

A Guide to Navigating your Menopause



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The information contained in this document is intended to be used for educational purposes only. It is not intended to be used for the diagnosis or treatment of any specific medical condition, which should only be done by a qualified physician or other health care professional.

WHAT WOMEN HAVE TOLD US

"It's great not having periods, I love my grey hair and I've developed a very short tolerance for bullshit which I'm no longer scared to express."

Lucy Golightly, in her Third Age

"I'm not quite at the end of my menopause yet. Have been peri for about 5 years or more. For me, the positivity has been to discover that I'm not actually losing my mind, that I can attribute some awful mood swings and anger to this rage from hell (that seemingly came from nowhere!). It's now that I've gotten onto HRT that I'm like "oh f**ck! This is what normal life feels like!" After years of suffering and making other people around me feel like s**t. That sudden realisation, forgiving of myself and total validation. It's given me the confidence to all of a sudden take up DJing, kick ass (in a good way!) and not give a damn as to what others think of me. It's like a really positive mid life crisis I suppose!

Cathy Coulthard

"No periods – hallelujah! No weight gain/tight clothing/frumpiness from monthly bloating – hurrah! Stable emotions and no moodswings – woohoo! Getting to the stage where I don't give a flying f**k what anyone else thinks anymore; my insecurities about "me" are no more. I was that person who hid at the back of the group photograph but not anymore! I'm happy in my skin at last."

Joanna Harding

"I went to the docs in my early 40s (43 maybe?) because it felt like I had heart palpitations. Over six months I had various blood tests, visits to specialists etc - each time I enquired whether it might be a symptom of menopause, and each time this was disregarded. Eventually I ended up back at my GP, who suggested it might be the menopause.

... I very much took on the mantle of 'doing it naturally', and when various symptoms started getting more disruptive I was looking at nutrition, exercise and relaxation techniques. It was only last year - aged 49/50 that I felt exhausted and that I had to 'give in' and succumb to HRT. Having formed this group by then and heard about other women's experiences, I went armed and ready to fight my corner. I printed out a copy of a checklist of the 34 symptoms of menopause and ticked all those I had, which was around 30 of them, and said I wanted HRT.

The youngish female doctor I saw hardly looked at the list but said OK we'll get you on HRT. She didn't look at specific symptoms or explore different options. She said she didn't know about HRT but she would do some research. ... she said I should have patches because I am overweight and they are safer with less risks, I had also read this info. She also said the NHS doesn't like GPs prescribing patches because they are more expensive, kind of suggesting she was doing me a favour."

Beccy Golding, founder of online peer support group Quixotic Women In Menopause (QWIM)

"Drs just don't listen and dismiss issues as age related. Getting to see a female dr was hard work with having to explain myself to receptionist. When it was at its worst i really was not coping. Had a job with knees ankles, unable to walk or carry too much weight. Hot flushes, up to 30 a day, literally not sleeping, angry, unreasonable, upset the kids many times, no enthusiasm for anything... palpitations etc. I'm now on Hrt and back to myself and gym and dancing. Still have high blood pressure but sleeping well, no hot flushes and feel fairly normal physically and mentally!

...My mum was really bad with her time but she didn't work, so was always lying down. I have two teenagers, single, working with my own business and have been caring for my mum prior to her going into care....without HRT, I was losing work and things could have been really bad. The point is that for women today, that is the reality and Drs are in the main, outdated and not aware how debilitating the symptoms can be."

Jane Glasson

"I was about 48 when I went on HRT (am 50 now) via NHS GP ... I had had terrible sweating and flushes for about 3 years before that - was at the end of my tether ... First GP very reluctant (in a kindly way) was concerned about the risks. ... She never got as far as asking me about my potential risk. She put me off it for a year or so till I went to current GP - we had more of an in-depth talk about it and she explained the risks and encouraged me to decide on whether it was worth it. I don't have any first degree reps with breast cancer so risk was fairly low. Weirdly in the end my dentist encouraged me to go on it - I've known him for 20 years and his best mate is a gynae consultant who said the benefits outweighed the risks."

Emma Ranger

"Heading try GP tomorrow for a review of my HRT. She was more than happy to prescribe for me according to the Menopause Doctors's EASY prescribing guidelines and it's been fab."

Rachell Llavin

"My GP experience has been awful. Around age 50 I was hit like a ton of bricks with anxiety, and was given antidepressants. I then started getting migraines, and suffered for years ... I then started getting fatigue and joint pain, had tests for rheumatoid arthritis and all sorts. All were negative so was basic just dismissed. Never once was menopause mentioned, despite me being over 50. My periods stopped suddenly at 56. It was only when the hot flushes started that I twigged. GP told me I couldn't have HRT because of the migraines!! I eventually discovered that this was wrong and am now on Evorel Conti. My GP was pretty clueless about menopause, had the printed flowchart, that was it. Seven years I was basically misdiagnosed. All of it menopause related.and I don't recognise, or like the person I have become. It was, and still is hell. I'm having terrible problems with anxiety still, despite the fluoxetine. I am so angry and let down."

Paula Flay

About half of the human population experience a major transformation in body-chemistry in mid life, on average between the ages of 45 and 55: bones, muscle, skin, hair, body-shape, odour, sleep patterns, cognitive function and attitudes can all be significantly altered – and that’s just the short-list.

We are one of only five species known to go through this transformation. It is a radical and fascinating process. And yet we humans know surprisingly little about this change that affects half of us – and this includes the half who are affected. Children aren’t taught much about it in school; health professionals receive little training on the topic; popular culture rarely portrays characters experiencing it, many people associate it with very negative ideas and few workplaces have policies on it, even in this era of enthusiasm for inclusive policies, policies, policies!

We’re talking about the menopause, of course, and the half of the population that experiences this change is the female half (although not all of these people will identify as women. We will be referring to ‘women’ throughout because that is how most people who go through the menopause think of themselves, but we do want this resource to be welcoming to anyone who might benefit from it.).

The aim of this Bristol Menopause resource is to bring together information but also ideas, ways of thinking, and personal stories that might help to transform the way women experience this transformation.

For some women, the menopause is a smooth, easy and welcome change. For others, it is physically and psychologically an extremely difficult time of life. And because it is something that we are taught so little about, there are many women who don’t even realise that the difficult experiences they are having are in fact caused by the menopause.

The hormonal changes of the menopause can have profound effects on a woman’s physical health and mental wellbeing. For example, we become more vulnerable to heart disease and osteoporosis (weakened and easily breakable bones). In the UK, these years are the highest-risk period of life for suicide amongst women (whereas for men these years are a period of decreased risk). And yet, one survey has shown that only half of health professionals have received any formal training on menopause – and whether that training is adequate is another question.

At Bristol Menopause we believe that whether you have a hard or any easy menopause, and whether you decide to take all the treatments available or refuse to swallow a single vitamin supplement, the most important thing is to be well informed. It is vital that you know what’s happening to you and why – and that you aren’t imagining it, exaggerating it, or the only one experiencing it. It isn’t a personal problem that you need to hide from the world and cope with alone as best you can: it’s the world that needs to adapt to you, to the needs of the half of the population it has neglected.

If you are well informed it may be easier to ask your doctors, your workplaces and your loved ones to make the adjustments they need to make. We want women to take ownership: it’s your body, your menopause, another chapter of *your life*.

WHAT IS MENOPAUSE?

Menopause is the change we go through as women when our ovaries stop functioning. For most women in the UK this happens between the ages of 45 and 55.

