



The University of
Nottingham

UNITED KINGDOM • CHINA • MALAYSIA

Bath, Philip M.W. and Gray, Laura J. (2005) Association between hormone replacement therapy and subsequent stroke: a meta analysis. *British Medical Journal*, 330 . pp. 342-345.

Access from the University of Nottingham repository:

http://eprints.nottingham.ac.uk/434/1/Bath__Gray_HRT_BMJ.pdf

Copyright and reuse:

The Nottingham ePrints service makes this work by researchers of the University of Nottingham available open access under the following conditions.

This article is made available under the University of Nottingham End User licence and may be reused according to the conditions of the licence. For more details see:

http://eprints.nottingham.ac.uk/end_user_agreement.pdf

A note on versions:

The version presented here may differ from the published version or from the version of record. If you wish to cite this item you are advised to consult the publisher's version. Please see the repository url above for details on accessing the published version and note that access may require a subscription.

For more information, please contact eprints@nottingham.ac.uk

Association between hormone replacement therapy and subsequent stroke: a meta analysis.

Philip M W Bath

Stroke Association Professor of Stroke Medicine

Institute of Neuroscience, Queen's Medical Centre, University of Nottingham, NG7 2UH

Guarantor for paper.

Contribution: Drafted paper, collated data

Laura J Gray

Medical statistician

Institute of Neuroscience, Queen's Medical Centre, University of Nottingham, NG7 2UH

Contribution: Reviewed paper, collated data, statistical analysis

Correspondence to:

Professor Philip Bath

Division of Stroke Medicine

University of Nottingham

Queen's Medical Centre

Nottingham NG7 2UH

Tel: 0115 970 9348

Fax: 0115 875 4506

Email: philip.bath@nottingham.ac.uk

All authors declare that the answer to the questions on your competing interest form

(<http://bmj.com/cgi/content/full/317/7154/291/DC1>) are all No and therefore have nothing to declare

ABSTRACT

Objectives: To review systematically completed trial evidence assessing hormone replacement therapy (HRT) to subsequent stroke risk, in particular assessing stroke by pathological type, severity and outcome.

Data sources: Randomised controlled trials of HRT were identified from the Cochrane Library, reviews and reference lists of relevant papers.

Review methods: Rates for cerebrovascular events were extracted, combined and analysed using a random effects model. Sensitivity analyses were defined to explain any heterogeneity, including phase of prevention (primary, secondary), type of HRT (mono/unopposed oestrogen, dual/opposed), type of oestrogen (estradiol, conjugated equine oestrogen), size of trial (<5000, >5000 patients), length of follow-up (≤ 3 years, >3 years), and gender.

Results: Fourteen trials (t), involving 34,976 subjects, were identified. HRT was associated with significant increases in total stroke, odds ratio (95% confidence intervals) 1.29 (1.12-1.47, t=14), non-fatal stroke 1.23 (1.06-1.44, t=11) stroke leading to death or disability/dependency 1.56 (1.11-2.20, t=4), ischaemic stroke 1.28 (1.06-1.56, t=5), and a trend to more fatal stroke 1.28 (0.87-1.88, t=12). HRT was not associated with haemorrhagic stroke 1.06 (0.64-1.75, t=5), or transient ischaemic attack 1.00 (0.75-1.33, t=6). No heterogeneity was present in any analysis.

Conclusions: HRT is associated with an increased risk of stroke, particularly of ischaemic type. Subjects having a stroke on HRT appear to have a worse outcome. HRT cannot be recommended for the prevention of stroke.

INTRODUCTION

Sex steroid hormones are believed to provide women with endogenous protection against cerebrovascular events. Pre-menopausal women have a lower risk of stroke relative to men of the same age^{1 2} whilst the incidence of stroke increases rapidly following the menopause,³ coincident with diminished circulating levels of oestrogen and progesterone. As a result, hormone replacement therapy (HRT) has been used widely for vascular prophylaxis in parallel with its known effects in reducing menopausal symptoms and bone loss. Longitudinal observational studies have suggested that HRT may reduce cardiovascular and cerebrovascular disease.⁴ However, a review of these studies (which also included two randomised trials) found that the number of strokes was increased.⁵ Furthermore, the results of randomised controlled trials (RCT) have given conflicting results with studies either finding no benefit or even apparent hazard. A recent non-systematic review of RCTs found that treatment with HRT was associated with an increased risk of stroke.⁶

The aim of this study was to review systematically completed trial evidence relating HRT to subsequent stroke risk, in particular assessing stroke by pathological type, severity and outcome.

