Perimenopause and Menopause with Dr Louise Newson

Speaker Key:

VO Voiceover

CB Chantal Boyle

LN Dr Louise Newson

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VO

Welcome to The Sunflower Conversations, where we explore the Hidden Disability Sunflower and its role in supporting people with hidden disabilities.

CB

Welcome to The Sunflower Conversations. My name is Chantal, and today I'm absolutely delighted to be joined by Dr Louise Newson, who is a GP and menopause specialist. Louise and her team at Newson Health are at the forefront of advocating for women to get the appropriate treatment to support their hormone health, as well as investing in research and training to help healthcare practitioners make the best decisions for their patients, which is crucial. So, welcome, Louise. Thanks for joining us.

LN

Thank you for inviting me. It's a great privilege and honour to be here, actually.

CB

Oh, brilliant. Well, I was having a little perusal of Instagram, because obviously it's been menopause awareness month last month, so there's been so much out there, which is great. There's lots of noise. But one thing I saw, it made me laugh, but also was like, oh, it was a post, and it's kind of taken from a spoof of the dictionary, menopause.

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And the description that's written underneath is, derived from the Latin for WTF, what the F, is happening to me? The time of life where a woman doesn't know if she is coming or going, on fire or freezing, happy or sad, wants to diet or eat everything in sight. Common phrases used during this time include muffin top, hot flush, mood swing, brain fog. Women in menopause may self-medicate with wine, chocolate, vodka, ice cream, carbs, new shoes, online purchases, Netflix, or by looking at pictures of Sam Elliot.

I did not even know who that was, so I did have to Google him. But yes, I thought, wow, that kind of does speak to a lot of women, I'm sure. So, let's start off by explaining, what's perimenopause, what is the menopause, and what changes are occurring in the body to women at this time?

LN

A really important questions for everybody to understand. Not just women, actually. If we break down the word properly, menopause, meno is the menstrual cycle and pause is stop. And what's very annoying in my mind about the whole menopause conversation is that menopause has to be officially diagnosed when you've had a year without your period.

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Now, there's nothing else in medicine I have to wait a year before I make a diagnosis. But also, a lot of women don't have periods. And also, a lot of women don't want to be defined by their periods. So, then other people think, well, it's due to loss of fertility, but it's not always. And actually, a lot of people don't want to be defined about their fertile status, as well, or identified whether they can be fertile or not.

So, what we need to then think about, what is it? What happens in our bodies? Now, it's something that happens to everybody, and it can happen at different times in different ages. My youngest patient was 12 when she was menopausal, because her ovaries didn't develop. My oldest patient who I've seen in the clinic is 94. So, once a woman is menopausal, she'll be menopausal forever.

And what happens is, our ovaries either are absent, because they might have been removed. Damaged, for example, with some treatments like chemotherapy or radiotherapy. Or the eggs just run out. We're only born with a finite number of eggs. But it's not about the eggs. It's about the hormones associated with this.

So, when our ovaries don't work as well, they don't produce as much hormones, and these hormones are really important. They do help regulate our periods, and they do help with fertility, but they do far more. They go into our bloodstream, and they affect every single cell in our body. They have biologically active processes in our brains, in our muscles, in our heart, in our skin. Everywhere, they have really important functions.

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And there are three main hormones. Oestrogen, progesterone, and testosterone. And this is the problem, in that the levels are low, and they stay low forever in the menopause. Now, in the perimenopause, peri is just a medical term meaning for around the time of. So, what happens for most women, not women who have their ovaries removed, but most women, the ovaries gradually decline in function.

And this gradual decline can sometimes take many years, even a decade. And many women who experience perimenopausal symptoms, which are the same as menopausal symptoms, will find that they have some days or weeks or months or even minutes where they feel fine, and others where they get an uncontrollable rage, or they're tearful, or they have joint pains, or they have headaches or palpitations.

And this is the fluctuating hormones that occur. So, they don't just decline gradually. They actually do it in a very yo-yo up-and-down way. And so, sometimes, people have high levels, sometimes they'll have low levels, and it's this chaos that's occurring with the hormone levels that actually can trigger more symptoms. So, a lot of people find that the symptoms of the perimenopause can be more stressful and cause more impact, actually, physically and mentally, than the menopause.

But it's more than that, and that's depressing, as well, I know. But when we have low hormones, because they're biologically active in our body, we have increased inflammation in

our body, which increases the risk of diseases. And they're important diseases like cardiovascular disease, so, heart disease and strokes, osteoporosis, type 2 diabetes, dementia, clinical depression, because our hormones work all over our body.

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And for many years, the menopause has just been, just put up with it. It's okay, it's a natural thing. We're all going to have it. Menopausal women have been a butt of jokes. It's always been about flushes and sweats. But we need to take a step further and think, we're living longer now because of advances in medicine.

Yes, you could argue that it's a natural process, but being in pain in childbirth is natural, having raised blood pressure as we get older is natural, but we don't ignore these things. And so, we shouldn't be ignoring that we've got a treatment that's available that only the minority of women are receiving.