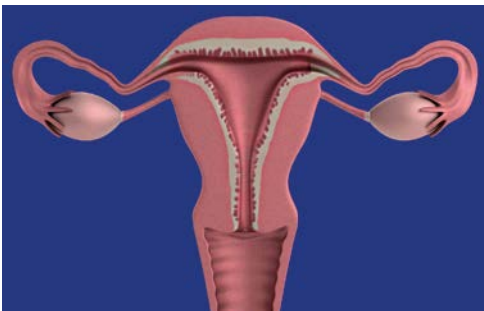
Between puberty and menopause, the ovaries carry out two major functions: they produce and release eggs (normally one per month), and they produce the sex hormones, mainly oestrogen and progesterone but testosterone as well. Oestrogen and progesterone work in a pattern to regulate the menstrual cycle or to create the changes necessary in pregnancy if the egg is fertilised, but they also play an important role in our health and wellbeing, especially oestrogen, which keeps our bones strong, our vaginas moist and our skin at the right temperature.

The function of the ovaries is controlled by two hormones that come from the pituitary, FSH and LH; as we approach menopause, the ovaries stop responding to FSH and LH, which means that they no longer function to produce eggs or the high levels of oestrogen and progesterone that regulated the menstrual cycle. We stop having periods and eventually can no longer get pregnant. The ovaries do continue to produce a little oestrogen, as well as testosterone.

“The ‘menopause’ itself actually refers to the very last period a woman ever has”

The change doesn't happen overnight: it's a process. The “menopause” itself actually refers to the very last period a woman ever has – which is said to be confirmed after she has had no period for 12 months running (without any other medical reason her periods might have stopped, such as being underweight, unwell or very stressed). In the UK the average age of this very last period, the menopause, is 51.

It is the huge decrease in our levels of oestrogen that causes the unpleasant effects associated with menopause.



Perimenopause

The period of change leading up to the last period is called the perimenopause. For many women the function of the ovaries grows less regular and they begin to experience menopausal symptoms such as irregular or very heavy periods, and the well-known hot flushes or flashes. In the Western world, this most commonly begins in our 40s, but can start in the 30s. The average duration of the

perimenopause is 4 years, but it can actually be anything from a few months to 10 years. Symptoms vary greatly from woman to woman, ranging from mild to severe, and about 25% of women actually experience very few of them; a small number experience none at all. Symptoms will be discussed in detail a little further on.

Post-menopause

Post-menopause refers to the years after menopause (the very last period) is confirmed. For some women the symptoms ease off at this time, but this can also be gradual, and for many women symptoms can persist for several years.

The other reason we need to talk about post-menopause is that lower levels of oestrogen cause a number of long-term changes in the body, which last beyond the period of transition: the risk of conditions such as osteoporosis and heart disease can be increased, as can “urogenital” problems such as difficulty with bladder control, vaginal discomfort (dryness, pain, unpleasant changes in vaginal discharge), and changes to the pelvic floor such as pelvic organ prolapse (see “symptoms” section for more detail). Most women find it easier to speak to doctors – and friends – about osteoporosis and heart disease, but many of us struggle to speak out and seek emotional or medical support for bladder and vaginal problems. This means that women are suffering in silence and not finding out about treatments that can help.

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Premature menopause

About 1 in 100 women experience menopause before the age of 40. This is known as early menopause, premature menopause, Premature Ovarian Insufficiency (POI) or Premature Ovarian Failure (POF). Getting this diagnosis can be shocking and upsetting for a younger woman who isn't expecting this change so early. Having lower oestrogen levels for more years of your life also means an even higher risk of osteoporosis and heart disease, so it's really important for women who experience early menopause to access medical help. It is advised that women in this situation take Hormone Replacement Therapy right up until the average age of menopause (51) even if they are not experiencing troubling symptoms, so as to replace the oestrogen which they would have had anyway, which is needed to protect the bones from osteoporosis.

Early menopause can be caused by a number of factors, including but not limited to:

- Chromosomal abnormalities (such as Down's Syndrome and Turner's Syndrome)
- Autoimmune disorders
- Infections such as mumps and TB
- A “Medical Menopause” or “Induced Menopause”, caused by
 - Surgery to remove both ovaries, known as a bilateral oophorectomy. This causes menopause very quickly, no matter what your age. This of course can be very difficult to deal with, as it comes on suddenly, potentially well before average menopausal age, and you are already dealing with the condition that required the surgery. Some women begin experiencing menopausal symptoms almost immediately after surgery. As well as HRT, testosterone (sometimes known as “androgen therapy”) may be recommended in this scenario, as you won't have even the low level of hormones produced by the ovaries after a “natural” menopause. Testosterone can help with the bone strength, memory, and sexual desire.
 - Surgery to remove the womb (hysterectomy), or the removal of one ovary (unilateral oophorectomy), can lead to menopause starting a little earlier than it might have (but not immediately as in the case of removal of both ovaries). If you have a hysterectomy but keep both ovaries, you have a 50% chance of entering perimenopause within the next five years. The symptoms of decreased oestrogen may take some time to appear, or even go unnoticed because you aren't having periods anyway and so won't be alerted by your cycle becoming irregular.
 - Chemotherapy or radiotherapy for any cancer can interfere with or stop ovarian function. This can be temporary or permanent. If you are already close to average menopausal age it is more likely that it will be permanent and you will go through your menopause once treatment is underway. If you are younger, for instance in your 30s, you are likely to experience menopausal symptoms at this point, but in some cases your ovaries may begin functioning again for a time after treatment has concluded. Even if this does occur, however, you are likely

to then go through a “natural” menopause earlier than if you had not had the treatment. Premature Ovarian Insufficiency as a result of such treatments is sometimes known as a “chemical menopause” and of course can be as difficult to deal with as any other form of early menopause.

- Breast cancer treatments other than chemo and radiotherapy can also stop the ovaries from functioning; once again, this may be either temporary or permanent.
- Sometimes no particular cause for POI can be identified: this kind of premature menopause may be genetic (resulting from an inherited predisposition to stop producing eggs early) as there is sometimes a history of premature menopause running in the family.

Menopause in transmasculine people

As mentioned in the introduction, not all people born with ovaries think of themselves as women. If you have ovaries, however, you will at some point undergo some form of menopause.

- If you do not undergo any surgical or hormonal transition your body will experience the loss of oestrogen much as any woman would, although of course the psychological and emotional significance may feel quite different.
- If you have surgery to remove your ovaries you will undergo an immediate surgical menopause, although the symptoms may not be as extreme if you are taking testosterone for the purpose of masculinisation.
- If you do not have surgery but take masculinising testosterone, this may cause an earlier menopause as well, but more gradually.

It seems, however, that masculinising testosterone masks the effects of menopausal oestrogen-loss, so whether you have your ovaries removed or lose ovarian function more gradually, you are likely not to experience many of the unpleasant effects of menopause. (Research on this is still scarce, however.) Your bone health, for instance, should be closer to the average man’s, protected by the “male” levels of testosterone you are taking – as long as you *are* getting the right levels; this should be monitored by the medical professional overseeing your masculinising hormone therapy. If you have additional risk factors for osteoporosis your masculinising testosterone may not be enough to protect you from osteoporosis, however. If you had your ovaries removed before the age of 45 and the levels of your testosterone treatment were inadequate then you would be at risk. And if you were to stop taking testosterone in later life your bones would no longer be protected.

“About 1 in 100 women experience menopause before the age of 40”

Whatever kind of medical gender transition you are undergoing, your hormonal situation might be complex so it is important to seek out information and advice tailored to your individual case.

Before we begin discussing the unpleasant effects that can be (but are not always!) produced by the hormonal changes of menopause, it's vital to say that not all women find the effects difficult to cope with – and even among those who do, many also report positive changes in postmenopausal life.

While we want everyone to recognise that the changes and challenges of menopause are real and not the products of hysteria, we're aware that focussing on these can make it seem as though menopause is some kind of natural disaster. But menopause doesn't have to signify the end of a woman's life: on the contrary, it can be the start of a new chapter. Think of our closest relatives, the great apes: they keep on reproducing up until the bitter end. But we, like certain marine mammals, get to enjoy a period of life during which we are freed from our reproductive role and can dedicate ourselves more easily to other aims.