METHODS

Searching

Publications were identified from searches of The Cochrane Library, Embase and Medline (from 1966 to May 2004), in addition the reference lists of previous reviews⁷⁻⁹ and reference the identified articles were made.

Selection

All completed and published randomised controlled trials of HRT against a control group reporting stroke events were included. Publications not reported in English or where event numbers were given for stroke or transient ischaemic attack and not separately were excluded. Trials were found which included both males and females, and in one case males exclusively. It was decided to include both genders in the review but to analyse those trials which included males separately to those which included females only. From the search 18 trials were identified, of which fourteen met our criteria for inclusion. Four trials did not meet our inclusion criteria (table 1).

Quality assessment

Studies were assessed in five areas, including method of randomisation, blinding, reporting of withdrawals, generation of random numbers and allocation concealment. Trials scored one point for each area addressed, therefore receiving a score between 0-5, with 5 reflecting the highest level of quality.¹⁰

Data abstraction

All data were independently extracted by the two authors (LG and PB). Disparities were resolved by consensus.

Study characteristics

Information on trial size, treatment regimen (oestrogen \pm progesterone), length of follow-up and outcome were recorded. Outcomes included stroke events (fatal and non fatal), type of stroke (ischaemic, haemorrhagic, not known), functional outcome (combined death and disability/dependency), and case fatality. Where available, data were also collected on the number of transient ischaemic attacks, but these were not included in the overall stroke outcome. Where obtainable, data related to intention-to-treat analyses.

Quantitative data synthesis

Data were analysed using Stata (version 7) and Cochrane Review Manager (version 4). The effect of HRT on dichotomous outcomes was assessed using the odds ratio calculated using a random effects model since the trials were expected to be heterogeneous. Pre-specified sensitivity analyses were defined to explain any heterogeneity, including phase of prevention (primary, secondary), type of HRT (mono/unopposed oestrogen, dual/opposed), type of oestrogen (estradiol, conjugated equine oestrogen), size of trial (<5000,

>5000 patients), length of follow-up (≤ 3 years, >3 years), gender (females only) and quality (those scoring 5/5 only). Interactions between subgroups and treatment were assessed. Publication bias was examined using Eggers test.¹¹

RESULTS

Study characteristics

Fourteen trials were identified for inclusion involving 34,976 subjects (table 1, figure 1). The trials varied in size between 134¹² and 16,608.¹³ The trials included four investigating primary vascular prevention¹³⁻¹⁶ and nine in patients with prior vascular events: stroke¹⁷⁻¹⁹, ischaemic heart disease²⁰⁻²³ and venous thromboembolism.²⁴ The average age of the patients varied between 55 and 71; three trials not only included post menopausal women but also included men, with one trial including men exclusively.^{12 18 19} Two trials required that women should not have had a hysterectomy.^{13 21} Follow-up varied between 0.9 and 6.8 years. Mono-HRT (oestrogen alone) was studied in seven trials and dual (or opposed) HRT in the others. Both mono and dual comparison arms of the 'Women's Health Initiative Trial' were terminated prematurely due to HRT treatment being associated with hazard.^{13 15} All trials, apart from two^{23 25}, were placebo controlled.

Data quality

Quantitative data synthesis

Stroke occurred in 2.3% of the participants randomised to no HRT and was significantly increased by one-third in those randomised to HRT (figure 2). This increase in stroke resulted from excess ischaemic strokes but not primary intracerebral haemorrhage, as also seen in WHI dual alone.¹³ An early increase in stroke occurred during the first 6 months of treatment in the WEST trial of secondary stroke prevention,¹⁷ analogous to the early increase in CHD events seen in the HERS trial of secondary CHD prevention.²¹

A poor outcome after stroke, judged as combined death and dependency, was increased by half with HRT; a non-significant increase in fatal stroke was also seen. This relationship between HRT and severe stroke was present individually in three trials – HERS, WEST, WHI dual (figure 3).^{13 21 26} HRT did not alter the rate of transient ischaemic attack (table 2). No statistical heterogeneity was seen for any of the stroke outcomes.