CB

So, that's obviously significant, is the biological, you used that word, biological impacts. So, can you talk me through some of the reports that your patients come to you with? What are the implications of these hormones lowering, and the fluctuations?

LN

Everybody's different. We're all individual. And so, everybody's experience is different, as well. And the most important thing, I think, for people listening, really, is to know that you don't have to compare yourself with others. You need to think about what's happening to you, and what symptoms are you experiencing that are having an impact on your life.

A lot of women we speak to say, well, I'm not too bad, because I'm not as bad as my friend or my sister or my auntie, but I still can't sleep, or I'm not functioning very well at work. But actually, it's about you as an individual. So, that's important.

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Now, most women, so, 98% of women we see in our clinic, have psychological symptoms. And these are symptoms such as low mood, anxiety, poor memory, reduced concentration, low stamina, poor sleep. So, these are all symptoms that affect our brains, because those hormones I mentioned, the oestrogen, progesterone, and testosterone, are neurotransmitters. They are not just hormones, but they're chemicals in our brain that light up our brain and have really important functions in our brain.

Now, for many women, not all, but many women, find it very difficult for their brain to function when they haven't got the right hormones. And then, it can also trigger migraines, headaches, palpitations, muscle and joint pains. Some people find their skin becomes very dry and itchy. There are some people find that they have dry eyes, dry mouth, burning mouth, tinnitus. The list goes on and on. Flushes and sweats are there, and that can really affect people, but they're not the main symptoms that are really affecting people.

And then, there's also other symptoms that are more local symptoms, if you like, that affect the vagina, the vulva, the surrounding areas. And that's not just causing painfully sex. Actually, a lot of women we see find it very hard to wear underclothes because of the discomfort, or sitting down find it really quite painful. And if they've got a desk job, for example, then how do you say to your line manager, oh, it's really uncomfortable? It's quite a hard conversation. But

urinary symptoms, as well…

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CB

It's very intimate, isn't it, and personal.

LN

Yes, absolutely.

CB

It's very difficult to share that with anybody, apart from maybe your loved one.

LN

Well, that's right. But also, urinary symptoms are very common. So, a lot of women get urinary tract infections, but also, some people get increased frequency of needing to pass urine, or a bit of incontinence. They might leak a bit if they cough or sneeze or run. But it's so normalised in a conversation that people think, well, that's just what is going to happen because I'm older. And it's not. They're usually related to low hormone levels.

CB

I can know from my own experience, and it's interesting you say about these fluctuations, because that is definitely how it's felt for me. So, almost it's been difficult to put a pin in it and say, this is what's happening to me, and maybe it's the perimenopause, because that's happened for some time, and then that's stopped, and something else has happened. But the frequent urination during the night has definitely been something, and then obviously that has an impact on your sleep, and then how you're functioning the next day.

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This drop in these hormone levels, it must presumably have an impact on women's lives, home life, social, socially, at work. I did read that I think it was 900,000 women have left work because of their menopause symptoms.

LN

Yes, we know around 10% of women give up their jobs because of the direct cause of those symptoms of the menopause. And the main symptoms are anxiety, memory problems, and fatigue, actually. But we also know from some of the research that we've done that people really struggle to perform their job properly. A lot more women go part-time. A lot of women take time off, leave sick, and often it's quite for long periods of time.

A significant proportion, a study we did, about 25% of women are taking at least eight weeks off work, and that really is quite disruptive. You can sort of shoulder a colleague if they're away for a work a week unor two, but right weeks is a lot. But also, a lot of people, we did an NHS survey of over 1,000 people working in the NHS, and 37% of women wanted to change their hours but couldn't afford to.

And I get that. No one wants to reduce their hours and have less pay and less status, and so

forth. But actually, if you're going to work and you're wanting to reduce your hours, you're not going to be doing the same job. You're not going to be giving it your all.

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And so, there's a lot of unspoken problems in workplace, because it's firstly, women don't realise often that they're perimenopausal, so they'll put it down to stresses and put it down to a job change, maybe a new boss, maybe changing hours, or maybe something going on at home. So, they won't realise it's related to their hormones, the way they're feeling.

But also, when they do, it can be quite difficult, as you say, to bring up in a conversation at work. But most importantly for me, as a doctor, these women are unable to receive treatment that they should have for their perimenopause and menopause. And if more women had treatment, there'd be less suffering and less of this conversation, because women would be able to work, but they'd also be feeling better, and be more productive, and be healthier, as well.

CB

Yes, it seems like there's such a simple fix to this crisis period, and that can occur for many women. And then, presumably, obviously that has an impact on their home life, not just at work. Breakdown of marriages, relationships with friends, etc., children.

LN

Yes. We see a lot of women in our clinic who, sadly, they've left their partners, and they said, I didn't want to, I still love them, but I'm just not the same person. Relationships with family members, with colleagues, with friends has been really affected. And we do know from some studies that domestic violence increases during the perimenopause and menopause. And it's no surprise when you think about the symptoms, and you think about the feelings a lot of women have of low self-esteem, reduced self-worth. There's lots of issues there, as well.