Many really appreciate being without that hormonal cycle, and feel calmer, more stable, more themselves (and perhaps more able to put themselves first, too). Some women who are prone to depression pre-menopause suffer from it less in postmenopausal life. Freedom from periods – the bleeding, the cramps and low mood – can be wonderful. It isn't necessarily the end of a fulfilling sex life, either; there are plenty of women who report that their libido returns after menopause – sometimes increased! – and some heterosexual women find it liberating knowing that pregnancy is no longer a risk. Other women are actually rather relieved to have less desire for sex and find this equally freeing.

For some the process of change itself, even if it is difficult, is a "rite of passage", a milestone or marker of moving on to the next stage. It can be a time of transformation that results in a significant shift in how we see ourselves. Perhaps, if the world were arranged a little differently, it could be this way for all women. Postmenopausal life could be seen as another phase in a woman's life: different, but not lesser. In a world that valued maturity in women as highly as in men, menopause could even represent an increase in significance and power. Post-menopausal orcas (killer whales), for instance, are the sages of orca society: they are the repositories of knowledge crucial to the survival of the group.



This is our aim: that women should take ownership of this transition, even if it isn't always plain sailing to cross from one side to the other.

There are women who say they have more energy and more confidence after menopause. Indeed, the anthropologist Margaret Mead once declared that "there is no greater power in the world than the zest of a post-menopausal woman." This phenomenon has been dubbed *PMZ*: Post Menopausal Zest or Zeal. Clearly, it's already the case that postmenopause can be a time of liberation and new beginnings!

Whether you prefer to think of these as symptoms, unpleasant effects or challenges, it helps to be prepared. Some say there are 34 “symptoms” of menopause, some say more. Not all women experience all of these effects, and all women experience menopause differently, because no two bodies will produce exactly the same hormonal fluctuations. Sharing experiences, however, can help women realise that what they are going through is, in fact, to do with menopause – because many of us think we’re just losing it, going through a hard time, or getting older. It can also be helpful to share this list with others in your life who are failing to recognise that your experiences are real. Below you will find some descriptions of the short- and long-term changes brought about by peri-menopause and menopause; we’ll come to the options for managing and treating these unpleasant effects afterwards, in the section ‘Managing the Menopause’.

- **Changes to your menstrual cycle.**

The hormonal fluctuations of perimenopause can cause just about any variation you could possibly imagine, but some common ones include:

“Some say there are 34 ‘symptoms’ of menopause, some say more”

- **Lighter bleeds lasting fewer days** – which occurs when oestrogen levels are lower.
- **Heavier bleeds lasting longer.** This affects about 25% of women in perimenopause; it is sometimes called hypermenorrhea, menorrhagia, or flooding. It may be a relatively harmless inconvenience, or it can be a sign of something that you need to get checked, so do read on for details:
 - One cause of heavier bleeds is progesterone being lower in relation to oestrogen. This can be merely an inconvenience, but if you regularly have an extremely heavy flow you may become anaemic and feel very tired, weak or sometimes dizzy. Taking an over-the-counter NSAID such as ibuprofen every four to six hours during heavy flow will decrease the period blood loss by 25 to 45, or you might want to consider treatments for anaemia. If heavy bleeding is extreme and prolonged you should see your doctor, who can check your blood count and iron levels – and make sure there isn’t another cause.
 - Polyps are another possible cause: these are small, tissue growths that can occur in the lining of the womb, and which can increase during perimenopause, causing bleeding. They are usually non-cancerous (benign), although some are or can eventually become cancerous
 - Fibroids, another kind of non-cancerous growth that can occur in or around the womb, may also be increased during perimenopause and can *sometimes* cause heavy bleeding, especially if the fibroid grows into the uterine cavity.
 - Sometimes bleeding has other causes – including, rarely, precancerous or cancerous growths – so it is important to see your doctor if bleeding is excessive – especially if it occurs at a time other than your period (difficult to know, sometimes, in perimenopause), or if it occurs when you have not had periods for more than 12 months and believed you were postmenopausal. If you are given treatment of any kind for heavy bleeding but it persists, it is also recommended you go back to the doctor for further tests.
- **Shorter cycles** – usually just a few days shorter but sometimes a week or more, so that you feel as though you’re starting a period when the last one has only just finished
- **Skipped periods** (particularly common later in perimenopause) which are often followed by a very heavy period the next month

- **No periods for several months followed by a single bleed, or by a return to a regular cycle;** more rarely, **no periods for more than a year followed by a return to bleeding.**

While being period-free for 12 months is commonly considered proof that you are now post-menopausal, there are such exceptions. It is recommended, however, that you see your doctor if this happens, as bleeding after 12+ months without periods can be a symptom of something else entirely.

- **The famous “hot flushes” or “hot flashes”** that affect more than 75% of menopausal women. These actually fall into a larger group of symptoms (“Vasomotor Symptoms”) and they occur because the dramatic loss of oestrogen affects the ability of the hypothalamus to regulate body temperature. Night sweats also fall under this umbrella. Interestingly, vasomotor symptoms are experienced differently across cultural groups: Japanese women, for instance, describe chills as opposed to hot spells. It’s easy for people who have never experienced these symptoms – men, but also younger women – to dismiss them as unimportant or something to laugh at. They are, however, very real: no one is making them up or exaggerating them. They can be distressing and difficult to manage, partly because they can cause dramatic sweating, which can be both physically and socially difficult to deal with, but also because they can be accompanied with heightened anxiety and palpitations. While these are not dangerous, they can feel exceedingly unpleasant and make life quite difficult – especially if you’re at work or doing something else important.
- **Vaginal dryness, discomfort or pain**, including your labia rubbing on underwear and pain during sex (caused by what is often termed “vaginal atrophy”, but we don’t like that term and prefer to talk about thinning of the vaginal tissue)
- **Increased likelihood of vaginal infections** such as thrush and BV
- **Increased likelihood of urinary tract infections**
- **Increased chance of pelvic organ prolapse**, which is when the muscles and ligaments which keep your uterus, bladder and rectum in place get too weak to do this job, meaning that one or more of these organs bulges into the vagina or even out of its opening. This is often experienced as a feeling of “ballooning” into the vagina or general dragging in the pelvis. While pelvic organ

prolapse is not exclusively linked to menopause, the muscles in this area (including the walls of the vagina) are sensitive to oestrogen and so are often weakened when oestrogen levels decrease. Repetitive strain, such as the strain involved in a lot of heavy lifting,

“Decreased sexual desire can be a direct result of hormonal changes”

being very overweight, or suffering with chronic constipation or a chronic cough, can increase the chances of prolapse. Giving birth or having a hysterectomy also increase the chances. There are options for treating prolapse, however, as well as for helping prevent it in the first place: see the sections on ‘Pelvic Floor Strength’ and ‘For Pelvic Organ Prolapse’ under ‘Managing the Menopause’.

- **“Stress incontinence”**, which is when physical strain such as heavy lifting, coughing, sneezing or laughing causes you to pass urine. Strengthening the muscles of the pelvic floor can be very helpful here, as these are the muscles that control the release of urine and faeces. Again, HRT may help – some women even find that local HRT has a positive impact on bladder problems.
- **“Overflow incontinence”**, which is when you don’t get the signal that your bladder is full and therefore end up passing urine accidentally.
- **Decrease in sexual desire or not wanting to have sex because it is uncomfortable.** Decreased sexual desire can be a direct result of hormonal changes, but a number of menopausal symptoms and changes can make women feel uncomfortable in their bodies (physically and/or emotionally) and therefore less sexual or sexually confident. Some women

feel uncomfortable even being hugged, kissed or touched at all. All of this can be difficult to come to terms with and difficult to talk about, and for those women who are in romantic/sexual partnerships it can sometimes lead to relationship strain, whether your partner is a woman or a man. Some women might not actually realise that this new dislike of intimacy has to do with (peri)menopause and therefore believe they are falling out of love with or no longer attracted to their partner. HRT helps some women with desire and with vaginal dryness; local oestrogen (creams, gels, pessaries) is particularly helpful with vaginal dryness if that is the main problem. Testosterone can also really help with desire if HRT isn't doing enough.