Pulmonary embolism was increased by three-quarters in those randomised to HRT (table 2). In contrast, CHD events were not more frequent with HRT. No statistical heterogeneity was observed for either PE or CHD.

Sensitivity analyses were performed on several prognostic factors for the total stroke outcome (table 3). The results of these analyses appear to be driven by the large WHI dual study and significant results are seen for the sub groups which contain this study. However, significant heterogeneity was not present between trials examining primary versus secondary prevention, mono versus dual HRT, CEE versus estradiol, shorter versus longer follow-up, smaller versus larger trials, and those including women and men versus women alone. No significant publication bias was found for the all stroke outcome (Eggers test $p=0.24$).

DISCUSSION

This systematic review supports the results of individual trials and previous reviews finding that HRT does not reduce the risk of stroke in post-menopausal women. Indeed, HRT was associated with an overall increase in the risk of stroke of 27%. This effect was driven by an increase in ischaemic but not haemorrhagic stroke. Importantly, the severity of stroke was increased since the frequency of a poor functional outcome, judged as combined death and disability/dependency, was 56% higher in those randomised to HRT. Similarly, fatal stroke was non-significantly increased.

Why HRT should increase ischaemic stroke and its severity when biological plausibility and previous observational studies suggested it might protect against cerebrovascular events remains unclear. This discrepancy between observational and intervention studies is not unique; for example, whilst antioxidant vitamins might on biological grounds have been expected to protect against vascular disease with observational studies supporting this hypothesis, several large RCTs involving antioxidant vitamins found no beneficial effect.²⁷ A number of possible explanations exist for why HRT promoted stroke. First, it is possible that the results of the RCTs are wrong although this is unlikely since none of the studies were positive, i.e. HRT did not reduce stroke in any study, with 11 trials being neutral and 3 negative. The absence of a beneficial effect on stroke was mirrored for VTE and CHD. If the trials are correct then the observational studies must have been falsely positive. Second, the trials involved either mono or dual HRT. Whilst long-term unopposed oestrogen therapy can promote cause uterine cancer, this would not explain an increase in stroke. In contrast, adding a progestogen could have had detrimental effects since this class of drugs can promote atherogenesis and vasoconstriction.²⁸ This is particularly true for medroxyprogesterone acetate which was used in most of the trials involving dual HRT. Nevertheless, no heterogeneity between trials of mono and dual HRT was present suggesting that oestrogen itself, given as oestradiol or CEE, might be the culprit. Third, within-class differences in HRT may mean that the most appropriate type of oestrogen has yet to be tested adequately; the RCTs assessed either conjugated equine oestrogens or estradiol but not other types such as phytoestrogen.²⁹ However, there was no evidence for statistical heterogeneity between the trials with respect to type of oestrogen.

Fourth, the dose of oestrogen (and progestogen if present) may have been too high. The usually starting dose of CEE and estradiol in the UK in older women are 0.625 mg and 1 mg respectively, although the dose may then be titrated up if menopausal vasomotor symptoms persist. These doses are below those used in several of the trials. Fifth, the delivery route may be important since important pharmacological differences exist between oral and transdermal administration of oestrogen, especially relating to first pass liver metabolism. Sixth, several of the trials may have been too short with a median length of less than 3 years contrasting with the earlier observational studies. Of note, both HERS and WEST found an early vascular hazard which disappeared later.^{21 26} The hazard during the first year of treatment appears to reflect the development of a thrombophilic state which may not persist. This raises the possibility that an extended follow-up would have

revealed long term benefit. An analogous situation exists with statin therapy whereby benefit was found in trials with longer rather than shorter follow-up.³⁰ Nevertheless, the largest two of the HRT trials, WHI dual and WHI mono, had follow-up for more than 5 years and yet found no beneficial effect on stroke risk.