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And I also, I've got three children, and I know when I was perimenopausal, I didn't have the same motivation to walk in the park, and cook properly for the children, and just enjoy having them around, because I constantly felt tired and irritable. So, of course you're going to just put the telly on and not play a boardgame, or you're not going to be as interested in what they're doing for their homework, whatever. So, women are not meaning to, but their children are silently suffering, as well, often.

CB

Yes. You can basically slowly retreat from life, can't you?

LN

Yes, of course you can.

CB

And the joy of life.

LN

Yes. And you're absolutely right. And I think we talk often about libido, especially when we

think about testosterone, the really important hormone. But if we think about how Freud defined libido, it's not just about a sexual pleasure. It is about the joy of life. And that's quite hard to measure, and that's why it's not really been done well in studies.

But lots of women, when they come back to the clinic and they're on treatment, they say, Dr Newson, I look out the window, and the sun's shining, and I feel happy. Or my children have said to me, gosh, Mummy, I didn't know you could sing. I heard you singing in the shower. Or I'm seeing your teeth more, because you're smiling.

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CB

That's a really interesting one, isn't it? Turn that frown upside-down. But yes, actually, teeth, it does affect your teeth, as well, doesn't it?

LN

It does, and your gums, yes.

CB

So, what will happen, then? What is the benefit of taking? Can we go through oestrogen, progesterone, and testosterone? Because I think that people tend to think that testosterone is something that men have, and maybe don't even appreciate that it's in a woman's body. Progesterone, I always kind of relate to contraception.

LN

It is. And it's very interesting, actually, and it's great you've asked. So, these hormones are really important in our body. I said they have lots of really important biological actions, and they help the way our cells work. And all our cells work to maintain our metabolism, our growth, everything that we do. So, they all have their own roles, if you like.

Now, oestrogen is the one we all know as the female hormone, and is very important. The best way of having oestrogen as HRT is through the skin, actually, as a patch or gel, so it goes straight into the bloodstream. And we prescribe the body-identical oestrogen, so the same oestrogen as we produce when we're younger.

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Now, progesterone, again, is very important. It's a very anti-inflammatory hormone. It's very good in our brains, in our muscles, in our joints, in our bones, and so forth. And when we prescribe HRT, we always have to give a type of progesterone to protect the lining of the womb. And a lot of people say that's the only reason you need progesterone, but actually, a lot of women find they benefit from progesterone for all the other reasons, as well.

And the best progesterone is the body-identical one, so the same structure, like I say, as the hormone progesterone we produce when we're younger. A lot of people say, well, I can't take progesterone because I was on the pill and it really didn't suit me, or the progestogen-only pill, or the implant is progesterone, as well, but these are all synthetic, so they've been chemically modified.

So, they don't stimulate the receptors in the same way. They don't have the same beneficial biological processes that occur when we take them, and they can cause more side effects,

and actually, small risks, as well. So, it's a lot better to always have the natural hormones.

CB

The progesterone, we are able to create natural progesterone?

LN

Yes, so, there's something called micronized progesterone in the UK. It's called Utrogestan, which is a capsule that's taken orally, or sometimes it can be used vaginally, as well, but it's the pure progesterone. Whereas any other type is this synthetic progestogen, so it's been just modified a little bit. So, they work differently in the body, and they have different side effects and effects, as well.

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And then, testosterone is really interesting, actually, because it's the most biologically active hormone we have. When we're younger, in our twenties and teens, we actually produce more testosterone than oestrogen, and the levels just decline as we age. So, it's not really a menopause hormone. It's just an age-related hormone.

And a lot of testosterone is produced in our ovaries, and that's why when women have a surgical menopause and their ovaries are removed, their testosterone goes very quickly. But actually, other areas of our body produce testosterone, including our brain, actually. And also, our brain produces oestrogen and progesterone, as well, showing how important it is in our bodies.

So, it's not just about from our ovaries, but testosterone is very anti-inflammatory, it works all over our bodies, and it also works as a neurotransmitter. So, we can give all the oestrogen and progesterone we like, but if someone's lacking testosterone, and often those symptoms are low mood, anxiety, really feeling quite sluggish, haven't got that stamina, that joy of living like you describe isn't really there so much, sleep can be affected, muscle and joint pains with low testosterone.

And we also know that testosterone helps build bone, as well, so it's good when we're thinking about reducing osteoporosis. But a lot of people find that their muscle strength goes. They have something called sarcopenia, which is loss of muscle mass. And there's lots of reasons why that can occur, but low testosterone can cause that, as well. So, a lot of people find when they use testosterone in just normal female doses, that their ability to exercise is better, their ability to have more stamina improves, but also to be able to build more muscle tone.

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And that's really important when we think about our long-term health, because a lot of what we're trying to do in medicine is to reduce disease, but also this whole healthy ageing is really important. It's not the age we die. It's our journey to that age. And what we want to do is keep people healthy, to reduce risk of diseases, improve their wellbeing, and keep them physically and mentally strong, as well. And so, all these hormones are very beneficial for that, as well.