- **Effects on mood and mental health.** Like the other symptoms of menopause, these can range from negligible to severe. Emotional and psychological symptoms may be more difficult to pin down, but they are no less real: oestrogen and progesterone play an important role in a woman's mood and the regulation of the other chemicals in her brain. On top of that, the other symptoms of menopause – such as loss of sleep and loss of sexual desire – can have an impact on your mental and emotional wellbeing. The fact that a number of other changes or challenges often arise at this stage of life can make it difficult to know whether your feelings have to do with menopause or not: if you had children they may be leaving home, or you may still be supporting them while also having to care for elderly relatives; you may be starting to face the combination of ageism and sexism that leads to many women feeling dismissed and invisible; or if you are going through a medical menopause you will be dealing with the blow of your diagnosis. Many women, in fact, experience emotional/psychological menopausal symptoms without realising that the cause is hormonal, and can be very frightened by them. Knowing these are common patterns can be very helpful:

- Mood swings: fluctuations in hormones can produce fluctuations in mood, as many of us already know from our menstrual cycles. The fluctuations of perimenopause, however, tend to be much less predictable and sometimes more disruptive. They can include peaks of irritability and anger, anxiety or panic, and extremely low mood.

- Increased anxiety: as oestrogen drops, anxiety increases. (Pre-menopause, this is why many of us feel anxious/stressed when expecting our periods.) This doesn't mean that you will have heightened anxiety for the rest of your life, as in most cases your system will adjust to the lower levels of oestrogen once the fluctuations of perimenopause are over. If you are suffering with anxiety during or after perimenopause, however, treatment may help.
- Low mood (including suicidal feelings): less oestrogen means less serotonin (often known as the happy hormone). Many women report extremely low mood, symptoms of depression and suicidal feelings in the years leading up to and around menopause. In fact, while the suicide rate for men declines from 40 to 54, for women it increases in this period, peaking between 50 and 54, which happens to coincide with the average age of menopause. Now, this certainly doesn't mean that women are guaranteed to feel suicidal at menopause, let alone to commit suicide, but it's clear that this phase of life can have a significant impact on the mental health and emotional wellbeing of women. While hormones may not be exclusively to blame (other life-

“Many women report extremely low mood, symptoms of depression and suicidal feelings in the years leading up to and around menopause”

changes and the ageism that affects women in particular may also have an impact), it certainly seems that some women are severely affected by hormonal changes. (This is why the days leading up to a period, and the weeks following childbirth are also times of excess depression for some women.) If you are struggling with low mood in this period of your life, please don't suffer in silence. HRT can really help, but there are other options if this isn't for you.

- For more information on mood changes and recognising depression in menopause, visit www.rcog.org.uk/en/patients/menopause/mood-changes-and-depression/

- **Sleep disturbances** from perimenopause through to postmenopause, many women report disruption to their sleep. It may be that you find it more difficult to fall asleep, or that you wake up in the middle of the night / early in the morning and can't get back to sleep easily; or you may simply feel less refreshed by your sleep than you used to. The famous vasomotor symptoms of reduced oestrogen – including hot flushes, night sweats and chills – as well as bladder problems and low mood or anxiety are often responsible for disrupting a woman's sleep in these years, but it may also be that the decrease in progesterone contributes directly to sleep disturbance. And the hormone melatonin, which is vital for sleep and decreases with age anyway, is further affected by the decrease in oestrogen and progesterone.

- **The risk of sleep apnoea (when breathing is disrupted because the throat relaxes in sleep)** may also be increased – possibly linked to weight gain, or because progesterone plays a role. This seems to be more common in women who have had a surgical menopause.

- **Restless Legs Syndrome:** tingling, creepy-crawly or uncomfortable sensations in the legs at night, often making you feel you need to keep moving them. Women are twice as likely as men to experience this, and it seems to worsen with menopause.

Loss of sleep can obviously have far-reaching impacts, further affecting mood, anxiety and your ability to function well. Many women find that HRT improves their sleep.

- **Fatigue:** this is less about having the desire to sleep than about your energy levels crashing suddenly through the floor (crash fatigue) or being persistently low over a long period. It's a feeling of weakness or crushing exhaustion rather than sleepiness. This may be accompanied with feeling irritable and unmotivated, and/or with difficulty concentrating. Oestrogen is important in regulating energy levels, so as oestrogen levels drop so can your energy. (Many women experience this, pre-menopause, around the start of a period, when oestrogen levels also drop.)
- **Headaches:** these are common during perimenopause, affecting 90% of women in these years.
- **Migraine:** women who are already prone to migraines sometimes find these worsen around menopause. This is because migraines seem often to be triggered by hormonal fluctuations – hence they tend to worsen at puberty, and some women will already have noticed a link between their period (especially a heavy one) and migraines. The fluctuations of perimenopause, then,



often trigger them even more. On the plus side, many women find that once the menopause is well and truly behind them (it can take a while for hormones to settle), they suffer far less with migraines than ever before. While menopausal symptoms persist, women often notice a link between hot flushes and migraines – therefore anything that helps with your hot flushes can help with migraines. HRT in the form of patches or gel are recommended rather than tablets if migraine is an issue, as they provide a more consistent flow of hormones.

- Memory lapses and trouble concentrating:** many women of menopausal age report become more scatty and forgetful – misplaced keys, forgotten appointments, difficulty keeping on top of everything you've got to do at work. This can be embarrassing and upsetting; it can knock your confidence, and many women simply feel they are "getting past it." Some worry that this may be the onset of dementia or Alzheimer's. The reality is that the loss of oestrogen affects cognitive functions like memory and concentration: many women find that HRT helps a lot, but the most important thing is to recognise that this is probably a menopausal symptom and not something to be worried or ashamed about. It's only if memory lapses are becoming both routine and serious that you need to worry that it's more than menopause – e.g. if you are getting confused about the time and place, having difficulty carrying out a normal conversation, regularly finding yourself unable to carry out mental tasks that used to be easy (such as handling money, doing the crossword, or making judgments and decisions). If you're experiencing difficulty with your memory, it is best to speak to your doctor – whether to look into getting HRT or to work out whether there is another cause.
- Skin changes, dryness and irritation.** Many women notice the feeling and appearance of their skin changing. Very dry skin, flakiness and itchiness are commonly reported, as is 'formication,' a kind of creepy-crawly feeling or tingling sensation, sometimes all over or sometimes in the extremities. This is because collagen reduces as oestrogen goes down, meaning skin actually gets thinner, loses some elasticity and has less ability to repair itself. Skin changes can also go the other way to oiliness and spottiness for a time.
- Hair thinning or loss / brittle hair.** Changes to hair growth and quality are commonly noticed in perimenopause. It may appear less thick, less healthy-looking, more brittle and breakable. It might grow more slowly. It might come out more in the shower or basin or when you brush. For some women hair becomes visibly thin so that the scalp shows through in patches (often at the crown) or quite generally over the head, and this of course can be very upsetting. It's very rare, however, to get complete baldness, and this would usually be caused by some other medical condition or chemotherapy. What happens to a woman's hair as she ages is known as Female Pattern Hair Loss (FPHL), and is partly caused by hormonal changes (oestrogen may play a role in promoting hair growth, while testosterone unbalanced by oestrogen in postmenopausal women may promote more hair-growth on the chin and less on the head!). FPHL is very common, though its prevalence seems to vary according to ethnicity and family history (as does male pattern baldness). Most women who experience changes to their hair will find that these changes slow down and things stabilise; if your hair loss is dramatic, however, there may be another cause, and you should consider consulting your doctor. Illness, stress and diet can all affect hair growth. Other causes include anaemia, thyroid dysfunction or skin disorders. Hormonal imbalances not caused by perimenopause can also cause hair loss, so if this change is accompanied by irregular periods, unusual increase in facial hair (more than just on your chin and upper lip) and new bouts of acne, then this may need to be explored.
- Changes to finger and toenails:** lower oestrogen levels can lead to dryness and brittleness in the nails as well as hair and skin. You may notice your nails breaking more easily, splitting, curling, changing in colour or displaying ridges on the surface. Nutrition, stress and certain diseases can also affect nail growth and appearance, however, so if this applies to you, you may want to find out more.