In summary we have found that the use of HRT is associated with an increased risk of stroke, typically ischaemic in type and severe in nature. HRT cannot be recommended for the primary or secondary prevention of stroke. Extrapolation of the data suggest that patients at high risk of stroke, e.g. those with previous stroke, coronary heart disease, or multiple vascular risk factors, should cease taking it unless there is a strong contrary medical reason.

ACKNOWLEDGEMENTS

LG is funded, in part, by The Stroke Association and BUPA Foundation. PB is Stroke Association Professor of Stroke Medicine; the Division of Stroke Medicine received core funding from The Stroke Association.

REFERENCES

1. Barrett-Connor E, Bush TL. Estrogen and coronary heart disease in women. *JAMA* 1991;265(14):1861-7.
2. Kannel WB, Thom TJ. Incidence, prevalence, and mortality of cardiovascular diseases. *Heart* 1994;185-197.
3. Wenger N, Speroff L, Packard B. Cardiovascular health and disease in women. *New Engl J Med* 1993;329(4):247-256.
4. Paganini-Hill A. Hormone replacement therapy and stroke: risk, protection or no effect? *Maturitas Journal of the Climacteric and Postmenopause* 2001;38:243-261.
5. Nelson HD, Humphrey LL, Hygren P, Teutsch SM, Allan JD. Postmenopausal hormone replacement therapy. Scientific review. *Journal of the American Medical Association* 2002;288(7):872-81.
6. Beral V, Banks E, Reeves G. Evidence from randomised trials on the long-term effects of hormone replacement therapy. *Lancet* 2002;360:942-44.
7. Wren BG. Megatrials of Hormonal Replacement Therapy. *Drugs & Aging* 1998;12(5):343-348.
8. Zec RF, Trivedi MA. Effects of hormone replacement therapy on cognitive aging and dementia risk in postmenopausal women: a review of ongoing large-scale, long-term clinical trials. *Climacteric* 2002;5:122-134.
9. Collins P. Clinical cardiovascular studies of hormone replacement therapy. *Am J Cardiol* 2002;90(supplement):30F-34F.
10. Moher D, Pham B, Jones A, Cook DJ, Jadad AR, Moher M, et al. Does quality of reports of randomised trials affect estimates of intervention efficacy reported in meta-analyses? *Lancet* 1998;352:609-13.
11. Egger M, Davey Smith G, Schneider M, Minder C. Bias in meta-analysis detected by a simple, graphical test. *BMJ* 1997;315:629-634.
12. McDowell F, Louis S, McDevitt E. A clinical trial of Premarin in cerebrovascular disease. *J Chron Dis* 1967;20:679-84.
13. Wassertheil-Smoller S, Hendrix SL, Limacher M, Heiss G, Kooperberg C, Baird A, et al. Effects of estrogen plus progestin on stroke in postmenopausal women. A women's health initiative: A randomized trial. *JAMA* 2003;289(20):2673-2684.
14. The writing group for the PEPI Trial. Effects of estrogen or estrogen/progestin regimens on heart disease risk factors in postmenopausal women. The Postmenopausal Estrogen/Progestin Interventions (PEPI) Trial. *JAMA* 1995;18(273):199-208.
15. The Women's Health Initiative Steering Committee. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy. *JAMA* 2004;291(14):1701-12.
16. Hodis HN, Mack WJ, Lobo RA, Shoupe D, Sevanian A, Mahrer PR, et al. Estrogen in the prevention of atherosclerosis. A randomized, double blind, placebo-controlled trial. *Ann Intern Med* 2001;135:939-53.
17. Estrogen after ischemic stroke: effect of estrogen replacement on risk of recurrent stroke and death in the Women's Estrogen for Stroke Trial (WEST). *Stroke*; 2001.
18. Report of the Veterans Administration Cooperative Study of Atherosclerosis. An evaluation of estrogenic substances in the treatment of cerebral vascular diseases. *Circulation* 1966;XXXIII and XXXIV:II-3 - II-9.
19. Effect of estrogen treatment in cerebrovascular diseases. *Cerebral vascular diseases*; 1965; New Jersey. Grune & Stratton.
20. The ESPRIT Team. Oestrogen therapy for the prevention of reinfarction in postmenopausal women: a randomised placebo controlled trial. *Lancet* 2002;360:2001-08.
21. Simon JA, Hsia J, Cauley JA, Richards CL, Harris F, Fong J, et al. Postmenopausal hormone replacement therapy and risk of stroke. The Heart and Estrogen-progestin Replacement Study (HERS). *Circulation* 2001;103:638-42.

