	2 - 3 pumps	4 pumps
Divigel (0.1% estradiol), gel	0.25 mg sachet	0.5 mg sachet	1.0 mg sachet	1.0 mg + 0.5 mg sachet	1.0 mg sachet x 2
Estradot (estradiol), patch <i>Change twice a week</i>	-	25 - 37.5 mcg	50 mcg	75 mcg	100 mcg
Climara (estradiol), patch <i>Change once a week</i>	-	25 mcg	50 mcg	75 mcg	100 mcg
COMBINATION THERAPIES (Estrogen with the Recommended Dose of Progestogen for Endometrial Protection)					
Bijuva (1 mg estradiol with 100 mg micronized progesterone), capsule	-	-	1 capsule	-	-
Activelle LD (0.5 mg estradiol with 0.1 mg norethindrone), tablet	-	1 tablet	-	-	-
Activelle (1 mg estradiol with 0.5 mg norethindrone), tablet	-	-	1 tablet	-	-
Angeliq (1 mg estradiol with 1 mg drospirenone), tablet	-	-	1 tablet	-	-
Estalis (50 mcg estradiol/ 250 mcg norethindrone), patch <i>Change twice a week</i>	-	-	1 patch	-	-
Estalis (50 mcg estradiol /140 mcg norethindrone), patch <i>Change twice a week</i>	-	-	1 patch	-	-

Progestogen Doses Recommended for Endometrial Protection					
Prometrium (Micronized Progesterone), capsule <i>Continuous (daily)</i>	100 mg	100 mg	100 mg - 200 mg	200 mg	≥ 200 mg
Prometrium (Micronized Progesterone), capsule <i>Cyclical (sequential)</i>	200 mg x 12-14 days each month	200 mg x 12-14 days each month	200 mg x 12-14 days each month	≥ 200 mg x 12-14 days each month	≥ 200 mg x 12-14 days each month
Provera (Medroxy Progesterone Acetate), tablet <i>Continuous (daily)</i>	2.5 mg	2.5 mg	2.5 - 5 mg	5 mg	5 mg
Provera (Medroxy Progesterone Acetate), tablet <i>Cyclical (sequential)</i>	5 mg x 10-12 days each month	5 mg x 10-12 days each month	10 mg x 10-12 days each month	10 mg x 10-12 days each month	10 mg x 10-12 days each month
Norlutate (norethindrone acetate), tablet			5 mg		
Mirena IUS (levonogestrel 52 mg/IUS, up to 5 years)	Yes	Yes	Yes	Yes	Yes
MHT Products Which Do Not Require A Progestogen (Estrogenic effects but formulation also protects endometrial lining)					
Duavive (0.45 mg conjugated estrogen with 20 mg bazedoxifene), tablet			1 tablet		
Tibella (2.5 mg tibolone), tablet			1 tablet		

Footnotes & Guidance Notes

*** Serum Estradiol Levels** These equivalencies are not based on serum estradiol or pharmacokinetic data. No robust head-to-head studies of serum levels across all formulations exist. Clinical response may not correlate with measured blood levels, and routine monitoring of serum estradiol is not recommended for dose adjustment, except in select cases of suspected non-response.

*** Individual Variation** Individual response to estrogen and progesterone therapy can vary significantly due to absorption, metabolism, comorbidities, and concomitant medications. Doses should be adjusted based on **clinical response, patient preference, and tolerability**.

*** Product-Specific Considerations** Not all products and doses are interchangeable. Ultra-low dose formulations (e.g., Divigel 0.25 mg) are not equivalent to standard doses and should be used cautiously when switching.

*** Progestogen Dosing for Endometrial Protection** The recommended doses of micronized progesterone (Prometrium) and medroxyprogesterone acetate (Provera) for endometrial protection are based on consensus and international guidelines.

- *Use of 200 mg daily as a continuous preparation or 300 mg as a sequential preparation may be required when using high-dose estrogen or if unscheduled bleeding occurs even at ultra-low to moderate doses.*
- **Higher doses of estradiol (e.g., in POI or after surgical menopause) often require proportionally higher doses of progestogen to protect the endometrium.**
- *Cyclic regimens are appropriate when MHT is initiated in perimenopause, with progestogen starting on day 12–14 after LMP or last bleed to mimic the luteal phase.*
- **Higher-Dose Indications** Higher doses of estradiol are often indicated in women with **premature ovarian insufficiency (POI)** or after **surgical menopause**, when the goal is not only symptom control but also bone, brain and cardiovascular health.

*** GSM Considerations** At ultra-low to standard systemic doses, genitourinary syndrome of menopause (GSM) may persist. **Local therapy may be added to target GSM** without altering the systemic progestogen requirement. Refer to the 2025 CMS Medication Tables for GSM for details.

*** Expert Opinion & Evolving Evidence** Some recommendations in this table are based on expert opinion and clinical experience, as well as published guidelines. Evidence continues to evolve, and providers are encouraged to stay current with updated literature and guidelines.

*** Monitoring & Follow-Up** Ongoing clinical monitoring is essential. Adjust therapy based on symptom control, side effects, and patient goals. Consider endometrial surveillance (e.g., ultrasound, biopsy) if persistent or unexplained bleeding occurs, particularly in women on higher-dose estrogen or at risk for endometrial pathology.

References:

Key references include guidance from the **Canadian Menopause Society, British Menopause Society, International Menopause Society**, and expert consensus communications among Canadian menopause specialists.

- Nese Yuksel, Debra Evaniuk, Lina Huang, Unjali Malhotra, Jennifer Blake, Wendy Wolfman, Michel Fortier, Guideline No. 422a: Menopause: Vasomotor Symptoms, Prescription Therapeutic Agents, Complementary and Alternative Medicine, Nutrition, and Lifestyle, Journal of Obstetrics and Gynaecology Canada, Volume 43, Issue 10, 2021, Pages 1188-1204.e1, ISSN 1701-2163, <https://doi.org/10.1016/j.jogc.2021.08.003>.
- Manley K, Hillard T, Clark J, Kumar G, Morrison J, Hamoda H, Barber K, Holloway D, Middleton B, Oyston M, Pickering M, Sassarini J, Williams N. Management of unscheduled bleeding on HRT: A joint guideline on behalf of the British Menopause Society, Royal College Obstetricians and Gynaecologists, British Gynaecological Cancer Society, British Society for Gynaecological Endoscopy, Faculty of Sexual and Reproductive Health, Royal College of General Practitioners and Getting it Right First Time. Post Reprod Health. 2024 Jun;30(2):95-116. doi: 10.1177/20533691241254413. Epub 2024 May 14. PMID: 38743767.
- S. R. Davis, S. Taylor, C. Hemachandra, K. Magraith, P. R. Ebeling, F. Jane & R. M. Islam (2023) The 2023 Practitioner's Toolkit for Managing Menopause, Climacteric, 26:6, 517-536, DOI: 10.1080/13697137.2023.2258783
- North American Menopause Society. Menopause Practice: A Clinician's Guide. 6th Ed. The Menopause Society, 2020.