“The reality is that the loss of oestrogen affects cognitive functions like memory and concentration: many women find that HRT helps a lot”

- **Osteoporosis** is a condition affecting the bones. Bone tissue stops being renewed and bone density decreases, meaning that bones become progressively weaker until they fracture very easily – in extreme cases, from as little as a cough or sneeze. Everyone loses bone density with age (after 35 or so) but osteoporosis describes a greater-than-normal weakening of bones, where fractures occur due more to poor bone health than to trauma. It affects 1 in 2 women aged 50+ as opposed to only 1 in 5 men: once again, it's the loss of oestrogen that's the cause. This is a long-term effect of menopause which doesn't go away once you're through the change. There

“The decrease in oestrogen makes us less able to transform the protein in our diets into muscle”

are a number of things you can do to protect your bone health, though, and treatment options if it emerges that you do have osteoporosis, or osteopenia – the stage of weakening before full-blown osteoporosis. We'll cover these in the section 'Love your Bones' under 'Managing the Menopause'.

- **Symptoms:** Most people don't realise they have osteoporosis until they fracture a bone. Loss of height, stooping and extreme back pain can be signs of osteoporosis (where all are caused by fractured or collapsed vertebrae), but again these symptoms only become apparent when the bones are already significantly weakened. For this reason all women should think about how to protect their bone health, especially if they have any **additional risk factors**:
 - an early menopause
 - no periods for an extended period of time prior to menopause (e.g. periods stopped for a year or more due to stress, ill health, low weight)
 - a family history of osteoporosis, or fractures are common in your family (especially hip fractures), or you yourself suffer fractures frequently
 - low body weight (e.g. a BMI of less than 19)
 - taking a medication that causes bone loss, such as steroids (often prescribed for asthma and arthritis)
 - a low-calcium diet (e.g. you don't consume dairy products and aren't sourcing adequate amounts of calcium elsewhere)
 - not getting enough Vitamin D (which helps you absorb calcium)
 - any condition that affect your ability to absorb nutrients, e.g. Crohn's disease
 - an eating disorder, especially anorexia or bulimia (because you will not be getting the necessary nutrients if you aren't eating well; also because if your periods stop for an extended period due to low bodyweight your oestrogen levels may be impacted)
 - not getting much exercise (because your bones, like your muscles, respond to the demand you put on them, and get denser with more exercise – especially weight-bearing exercise)
 - smoking
 - excessive alcohol consumption
- **Reduced muscle mass:** Both sexes naturally lose muscle mass with age. It seems that the effect is larger for post-menopausal women, however. The decrease in oestrogen makes us less able to transform the protein in our diets into muscle. As with bone health, however, there are a number of things we can do to prevent muscle loss accelerating: see the section 'Maintain your Muscles' under 'Managing the Menopause'.
- **Joint and muscle aches; muscle cramps:** many women notice that they feel more body pain, especially joint pain, at this time in their lives. It is believed that oestrogen helps to keep joints hydrated and inflammation-free, which may be why women often experience more joint pain and stiffness (particularly in the mornings). In addition to this, oestrogen facilitates the uptake of magnesium, which is needed for muscle function. Low magnesium causes muscle fatigue, aches, and cramps. It also affects your mood and sleep pattern.

- **Mouth and teeth:** the loss of oestrogen can affect oral tissues, including the gums, salivary glands and jawbones. The risks of gum problems (e.g gingivitis) and tooth decay are increased. Without oestrogen all our mucous membranes get drier, and there can be a decrease in saliva production, so that your mouth feels dry when you're trying to speak or eat; food can suddenly seem to need more chewing. Then there's an experience sometimes known as 'burning mouth syndrome', a sensation of burning, tingling, scalding, tenderness or numbness in their mouths. And your taste buds can become less sensitive to sucrose, giving some women increased cravings for sweet foods!
- **Dry/watery eyes:** as with the vagina and mouth, the eyes can also be affected with dryness due to menopause. Confusingly, women can feel that their eyes get both dry and watery. This may be because hormonal changes affect the make-up of our tears so that they're too watery and don't actually stick to our eyes and lubricate them.
- **Weight gain and slowed metabolism:** many women find themselves gaining weight, and especially growing more apple than pear-shaped (let alone hour-glass) post-45. In this fat-hating society of ours, the majority of women struggle life-long with difficult feelings around their weight and shape, as well as with attempts to control and change these. This can become even more difficult in mid-life, for a number of reasons.
 - Hormonal changes increase the body's tendency to deposit fat and affects the way we store it: more around the middle than on the hips – as men tend to do.
 - The loss of muscle mass mentioned above also plays its part here. Muscle burns more energy than fat does, even while you're sitting on the sofa – meaning that as your body begins to make less muscle and more fat, your metabolism slows down. (Dieting also leads to loss of muscle mass, by the way.)
 - In mid-life we simply need fewer calories than we did before – but often continue eating as much as ever, if not more.
 - Then there are the lifestyle factors: it may be that we exercise less as we grow stiffer and achier, or because problems with bladder control make exercising more difficult or embarrassing. It may be that young children kept us running around previously, and that at this age we grow more sedentary – whether that's at home or at work.
 - Loss of sleep and the crushing feeling of exhaustion that can come with menopause may also lead us to eat more to try to give ourselves energy, as well as prevent us from being as active as before.
 - Anxiety and stress also tend to lead to weight gain – not only because we may comfort-eat, but because the stress hormone cortisol actually breaks down muscle tissue to reduce energy, promoting the storage of fat. And a study has pointed to higher nighttime levels of cortisol in menopausal women.
- **Changes to your breasts:**
 - The hormonal fluctuations of perimenopause can cause breast tenderness – much like premenstrual tenderness, but in a less predictable pattern. If you have very persistent pain, however, you should go and get checked out.
 - Closer to menopause, as oestrogen levels drop the glandular tissue in our breasts (the milk system) begins to shrink. This means that our breasts grow less dense. They may appear less full, less firm, and changed in size or shape. The fact that most of us gain weight over our lives mean that the majority of women go up in bra size in mid and later life, despite the shrinking of glandular tissue. Any dramatic change in shape, however, is something you should get checked.



MANAGING THE MENOPAUSE

(OR, MAKE THE MID-LIFE THE GOOD LIFE)

Whether you feel like you've got permanent PMT or already love your new PMZ, you may want to consider taking some form of action to manage the short- and long-term effects of this change and to live your life well. This could involve targeted exercise, dietary adjustments, alternative or mainstream medicines. Knowledge is power: if we know what to expect, and understand what causes our suffering during and after the change, we can find ways of pre-empting, preventing, coping and living well.

Lifestyle

Putting your suffering down to your lifestyle can sound like blame – and that's the last thing we want to do. The loss of oestrogen has real impact and even the fittest and healthiest of women can experience the effects. Nevertheless, there may be certain things you can do, before, during and after menopause, that may help to lessen or alleviate the impact, and thus improve your quality of life.

Strategies for vasomotor symptoms

Dress to sweat less

We're not suggesting that you can fix everything with the right kind of clothing, but this is the kind of wisdom that women share amongst themselves when it comes to dealing with hot flushes:

- Wear natural fibres such as cotton and linen – these "breathe" better (and tend to smell less!)
- Rather than a single warm layer opt for multiple light and easily removable layers so that you can take some off at the first sign of your temperature going up
- Wear sleeveless garments
- Avoid jumpers, scarves and polo-necks
- Carry a hand-held fan

For night sweats

- Keep the room temperature low
- Have a fan blowing
- Use a light cotton duvet or cover
- Have a separate cover for yourself if you share the bed with someone
- Turn the pillow over to the cool side when you feel warm
- Put a cold pack under the pillow
- Do away with pyjamas, or wear something light and loose to sleep in
- Have cool water to sip
- Establish a calming bedtime routine so that you are relaxed

Food for flushes

Certain foods and drinks may trigger hot flushes more than others. It is quite common to find that refined carbohydrates, sugar, spicy foods, alcohol, caffeine and smoking are linked to hot flushes, but triggers can be very individual so it may be useful to keep a food/flush diary to try to spot patterns.