CB

I'm just thinking, because I do reformer Pilates, and I've done it for years. And I'm not saying I'm brilliant at it, because I'm still not, I only go once a week. But there's one particular exercise which is with the arms, where you have to pull your thing back and forth. And for reformer Pilates, for people that don't know, it's kind of like a resistance-based workout on a bed.

Google it, it's quite interesting to look at.

And this exercise that I've been doing for ages, I've noticed in the last couple of years that I'm finding it so difficult, and it's not a heavier resistance. It's the same one. But that must be due to the testosterone, I guess, and my muscle density starting to deplete.

LN

Yes, absolutely, and it can be. And it can make a big difference. We see lots of women who are performance athletes, or they just exercise a lot, and say, look, nothing's changed, but my performance time isn't as good. My recovery isn't as quick. And a lot of it is related.

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And we know it's related, because when we rebalance the hormones with the right dose and type of oestrogen, and often testosterone and progesterone, they feel better, and nothing else has changed. And increasingly we are realising there are a lot of women who are more testosterone deficient than oestrogen deficient. So, there's no point just giving oestrogen and progesterone, because you're missing out on another important hormone.

CB

So, is that something that you would generally advise that, if you're going to start on hormone replacement therapy, that you would actually go with three of them?

LN

It depends. Everything's very individual. So, having individualised consultations with someone who understands is really important. And one of the problems is, there's no easy test. And this often, we all like numbers. We like to do, what are our hormones doing? Can I just have a quick blood test or saliva test? And you can't, actually, because especially in the perimenopause, as I've said, our hormone levels fluctuate.

So, you might have a blood test at a time when your levels are high or normal, but just at that time. And there'll be other times, of course, your hormones will be low. But how do you know how to capture them and do the blood test? And even the finger prick ones you can do at home are just not reliable when it comes to measuring oestrogen levels.

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Testosterone level, you can measure the level, but a low level doesn't always mean that that's causing your symptoms. So, it's not as easy as just do a blood test, show it's low, and let's just take some testosterone. And often, the beauty of the hormones that we can prescribe, both privately and in the NHS, is that we give them individually. So, if I think someone wants more oestrogen, I can increase that without increasing the progesterone. If they needed slightly more testosterone or slightly less testosterone, we can tailor it.

And that's really important, because in the perimenopause, the dose that we start people on is often different with time, as well, as their own hormones decline. So, having a constant review with someone who understands is important. And we do often do blood tests when we're reviewing patients, as well, just to see whether they're absorbing the hormone properly, how it's in line with their symptoms. And obviously looking at their everything else, their wellbeing, their exercise and nutrition. It's all working together, which is really important.

CB

Yes, and it's important that we mention that about the exercise and nutrition. It's not just take the hormones and it's your whole health.

LN

No, that's exactly right. And it's very important, because there's a lot of a debate as, oh, it's just HRT or nothing. And actually, this isn't. HRT is part of the treatment. Obviously, HRT with testosterone is replacing the missing hormones. But whether we take HRT or not, whether we take testosterone or not, we all need to be thinking about our nutrition and our exercise and everything else, as well. But we can't eat our way out of the menopause or exercise our way out of our low hormones.

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And that's one of the problems, is, many people think, well, I'm not going to take HRT because I'm worried about the perceived risks. But if I improve my diet or if I do this exercise, then I'll feel better. And often, they won't, because the symptoms are due to the low hormones. So, they might improve their muscle tone, they might improve their wellbeing, but they're not going to necessarily… They might improve a little bit. Some people say, if I exercise, I don't get as many sweats or flushes, or I sleep better.

Of course, but you're not treating the underlying cause, and that's where we need to be thinking about hormones, which are very safe and have far more benefits than risks.

CB

Yes, that's always the worry, isn't it, I think, for anybody taking any medication of any type. If you look at the side effects, you go to the side effects. And whatever it is, in fact, even probably with a paracetamol, you'd be like, I'm not actually going to take that. I'm really concerned and worried. So, has Newson Health been investing in lots of research? And what have you discovered to put people's minds at rest?

LN

Yes, so, there's a few things. I fund a small research team. We don't do any paid work with any pharmaceutical companies or have any vested interest, just to be really clear to people. And that's really important. But what we have also been doing is looking objectively at the evidence, and that's really important. And unpicking some of this scaremongering that's happened for 20 years, actually.

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And what we do know is that HRT is very safe. The study that showed this increased risk of breast cancer used older types of HRT that are synthetic, that we don't usually prescribe. And even if you look at the worst interpretation of this study, this increased risk of breast cancer wasn't statistically significant. And oestrogen on its own was shown to have a 23% lower risk of breast cancer and a 40% lower risk of death from breast cancer.

Which is really important for people to know, because we've always thought oestrogen equals breast cancer, and it doesn't, because it's very anti-inflammatory. But we also know that taking any type of HRT reduces the risk of all the diseases that I mentioned and improves quality of life, of course. So, that's really important.