22. Waters DD, Alderman EL, Hsia J, Howard BV, Cobb FR, Rogers WJ, et al. Effects of hormone replacement therapy and antioxidant vitamin supplements on coronary atherosclerosis in postmenopausal women. A randomized controlled trial. *JAMA* 2002;288:2432-2440.
23. Angerer P, Stork S, Kothny W, Schmitt P, von Schacky C. Effects of oral postmenopausal hormone replacement on progression of atherosclerosis. A randomized controlled trial. *Arterioscler Thromb Vasc Biol* 2001;21:262-268.
24. Hoibraaten E, Qvigstad E, Arnesen H, Larsen S, Wickstrom E, Sandset PM. Increased risk of recurrent venous thromboembolism during hormone replacement therapy. *Thromb Haemost* 2000;84:961-7.
25. Holmberg L, Anderson H, For the HABITS steering and data monitoring committees. HABITS (hormonal replacement therapy after breast cancer-is it safe?), a randomised comparison: trial stopped. *Lancet* 2004;363:453-55.
26. Viscoli CM, Brass LM, Kernan WN, Sarrel PM, Suissa S, Horwitz RI. A clinical trial of estrogen-replacement therapy after ischemic stroke. *The New England Journal of Medicine* 2001;345(17):1243-1249.
27. Yusuf S. Two decades of progress in preventing vascular disease. *Lancet* 2002;360:2-3.
28. Badimon L, Bayes-Genis A. Effects of progestogens on thrombosis and atherosclerosis. *Human Reproduction Update* 1999;5(3):191-199.
29. Glazier MG, Bowman MA. A review of the evidence for the use of phytoestrogens as a replacement for traditional estrogen replacement therapy. *Archives of Internal Medicine* 2001;161(9):1161-72.
30. Collins R, Armitage J. High-risk elderly patients prosper from cholesterol-lowering therapy (Commentary). *The Lancet* 2002;360:1618-1619.
31. Vickers M, Meade T, Darbyshire J. WISDOM: history and early demise - was it inevitable? *Climatrerics* 2002;5:317-325.
32. de Kleijn MJJ, Bots ML, Bak AAA, Westendorp ICD, Planellas J, Coelingh Bennink HJT, et al. Hormone replacement therapy in perimenopausal women and 2-year change of carotid intima-media thickness. *Maturitas* 1999;32:195-204.
33. Herrington DM, Reboussin DM, Brosnihan KB, Sharp PC, Shumaker SA, Snyder TE, et al. Effects of estrogen replacement on the progression of coronary-artery atherosclerosis. *The New England Journal of Medicine* 2000;343(8):522-529.
34. Clarke SC, Kelleher J, Lloyd-Jones H, Slack M, Schofield PM. A study of hormone replacement therapy in postmenopausal women with ischaemic heart disease: the Papworth HRT Atherosclerosis Study. *British Journal of Obstetrics and Gynaecology* 2002;109:1056-1062.

TABLE 1

Randomised controlled trials excluded from the review

Trial & year	Indication	Subjects	Intervention (daily dose)	Reason for exclusion
WISDOM ³¹	Healthy	5,664	CEE + MPA CEE	Trial completed but not reported at time of writing
De Kleijn et al, 1999 ³²	Healthy	121	E2 (1.5 mg) + DG (0.15 mg), or CEE (0.625 mg) + N (0.15 mg)	No stroke events reported
Herrington et al, 2000 ³³	Coronary disease	309	CEE (0.625 mg), or CEE (0.625 mg + MPA (2.5 mg)	Numbers only given for stroke or TIA and not separately
Clarke et al, 2002 ³⁴	IHD	255	E2 (2.5 mg) or E2 (3 mg) + NG (4 mg)	Numbers only given for stroke or TIA and not separately

TABLE 1

Randomised controlled trials of hormone replacement therapy in the primary and secondary prevention of vascular disease included in the meta analysis.