There is evidence to suggest that foods high in omega-3 fatty acids, such as oily fish, may reduce the frequency of hot flushes as well as reduce joint inflammation and alleviate some of the low mood or depressive feelings associated with menopause.

Some believe that consuming higher levels of plant oestrogens can reduce the unpleasant effects of oestrogen-loss (see also the section 'Soya products, isoflavones, and red clover (phytoestrogens)' under 'Herbal treatments for Vasomotor Symptoms'). Soya products, flax seed (also high in fibre and omega-3 fatty acids) and linseed are examples.

Don't diet: eat what you need

Being underweight can have a negative impact on your bone health, and in this fat-hating society it's important to remind ourselves that slim doesn't automatically mean healthy. Equally, there is evidence to suggest links between obesity and a number of diseases that may particularly concern women in mid- and later-life, such as breast cancer and heart disease. There is also evidence suggesting that carrying more weight may be linked to greater severity of hot flushes and night sweats. And as discussed in the section 'Symptoms or Unpleasant Effects', the hormonal changes of menopause affect the way your body stores and distributes weight.

“Some believe that consuming higher levels of plant oestrogens can reduce the unpleasant effects of oestrogen-loss”

For all these reasons it is recommended that rather than “dieting” (not healthy in any phase of life!) you eat well, but not too much, and exercise if you can.

If you have noticed that your gaining weight, or if you want to pre-empt this:

- Don't try a crash or fad diet. Simply make all your portions a little smaller. It's likely that you need less food than you used to.
- Make sure those portions contain everything you need, however, for bone, heart and mental health! All the food groups need to be present, including carbohydrates and fats. Plenty of protein for your muscles, lots of fruit and veg, oily fish, nuts, wholegrains and white meat over red.
- Avoid processed and sugary foods.
- Avoid stress as much you can! Cortisol, the stress hormone, leads to more storing up of abdominal fat, which is less healthy.
- Keep as active as you can. Exercise increases muscle and brown fat, both of which burn more calories for us.
- Some medical professionals also suggest that HRT might help to keep your weight down. Maintaining higher oestrogen levels discourages the abdominal fat from building up, and you might be more likely to exercise and less likely to over-eat if you are not feeling overcome by symptoms.

Exercise for anxiety, low mood, and just about everything else

It is very common for anxiety levels to go up and mood to go down around this time. Many find that exercise really helps, using up nervous energy and releasing endorphins that provide a feeling of wellbeing.

Feeling fit and able in one's body can also really help with the low self-esteem that affects many women around this time. And then, of course, keeping fit has numerous health benefits, to which we'll return...



Love your bones

If you have been diagnosed with osteoporosis or osteopenia (the stage of bone weakening before full-blown osteoporosis) your doctor will discuss the treatment options with you.

If you suspect that you may have osteoporosis or have any of the additional risk factors you should talk to your doctor; a DEXA scan can assess bone density, the level of risk and need for treatment.

What we will cover here are some things that all women can try, pre- and post-menopause, to keep their bones healthy.

- **Get regular exercise**, especially weight-bearing exercise, as this stimulates the renewal of bone tissue. Brisk walking, hiking, climbing stairs, jogging, running, dancing and playing tennis are all examples. Strength training (e.g. lifting weights) can also strengthen bones. While swimming and cycling are great for your heart and muscle health (and having stronger muscles does protect your bones somewhat), they don't have as much direct impact on bone density.
- **Eat well.** Your bones need the full range of nutrients: carbohydrates and fats as well as protein, vitamins, minerals and so on.
- **Calcium is especially important.** The recommended daily **minimum** is 700mg, equivalent to one pint of milk; yoghurt and cheese, especially hard cheeses, are also a good way to take in calcium. If you don't consume dairy products you will need to make a little extra effort (the body absorbs calcium more easily from dairy than from plant sources). Naturally calcium-rich foods include green leaves such as watercress and curly kale, seeds such as poppy, sesame and chia, dried fruit such as currants, and tinned fish containing bones such as sardines. If you use a cow's milk alternative make sure it's one that is enriched with calcium.
- **Get sunshine or supplements for Vitamin D.** We need Vitamin D in order to actually benefit from calcium. Most white people can get enough of it from the sun from April to September, but in autumn and winter you need to get it from your diet (oily fish, red meat, liver, egg yolks) or consider supplements. If your skin doesn't see the sun much (because you remain indoors, or cover up when you go out) supplements may be important all year round. If you are darker-skinned (e.g. of African, Afro-Caribbean, south Asian or Latin American ethnic background) you are at higher risk for Vitamin D deficiency and may be unable to get enough of it from the sun, especially the British sun, so should also consider supplements all year round. 10mg/day (for adults) is generally enough, whether for seasonal or year-round supplementation.
- **Consider other lifestyle changes**, such as giving up smoking and reducing alcohol consumption.
- **Consider HRT.** The oestrogen has been shown to reduce the risk of osteoporosis and fracture. Keep in mind, however, that when you stop taking HRT its protective effect will wear off and you will need to consider other options for your bone health.

Maintain your muscles

As discussed, muscle loss accelerates for women when oestrogen is lost. But this can be slowed down or counteracted to a degree.

- Regular exercise, but especially resistance exercise or strength training – e.g. lifting weights, doing squats and press-ups – can really help to maintain your muscle mass.
- Getting enough protein in your diet is also really important for maintaining muscle: meat, fish, eggs and nuts are among the best sources.

Remember that stronger muscles also provide some protection from joint problems (including in the spine) and from fractures.

Pelvic floor strength

As discussed in the section on effects, the weakening of pelvic floor muscles associated with menopause increases the likelihood of urinary incontinence and pelvic organ prolapse – with each of these problems affecting about 40% of women. It can also diminish sexual pleasure. Having had children further increases the likelihood of problems with these muscles, and having had a hysterectomy adds to the likelihood of experiencing a pelvic organ prolapse. Pelvic floor exercises, then, might be among the most important forms of exercise a woman can do – and the bonus is you can do it sitting down!

Prevention is better than the cure, and a number of women in mid- and late-life might like to go back and tell their younger selves to begin doing these exercises early on. If all girls and women were informed and practised these exercises life long, they might be spared much distress. Even starting them later on can be very beneficial, however, and significantly reduce existing problems with stress urinary incontinence.

Do some research on pelvic floor exercises, or visit this link for a very handy guide: http://thepelvicfloorsociety.co.uk/budcms/includes/kcfinder/upload/files/eng_pfe.pdf

If you are already suffering from a pelvic organ prolapse, these exercises in combination with physiotherapy for your core muscles may help alleviate the symptoms. There are further options, however: see the section, 'For Pelvic Organ Prolapse.'

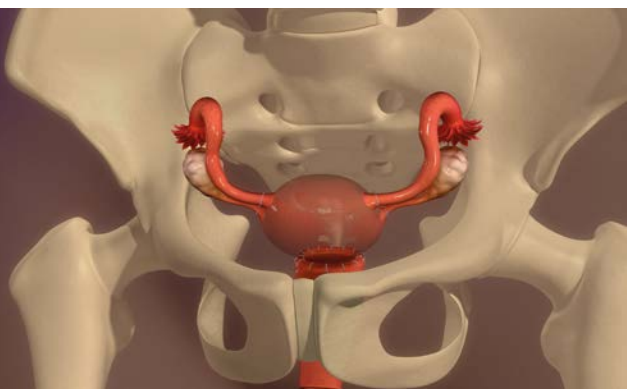
“Your bones need to the full range of nutrients: carbohydrates and fats as well as protein, vitamins, minerals and so on”

TREATMENTS

For pelvic organ prolapse

As suggested above, pelvic floor and core strength exercises are important for prevention of pelvic organ prolapse and can also be used to treat it if it happens. Because the loss of oestrogen contributes to the weakening of our pelvic floor muscles, taking HRT during menopause may also help to reduce the likelihood of prolapse.