Also, we've been looking at our patients on testosterone, and looking at symptoms other than improved libido. So, like I've said before, the anxiety, the low mood, the poor sleep, and we've

shown that those improvements are actually more statistically significant than their libido improvements. Which is no surprise, but we've got big numbers of data.

And then, we're also looking at doses of HRT, because using the skin to get the oestrogen through is good, but the skin is still a barrier. And we know from some very small studies, in fact, there's studies where the dose of HRT was licenced, that there is a real variability of absorption. And so, our data, we've got big numbers because we've got so many patients, is showing that women do really vary with the way that they absorb, so therefore the dose that they need.

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And this is really important. So, we're writing all that up to put it for publication so we can share with others, because learning from our clinical experience and learning through our patients is really crucial to get the agenda forwards, and also show that we're improving symptoms for women, as well.

CB

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I was going to do an interview with a Sunflower wearer who has PMDD, and she was put into chemical menopause. So, a lot of people have reached out to us to say, you need to talk about chemical menopause, surgical menopause. This is huge, and we need some support, as well. And so, I wonder if you could just quickly explain for our audience what that is.

LN

Absolutely. So, chemical menopause basically means, obviously, menopause that's been caused literally by chemicals, but it's usually by drugs. Now, when you're looking at it in context with PMDD, which is a severe form of PMS, some women, especially their brains, are very sensitive to changing hormone levels.

So, quite a few of us will have known the day or two before our periods, we just feel a bit flat, not quite right. And then our period comes, and you think, oh, good, I feel a bit better now. But actually, for women with PMDD, these symptoms can be really awful, and have very, very dark thoughts, very low mood.

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And so, one of the treatments is to stop the ovaries working, so then, if you don't have your ovaries working, of course you have no fluctuation in hormones. So, theoretically, you think, well, people will feel better. But I've already said you can get symptoms when you don't have hormones, and there are health risks, as well. They do give an injection of something that stops the hormones in our brain that have a feedback with our ovaries. They stop them working to induce the menopause.

But actually, a lot of women still need add-back hormones. So, we often give what's called add-back HRT, but at a constant level. So, rather than these women having fluctuating levels, you just give back a low dose of the hormones they need. Often a combination, but sometimes just one of them, oestrogen, progesterone, testosterone, and add that back, and then women get the benefits of hormones without the fluctuations.

Now, women with PMS and PMDD have been neglected for centuries. It's the same in almost the menopause, where people say, oh, it's just normal to feel a bit rubbish before your period.

But it's not, actually, because these women, even if they only have symptoms for two or three days a month, there's 12 months in a year, so that's nearly a month a year that they're out of action and often not working. And not able to talk about it, because people say, well, it's just your period, and everyone gets periods.

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But actually, it's a hormonal problem. And we see a lot of women in the clinic who have had a history of PMS and PMDD. Their perimenopause, they really struggle, because they're so sensitive to hormonal changes. When we give them hormones, they say, I wish I'd started this ten, 20, 30 years ago. So, increasingly, we do see women with PMS and PMDD in the clinic, because it's just a variation of a hormonal problem.

And when you look at the guidelines, they do mention hormones. They also mention antidepressants and various other treatments. But in medicine, we should treat the underlying cause. So, I always feel, let's just try hormones first. And these are the natural hormones, not the synthetic hormones. Because some people with PMDD are put on the pill and they feel worse, because it's synthetic hormones. So, it's really important that it's not normalised, that it's actually treated with someone who really understands what it means.

CB

Thank you. Thank you for explaining that. So, NICE has recently issued some new guidelines talking about, well, recommending talking therapies as a form of treatment. What is your opinion on that?

LN

So, it's just a draft consultation. So, we've just registered, actually, as a stakeholder, so people can put in their comments, which will be listened to. And that's just using comments@newsonhealth.co.uk Because if you go through a stakeholder, then they can publish comments, as well, which is really important.

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I think it's really disappointing, actually. Their press release did say CBT can be used as an alternative for HRT. Now, for some women who really don't want to take HRT, then absolutely, look up every treatment. But having a cup of tea often will help with the menopause, because you're sitting down and chatting with a friend. But actually, that's not as an alternative to treating with hormones.

And so, I do have a bit of an issue, because women have been gaslighted. I've used to word gaslighted before, and it is, really. Women haven't been listened to for decades, and actually hundreds of years. So, we've always been, oh, there, there, don't worry. And this is another thing, actually. It's not just about how we feel mentally, and the CBT research actually has looked at flushes and sweats.

But actually, it's more than that, as well. And even if we don't have symptoms, we've got these health risks, as well. CBT will not strengthen your bones, whereas taking HRT will reduce the risk of osteoporosis, which affects one in two women who are menopausal. So, we have to be thinking beyond just some cognitive behavioural therapy, which is really hard to access, by the way.

And CBT can be really good for some people, but it is a form of psychological treatment. Some

people need psychotherapy. Some people need other types of treatment. And so, I wouldn't want people to think CBT's the only alternative, as well. And I take HRT. I got up early this morning and I've done my yoga practice. I do a headstand most mornings. That's a really important part of me and my wellbeing and my treatment, but I wouldn't call it my menopause treatment. That's just part of me being healthy.