Trial & year	Indication	Subjects	Age (years)	Female (%)	Ethnicity white (%)	Uterus present (%)	Follow-up (years)	Stroke rate (control group, %/year)	Intervention (daily dose)	Compliance (%)	Quality score (0-5)
Marmorston, 1965 ¹⁹	Cerebral thrombosis	200	62.1	37	?	?	?	?	Females: CEE (0.625mg) Males: CEE (0.625-2.5 mg)	?	2
Veterans Administration Cooperative, 1966 ¹⁸	Cerebrovascular disease	592	?	0	79.2	?	1.4	7.72	CEE (1.25 mg) after 1 year CEE (2.5 mg)	94	5
McDowell et al, 1967 ¹²	Non-embolic cerebral infarction	134	64	25	?	?	Treated 0.9, control 1.2	0	CEE (1.25mg)	84	3
PEPI Writing Group, 1995 ¹⁴	Healthy	875	56	100	?	68	3	0	CEE ± MPA or MP	76	5
Simon et al, 1998 ²¹	IHD	2,763	67	100	?	100	4.1	1.18	CEE (0.625 mg) + MPA (2.5 mg)	78	5
Høibraaten et al, 2000 ²⁴	VTE	140	56	100	?	?	1.3	1.11	E2 (2mg) + NTA (1mg)	76	5
Hodies et al, 2001 ¹⁶	Healthy	222	62	100	58	62	2.0	0	E2 (1 mg)	94	5
Angerer et al, 2001 ²³	Carotid athero	264	?	100	?	?	1	0	E2 (1 mg) + GG (0.025 mg)	98	4
Viscoli et al, 2001 ²⁶	Stroke	664	71	100	?	55	2.7	6.34	E2 (1 mg)	66	5
The ESPRIT team, 2002 ²⁰	MI	1,017	62.3/62.9	100	?	?	2.0	0.59	E2 (2 mg)	53	5
Waters et al, 2002 ²²	IHD	423	65	100	?	41	2.8	0.67	CEE (0.625 mg) + MPA (2.5 mg) †	69	5
Wassertheil-Smoller et al,	Healthy	16,608	63	100	84	100	5.6	0.24	CEE (0.625 mg) + MPA (2.5 mg)	60	5

2003 ¹³											
Holmberg et al, 2004 ²⁵	Breast cancer	345	55	100	?	?	2.1	0	No specified treatment	?	3
WHI Steering Committee, 2004 ¹⁵	Healthy	10,739	63.6	100	75.3	0	6.8	0.32	CEE (0.625 mg)	46.2	5

CEE, 'conjugated equine estrogen'; DG: desogestrel; E2, 17 β -estradiol; GG: gestogene; IHD: ischaemic heart disease; MI: myocardial infarction; MPA: medroxyprogesterone acetate; NG: norgestrel; NTA: northisterone acetate; VTE: venous thromboembolic. † progesterone given if no hysterectomy

TABLE 2

Effect of hormone replacement therapy on stroke, its type and outcome. Odds ratio (95% confidence intervals) using random effects model, and heterogeneity

	Trials	Subjects	Events	Control event rate (%)	Odds ratio (95% CI)	p	Heterogeneity p
Stroke, all	14	34,976	916	2.32	1.29 (1.12 – 1.47)	0.0003	0.46
Ischaemic	5	20,510	442	1.91	1.28 (1.06 -1.56)	0.01	0.46
Haemorrhagic	5	20,510	63	0.30	1.06 (0.64 -1.75)	0.82	0.56
Transient ischaemic attack	6	5,451	203	4.08	1.00 (0.75 – 1.33)	1.00	0.71
Outcome							
Fatal	12	33,718	129	0.33	1.28 (0.87 – 1.88)	0.21	0.39
Non-fatal	11	33,518	710	1.93	1.23 (1.06 – 1.44)	0.007	0.45
Death or dependency	4	17,733	145	0.65	1.56 (1.11 – 2.20)	0.01	0.93

TABLE 3

Sensitivity analyses of the effect of hormone replacement therapy on total stroke