If you already have a prolapse it is a good idea to go to see your doctor. For a less serious prolapse exercises and physiotherapy may be enough, but there are other options. If you go to a doctor you may be offered a pessary (a device inserted into the vagina to support the pelvic organs); if it's more severe then surgery may be recommended. This may be with or without the insertion of "mesh" to hold your organs in place; we would recommend caution before accepting a solution involving mesh, as a number of women have reported ongoing problems with these procedures. If this is recommended to you, be sure to ask about the alternatives, the pros and cons, and how much experience and success your surgeon has had with inserting mesh in the past. You may want to seek out additional information and advice.



Hysterectomy

Some women want or are recommended a hysterectomy for management of menopausal symptoms such as heavy/irregular bleeding. While this may be appropriate in some cases, for instance where the cause of heavy bleeding is fibroids, it is an invasive and irreversible surgical procedure with potentially adverse effects and therefore is a step that should be considered very carefully. For example, the risk of vaginal vault prolapse is increased after hysterectomy – particularly if you have also given birth.

Hormonal options

Because the unpleasant effects of perimenopause and menopause are caused by the decrease in or loss of oestrogen, one option is to try to get this hormone from somewhere else. There are a number of plants and foods that contain a version of it, there are "natural" remedies that use these plant oestrogens, and then there is pharmaceutical hormone replacement therapy (HRT).

Hormone replacement therapy (HRT)

There has been a lot of controversy and stigma around HRT, so we'll address this first.

It is estimated that only 10% of UK women with menopausal symptoms are using HRT. At Bristol Menopause we believe that taking HRT or not taking HRT are equally valid choices – that is, when a woman makes an informed choice freely, for herself. Because while there are plenty of women who do manage menopause perfectly well without HRT, we are concerned that a pressure to "do things naturally", as well as widespread exaggerations of the risk involved in HRT, may be preventing others from experiencing a better quality of life. We know that there are women whose doctors refuse them HRT when they ask for it, for the wrong reasons. On the other hand there are women who use HRT because their doctors assume or insist, or because they feel it is the only option for improving their quality of life during menopause.

The aim of this section, then, is to bring together information and ways of thinking that will help

women to make this choice truly their own: whether that means hunting down all the replacement oestrogen you can find, or wearing your hot flushes loudly and proudly while refusing to let even a single plant hormone pass your lips.

“HRT can be taken in tablet form, as patches on the skin, as a long-lasting implant, or vaginally”

We have heard many women expressing the feeling that they *should* be able to “do it naturally,” and that to take HRT would be to give in, to fail as women somehow. We’ve also heard men say that as menopause is a natural process women really should just go through it without interfering in it – all the while happily interfering in their own hangovers, heart disease and flu. There are so many things we humans benefit from on a daily basis which aren’t “natural”. In a world of painkillers, antibiotics, radiotherapies, incredible keyhole surgeries and sparkly dentistry, why is it only the menopause that should stay “natural”? It’s interesting that there should be so much more such stigma around using the tool of medicine to improve the quality of life for menopausal women than there is, say, around the use of antibiotics, or birth control for that matter; perhaps it is because these interventions also improve the quality of men’s lives...

On the other hand, there are many perfectly legitimate reasons for resisting the medicalisation of this phase of our lives. There are those who feel that the medical model is very patriarchal, depriving women of authority over their own bodies and experiences. And an assumption or pressure that women *should* keep their oestrogen levels high (their skin youthful and their vaginas moist) might come from the attitude that what’s most important about a woman is her sex appeal. Some women welcome the changes that come with the end of fertility, heralding a new phase of life.

Every woman should be given the chance to weigh up these arguments and decide what fits best with her outlook on life and the experiences she’s having.

It’s important to say though, that for those who are going through an early menopause (where periods stop before the age of 45, whether naturally or due to medical intervention), experts very strongly recommend HRT be taken up until the average age of “natural” menopause, because living without oestrogen for a longer-than-normal period of your life can be very harmful to bone and heart health.

As for the risks, there’s a whole section on this coming. First of all, we’ll outline what HRT actually is.

Types

HRT can be taken in tablet form, as patches on the skin, as a long-lasting implant, or vaginally. But as well as these different options for administering the hormones, there are a number of different basic models of HRT, which have different advantages and disadvantages:

Systemic HRT (i.e. affects your overall level of oestrogen):

- **Oestrogen-alone HRT:** this is normally only prescribed for women who have had their womb removed. (It’s oestrogen that helps with the adverse effects of menopause, but progestogen is needed to protect the lining of your womb if you still have one).
- **Cyclical HRT:** this combines oestrogen with progestogen and mimics the menstrual cycle so that you still have a monthly bleed (a “withdrawal” bleed, as with the contraceptive pill).
- **Continuous Combined Therapy HRT (CCT):** this also combines oestrogen and progestogen, but continuously so that you have no periods. Usually you would start on cyclical HRT and change to CCT later.

- Tibolone is a synthetic form of period-free HRT (manufactured from yams) which may have similar benefits to CCT. It is considered suitable for post-menopausal women (it may cause irregular bleeding in women who have not yet had their last period). It is taken continuously in tablet form.
- Long cycle HRT: this gives you withdrawal bleeds every three months instead of every month, and is most suited to women who suffer side effects when taking progestogen. Long term use of this HRT may not, however, be as safe for the lining of the womb (this is in question).

Local oestrogen (ie. doesn't affect your overall level of oestrogen):

- **Vaginal tablets, creams, gels or rings:** these can be used for treating local urogenital problems, such as vaginal dryness or pain, and bladder problems or infections. Because local oestrogen doesn't affect your overall level of oestrogen, it can be taken in combination with "systemic" HRT (all the forms above), or alone – even if systemic HRT has been considered unsuitable for you. It is not known to have any adverse side effects or associated risks.



Bio-identical hormones

The phrase "bio-identical hormones" carries more than one meaning. Literally and medically it means hormone preparations which are identical molecules to those produced by the body. According to this definition, some traditional HRT is already using "bio-identical" hormones, especially oestrogens. Most, but not all of the progestogens available on the NHS are synthetic versions, known as progestins. These have been developed because progesterone (the main progestogen found in the human body) is expensive to produce and doesn't have a very long shelf life. There have been many different progestins over time as medical science advances.

In practice, however, the term "bio-identical hormones" is also being used to market an alternative to traditional HRT. In this case, it usually refers to a mixture of hormones prescribed by private clinics and put together by "compounding chemists" or "compounding pharmacies" with the claim that these preparations, which mostly have plant origins but still have to be manufactured in a lab, are more "natural" and safer than traditional HRT. Often they are marketed as tailor-made to the individual's own hormone levels. These are most often taken from samples of your saliva.

The term can also refer to products available to buy online.

The British Menopause Society say there is "absolutely no evidence" that these compounds of bio-identical hormones are safer than those used in traditional HRT: they are likely to present the same risks as any other hormonal therapy. Indeed, they might even be *less safe*, as they are not being quality controlled. The usefulness and safety of salivary hormone tests are "questionable." Dosages may be inaccurate or inconsistent, purity is not being monitored by an external authority, and the producer is not obliged to test the safety of their product in the way they would be if it was regulated.

Doctors working with these compounds claim that their bio-identical progesterones are safer than the synthetic progestins, but Dr Heather Currie, chair of the British Menopause Society, counters that some of these "bio-identical" progesterone creams have not been proven to protect the lining of the womb. She advises women to be cautious about taking any hormonal preparation that hasn't been approved by the Medical and Healthcare Products Regulatory Agency (MHRA).