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So, I don't want to be defined as a menopausal woman. I just want to be defined as a woman who wants to be as healthy as possible. And so, we shouldn't be just saying to these women, and there is a bit of, well, if you have CBT, dear, you don't need to go and see a doctor. But actually, you often do need to see a doctor to be started on treatment.

And we know that when women are on HRT, they go back to their doctors less, because they have less symptoms, they have less diseases going forward. So, it's short-term investment for long-term savings, actually, if we get menopause treatment right.

CB

I think there's so much to do with the healthcare in this country in particular needs to follow that model. I feel very often we're just firefighting. Now you're really ill, so let's give you some meds, as opposed to, actually, let's look at your health.

LN

There's always been a debate, and it's sort of heated up over the last few years, about, we're medicalising the menopause, and it's a natural process. Well, actually, the menopause has been medicalised already. We see a lot of women on antidepressants, on painkillers, sleeping tablets, blood-pressure-lowering treatments. So, let's medicalise it with natural hormones first, and then see whether people need all these other medications.

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CB

I think, also, it's quite important, you mentioned that it's actually difficult to access this counselling. I'm in the Borough of Croydon, and I tried to access it for myself. We've got free therapies, free therapies, and then you do a 50-minute consultation with somebody who basically triages you, and it's not free, because I think you've basically got to be in crisis for it to be free.

LN

Well, I think, also, often on the NHS, you can only have six sessions, or there's a long waiting list. And yes, it's just a shame.

CB

So, the conditions that you mentioned at the beginning of this conversation that HRT can help, dementia, osteoporosis… I'm now having a bit of brain fog myself, because I can't remember the others.

LN

Well, there's all the inflammatory conditions, so, cardiovascular disease, diabetes, clinical depression, Parkinson's disease, inflammatory bowel disease, different cancers, lots and lots

of inflammatory conditions that occur.

CB

Thank you. So, these are all what we would class as non-visible disability. So, what are your thoughts about the menopause being classed as a protected characteristic under the Equalities Act?

LN

Yes, I think it's very interesting, and it is a bit of a debate, actually. And you can argue it both ways. I can argue lots of things lots of ways. But actually, if you look at the definition of what a disability is, and I don't need to spell it out for you, menopause for some women can, because it has physical, psychological long-term consequences. So, it can for some women.

00:36:13

And so, actually, and it has an impact. Not just, like we've already said, not just at work, but at home, and on that person's life. And it is invisible. You don't wear a badge, saying, I'm menopausal. It's not obvious to look at women to know whether they're menopausal, especially when they're younger, as well.

But for me, there's a treatment. A lot of disabilities, there isn't treatment. So, actually, I feel everybody who's thinking about the menopause as a disability, number one, should be seeing somebody who really understands. And I think I said to you, my daughter wears a Sunflower lanyard, and she has intractable migraines, which I feel very guilty, because I've given her… It's an inherited condition.

And often, she says to me when we're in airports, which is an overwhelming environment for most of us, and you've got these bright lights, you've got noise, you've got smells, it's impossible to get healthy food, that's where the lanyard comes into its own. And she often says to me, Mummy, you need one, too. And when I travel by myself, I was travelling to Australia recently, and I thought, I wish I'd listened to Jessica, because I absolutely feel so sick now, and I really don't want to get a migraine, because I'm lecturing when I land in Australia.

CB

Yes.

00:37:26

LN

But actually, it's not always. Like today, there's no way I'd need one. So, if I was perimenopausal, I wouldn't be needing to tell people or even to think about a lanyard most of the times. But there are times, absolutely, where I would want it to be… I don't need to explain myself. And what's been wonderful, actually, about Jessica… Or not wonderful, that's the wrong word, I suppose. But when she wears the lanyard, no one's questioning her. No one's looking at her weirdly, thinking, wonder what's wrong with her? It's just fine, crack on.

And quite a lot of respect, because I've got three children, so there's five of us who often go through a fast-track lane just with Jessica, but no one's looking at her. And I think that's what's wonderful, is that you don't have to justify yourself. Because when she starts talking about migraine, it's like, oh, it's just a headache, then, that you get, love. No, it's not, actually. It's

really ruining her life.

But it's the same with the menopause. I don't want to be saying to people, oh, so you're just menopausal. Oh, why don't you just go and have a fan, and sit in a room? It's not that. So, I think, actually, the ability for women to decide whether it's a disability, I don't need to be registered. I don't need to fill out forms and forms of paper, and have something all over my car telling people.

But actually, that's where your organisation, I feel, is so important, because disabilities can be temporary. But also, they can be treated, but not overnight. It's taken years for my daughter to have the right treatment, and she's still affected at times. And it's the same with the menopause and the perimenopause. It can take a while. And so, what do you so in that interim until you're getting the right dose and type of hormones?