	Trials	Subjects	Control event Rate %	Odds ratio (95% CI)	χ^2 Interactio n
Stroke, all	14	34976	2.32	1.29 (1.12 – 1.47)	
Prevention					0.32
Primary	5	28789	1.61	1.36 (1.14 – 1.61)	
Secondary	9	6187	5.59	1.17 (0.90 – 1.52)	
HRT					0.75
Oestrogen alone	7	13558	3.18	1.20 (0.90 – 1.62)	
Oestrogen & progesterone	7	21418	1.75	1.31 (1.08 – 1.60)	
Type of oestrogen †					0.59
Estradiol	5	2307	5.71	1.15 (0.80 – 1.65)	
Conjugated equine oestrogens	8	32669	2.09	1.29 (1.06 – 1.55)	
Trial size					0.31
Small (<5000)	12	7629	4.87	1.17 (0.94 – 1.44)	
Large (>5000)	2	27347	1.66	1.36 (1.14 – 1.61)	
Length of follow-up					0.35
Shorter, <3 years	11	4866	4.88	1.14 (0.83 – 1.56)	
Longer, >3 years	3	30110	1.96	1.33 (1.14 – 1.55)	
Gender					-
Females only ‡	12	34133	2.18	1.30 (1.13 – 1.50)	

Quality

Score of 5 only	10	1.28 (1.12 – 1.46)
Score 0-4	4	2.11 (0.14 – 32.18)

† Habits ²⁵ not included as type of oestrogen left to investigators judgement

‡ Including women only from Marmorston ¹⁹

FIGURE 1

Flow diagram of search strategy

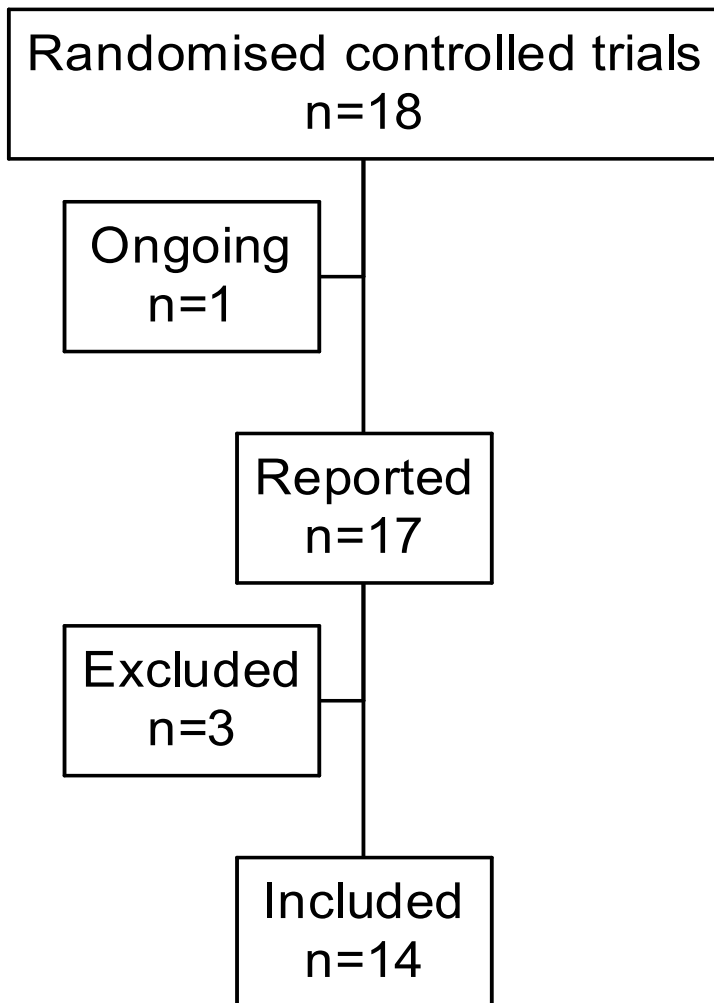


FIGURE 2

Forrest plot of randomised controlled trials of hormone replacement therapy in the primary and secondary prevention of stroke, coronary heart disease and pulmonary embolism