00:39:13

And so, that's where it is really important that we recognised, but not laughed at. I don't want a menopause badge saying, give me attention. But there are times that having a Sunflower lanyard for a lot of women, I think, is, wow, okay, I'm acknowledging that I'm struggling. But also, I think everyone who applies for a lanyard should be, have you downloaded the Balance app? Do you know that there's evidence-based treatment? Have you seen someone who really understands? Because then it's really…

And a lot of my work is about empowering women. I'm not here saying you have to take HRT, or you have to do headstands most mornings. It's up to you what you do, but just have that information so you can make the decision that's right for you. And if it's not right from the first healthcare professional you see, you absolutely can get a second opinion, and that's really important. And if we've got communities of women who are lifting each other up and really helping guide to the right resources and the right treatment, then that's going to be really powerful, I think.

CB

Absolutely. And if anybody doesn't know about the Balance app, the Balance app has been created by Louise and her team. It's absolutely fantastic. It's free. You can download it from the App Store, or Google Play, or whatever phone device you use. And you can use it to log your symptoms, your mood, your periods, a whole host of things related to you as an individual and how you feel.

00:40:44

So, we'll definitely be putting that in the show notes and promoting it, because it is going to help you. And also, the fact that you're talking about disability can be situational, temporary, etc.

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I've got some questions. We've got 15 minutes left. So, I'll try and get through as many of them as I can. This is from the Sunflower Community. But as I was doing this, I was like, oh, I need to talk to you every week. We've got so much to go through. So, somebody has asked, my auntie and cousin both died of breast cancer a number of years ago, and my sister has recently received a breast cancer diagnosis. Should I stop using my progesterone and oestrogen patches?

LN

Very good question. And breast cancer's very common, so it affects around one in seven women in the UK, and the incidence is increasing despite HRT prescribing having been very low. So, we also know that most types of HRT are not associated with the risk of breast cancer, whether you've got a family history of breast cancer or not.

Some people who've got a strong family history do have a genetic tendency, so like having a BRCA gene, for example. We know from limited research that even people who have a BRCA gene do not increase their risk of breast cancer by taking HRT. So, HRT still has the same benefits, whether you've got a family history or not, as well.

00:42:24

So, obviously, this lady's probably got an increased risk of breast cancer because of her family history. So, if she were, or someone like her did develop breast cancer in the future, it wouldn't be the HRT. It would just be because of the family history. But like I say, some studies have shown that there's a lower incidence because HRT can be very anti-inflammatory, as well.

So, there's not a reason to not take it, if you see what I mean. So, women who have a family history of breast cancer, even if it's a strong family history, like this one sounds like it is, you can still take HRT, because taking it won't increase your risk further, if that makes sense.

CB

That does. Thank you, and that's really clear, and I think that will really set that lady and many other people's minds at rest. Women talk about hot flushes, but in perimenopause I have had incidents of being freezing. So, moments of freezing. Also, some foods now just taste terrible. I don't drink alcohol. I eat well. I'm a healthy weight. Lots of random symptoms and generalised body pain. This person also doesn't currently take HRT. Any thoughts? That's obviously quite a wide… Any thoughts?

LN

Yes, so, lots of people have all sorts of weird symptoms. Smell changes often in the perimenopause and menopause, so that can affect taste. But also, saliva can change, our mouth can change, because our hormones, like I say, get everywhere. Lots of symptoms. If I see a woman, I don't know how many of their symptoms are related to their hormones. Obviously, I don't have a crystal ball. I have no idea.

00:44:04

But what I do know from the evidence and the guidelines, that for the majority of women, the benefits of taking HRT outweigh any risks. And the earlier a woman takes it, so ideally in the perimenopause, the better for her future health, as well. So, all I often say to women is, look, if you want to take HRT, I'll give it to you. It might take a few months to get the right dose and type, and then see what symptoms are left.

And so, if a woman says, well, all my symptoms have improved, but I'm still getting muscle and joint pains, then that's when I'll think, well, is there another reason? Has she got an arthritis? Is there something else? So, the proof is in the pudding, really. So, it would be worth going to see somebody, and then discussing about systemic hormones, and see how many symptoms, and probably most on the list will improve.

CB

Thank you. Another Sunflower wearer asks, I've had a hysterectomy. How long should I continue with my oestrogen? How do I know when to stop taking, or do I take it forever?

LN

So, yes, the short answer is, you don't need to stop. The guidelines are clear. Women should be reviewed every year, and if the benefits outweigh the risks and the woman wants to carry on taking hormones, of course she can. Because it's not just about symptoms. It's about future health, as well.

00:45:20

Now, what's interesting is, when women have oestrogen on its own after a hysterectomy, the studies have shown there's a lower risk of breast cancer, like I've said. So, if you think about the risks for this lady, there's no risk of breast cancer. In fact, a lower risk. If she's having oestrogen through the skin as a patch or gel, there's no risk of clot or stroke, so that's good. If she started HRT straight after her hysterectomy and was under the age of 60, there's a lower risk of heart disease, as well.

So, actually, I can't think of a risk of taking hormones. But there are plenty of benefits. And so, for most women, they can just carry on taking it. If I stop taking my HRT today, I might or might not have symptoms. I probably will, because I'm quite sensitive to hormonal changes. But as soon as my patches come off, I've got this increased bone turnover. So, increased risk of osteoporosis. And I'm personally very worried about osteoporosis, especially with my spine.

And so, that's a reason why I will take HRT forever, to keep my bones as strong as possible, and hopefully reduce my risk of dementia and heart disease and everything else, as well. So, it's an individual choice. Some people say, I'm only going to take it when I have hot flushes, and then I'll stop it.

But increasingly, women are understanding the bigger benefits of hormones. And so, you don't have to, even if I always hear every day, actually, on social media, that my doctor's told me I can only be on it for five years, or ten years, or stop at a certain age. That's not actually in line with the guidance at all, so you can contest that and carry on, if you want to.

00:46:51

CB

That's really helpful to know that. I didn't know that. This kind of links back to what you were talking about earlier on about progesterone, and it just shows there's so much knowledge that we all still need to learn from experts such as yourself. Because this question is, I've been prescribed with progesterone with my oestrogen, because I still have periods. So, how will I know when my periods have stopped?

And just also, that's one question, but I'm thinking back to when you said about progesterone, when you can have it locally, I guess, like with a coil. That's just protecting the lining of your womb, but you're not getting the other benefits for your…

LN

No, that's all right. Some people don't need progesterone. Some people, if they're on oestrogen and testosterone, and they feel fine, we wouldn't just start progesterone if they're

using a Mirena coil or have had a hysterectomy. But if you start HRT when you're perimenopausal, so when you're still having periods, you won't know when you're officially menopausal. The only way to do it is to stop taking HRT, wait a year, and see if you have a bleed. But why would you want to do that?

The symptoms of the perimenopause and menopause are the same. The health risks are exactly the same. It's just a label. And so, I started HRT when I was perimenopausal, aged 45. I'm now 53. I probably will be menopausal. But there's no way I'm going to stop and see. And anyway, I've had a hysterectomy. So, I will have no idea. But actually, aged 53, my hormones are not going to be the same. It actually doesn't matter.

00:48:31

So, when people are perimenopausal and we start HRT, we do it in the way that people still have periods, and then after about six to 12 months, we change it so it's continuous that people don't have periods. Some women who are younger might like to have periods, in which case you can continue taking this cyclical HRT for longer, but a lot of us just go to, well, that's the best thing about perimenopause or menopause, is not having periods.

CB

So, with regard to that, if you've got the coil, though, because you're not getting… Are you getting any benefit if you've got the coil, but actually you are menopausal?

LN

Yes, so, if you've got the coil, then often, if it's a Mirena coil, then it gives women a small dose of progestogen to the lining of the womb, so it keeps the lining of the womb thin. Which is great, because it means people don't have periods. It also is very good as a contraceptive. But it's only part of hormonal treatment.

So, some people say, oh, my doctor says I'm on hormones because I'm using the Mirena coil. No, you need to have oestrogen as well, but you don't always need to have progesterone. You can carry on the Mirena, and it will last for five years. So, the oestrogen as a patch or gel, and then testosterone as well, if needed.

CB

Okay, thank you. Next question. I've had terrible side effects from oestrogen. Are there any alternatives? So, for example, tablets, difference in gel.

00:49:56

LN

Yes, so, there are differences. So, about a third of people we see in our clinic are already on HRT, but it's clearly not suiting them. So, some people think it doesn't suit them, but they're on the wrong dose or type. So, if somebody's on, for example, a patch, and they're getting symptoms, we often then do a blood test. And if their oestrogen level's low, we know we can increase the dose, and they probably start to feel better.

Some people find they feel a lot better if they take a tablet or use the gel rather than a patch. But sometimes it's not an oestrogen-deficiency symptom. It might be testosterone-deficiency symptom, or a thyroid deficiency, or an iron deficiency, or vitamin B, or vitamin D deficiency.

So, that's why it's really important to see somebody who understands more than just the menopause, as well. I've done a huge amount of hospital medicine. I've been a doctor for 25 years. I don't just look at the women and say, right, it's all about your hormones. Of course, there are other reasons why you could get symptoms. So, it's important to just have a good conversation with someone who understands.

CB

Thank you. Right, well, I think we've done a really good job. We've gone through lots and lots of questions, and I do have 100 more now because of the answers that you've given. But maybe we'll save that for another time. Do you have a golden nugget of advice for somebody embarking on this menopause journey?

00:51:20

LN

Absolutely. The most important thing is, get the information that's right for you. Make sure that you are knowing what's going on and know how you want to manage your perimenopause and menopause. And know that you can change your mind, as well. It can be quite overwhelming, and it's really easy to look at all these people and think, oh, they're great. How do they do that? How does she do that?

But actually, most of us have struggled to get the right treatment for us, and it can take a little while. It's being really patient. When you start taking any treatment, or start doing a form of exercise, or changing your lifestyle, we have to be really patient. So, having information, sharing how you're feeling with others, as well, and knowing that you're not alone is really, really important.

CB

Thank you, Louise. Thank you so much.

LN

Thank you.

CB

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