Is HRT really that risky?

Many people, including medical professionals, are alarmed by the side effects / risks associated with HRT, and this is a very common reason that women opt not to take HRT. When the evidence is examined, however, it can be seen that these fears are often exaggerated.

Women's Health Concern (an independent advisory service), in a fact-sheet reviewed by the British Menopause Society in November 2017, examine the risks and "the controversy that still surrounds" HRT, and conclude that:

- "For the majority of women who use HRT for the short-term treatment of symptoms of the menopause, the benefits of treatment are considered to outweigh the risks."
- "Although there have been concerns raised about HRT and the potential risks to various aspects of women's health, more recently published findings show that although not entirely risk free, it remains the most effective solution for the relief of menopausal symptoms and is also effective for the prevention of osteoporosis. It may in certain age groups provide protection against heart disease."
- "The balance of benefit to harm always needs to be assessed but appears to have shifted favourably for HRT."
- "Women on HRT should be re-assessed by their doctor at least annually. For some women, long-term use of HRT may be necessary for continued symptom relief and quality of life."

The "controversy" and "concerns" referred to here arose from two studies conducted in the 1990s (results published in 2003 and 2004), one in the US and one in the UK, which suggested that the use of HRT could increase the risk of heart disease, and that its extended use could increase the risk of breast cancer. These claims were well-publicised and created something of a panic, amongst the general public as well as medical professionals. Guidelines for doctors in the UK were changed to discourage its prescription, and the numbers of women using HRT fell by a half. These numbers haven't risen significantly since then, even though the findings of the two studies have since been questioned.

Increased risk of breast and ovarian cancer?

The women in the US study were in their mid-sixties and the majority were overweight – and it happens that age and excess weight are two factors which themselves increase the risk of breast cancer. (In the UK, the risk of being diagnosed with breast cancer increases from about 1 in 1900 women aged less than 30, to 1 in 15 women by the age of 70. Being overweight or obese can increase the risk very significantly, while regular exercise decreases it.)

"Oestrogen-only HRT doesn't seem to increase the risk of breast cancer at all, and combined HRT only increases it slightly"

In fact, oestrogen-only HRT doesn't seem to increase the risk of breast cancer at all, and combined HRT only increases it slightly – not more than the combined hormonal contraceptive does. This risk returns to normal once you stop taking combined HRT. Never giving birth represents a far larger increase in risk. (Multiple births and breastfeeding reduces risk significantly.) In other words: there does seem to be a small increase in breast cancer diagnoses among women who take combined HRT, but there are a number of lifestyle and reproductive factors that actually represent a greater increase in risk than HRT does. Take a look at the images overleaf to compare the various lifestyle and reproductive risk factors:

Risk of breast cancer diagnosis associated with lifestyle and reproductive risk factors

	Absolute risk of diagnosis per 1000 women aged 45 to 79 (baseline risk 23/1000 over 7.5 years)		
	Number of cancers diagnosed	Number of cancers not diagnosed	Excess risk
No exposure	12	988	–
Risk increased:			
Postmenopausal obesity or overweight	27-40	960-973	+4 to +17
Never having given birth	39	961	+16
Late age at first live birth (31 years or older)	31	969	+8
Alcohol (regularly drink two units or more per day)	29	971	+6
Combined hormonal contraceptives	29	971	+6
Combined HRT	29	971	+6
Smoking (current smoker)	26	974	+3
Risk reduced:			
Having your first period at 15 or older	19	981	-4
Estrogen only Hormone Replacement Therapy (HRT)	17	983	-6
Giving birth to 4 or more babies	15	985	-8
Taking at least 30 minutes moderate exercise five times per week	13	987	-10

This factsheet has been produced by Women's Health Concern and reviewed by members of our Medical Advisory Panel. It is for your information and advice and should be used in consultation with your own medical practitioner.

Reviewed: December 2017

Next review due: December 2019

Women's Health Concern is the patient arm of the British Menopause Society

Understanding the risks of breast cancer



A comparison of lifestyle risk factors versus Hormone Replacement Therapy (HRT) treatment.

Difference in breast cancer incidence per 1,000 women aged 50-59.

Approximate number of women developing breast cancer over the next five years.

NICE Guideline, Menopause:
Diagnosis and management
November 2015

23 cases of breast cancer diagnosed in the UK general population



An additional four cases in women on combined hormone replacement therapy (HRT)



Four fewer cases in women on oestrogen only Hormone Replacement Therapy (HRT)



An additional four cases in women on combined hormonal contraceptives (the pill)



An additional five cases in women who drink 2 or more units of alcohol per day



Three additional cases in women who are current smokers



An additional 24 cases in women who are overweight or obese (BMI equal or greater than 30)



Seven fewer cases in women who take at least 2½ hours moderate exercise per week



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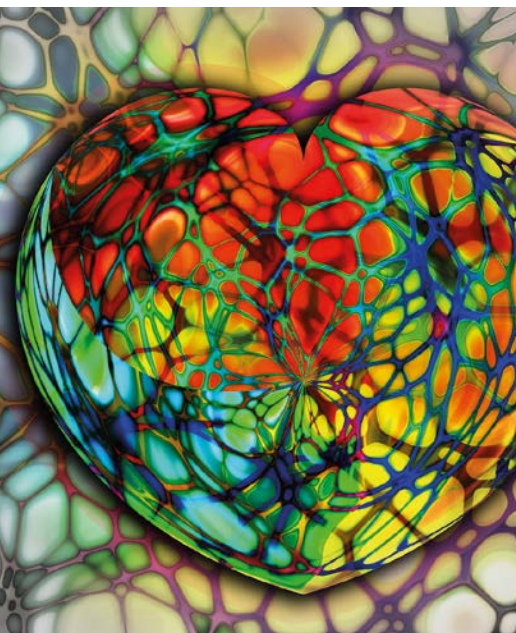
Women's Health Concern is the patient arm of the BMS.
We provide an independent service to advise, reassure and educate women of all ages about their health, wellbeing and lifestyle concerns.

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March 2017



WHC sum it up like this:

"The risk of breast cancer with combined HRT is less than that associated with being overweight over the age of 50 or that associated with drinking 2 or more units of alcohol per day. ... For women experiencing hot flushes and night sweats, with a low underlying risk of breast cancer (i.e. most of the population) the benefits of HRT in the short-term (up to 5 years' use) will exceed any potential harm. There is no evidence the risk of dying from breast cancer is increased in women with a history of using it."

And even the breast cancer risks that do exist only apply to women over 50 years of age: as Menopause Specialist Dr Louise R Newson has put it, "If you are taking HRT and you are aged under 51 years of age then you do not have an increased risk of breast cancer, regardless of the type of HRT you are taking." For coping with the symptoms of perimenopause before 50, and especially for management of an early menopause, then, there is no breast cancer risk to outweigh at all: there are only benefits.

"There remains widespread confusion and uncertainty amongst both doctors and HRT users"

HRT and heart disease: benefit rather than threat

Whereas newer studies do still show some increase in breast cancer risk, dependant on HRT type and other factors like a woman's age, the same is *not true* for heart disease. On the contrary, experts now suggest that HRT can protect heart health.

A large 2012 trial in Denmark showed that (otherwise healthy) women who took combined HRT for 10 years after menopause actually had *reduced* risk both of heart disease and of dying from it. Looking back at the US study which caused the scare, it can be seen that its authors misrepresented their findings. They claimed initially that age made no difference to a woman's heart disease risk, but a full analysis of the findings later revealed this wasn't true: in fact, there was *no increase* in heart disease for women starting HRT (either combined or oestrogen-alone) within 10 years of menopause.

Headlines aren't guidelines

Funnily enough the more positive findings have never been given as much media coverage. The guidelines for prescribing in the UK have changed again to reflect the more positive findings – although these aren't always put into practice (perhaps not always getting read by GPs) and there is still a great deal of prejudice against HRT. It doesn't help that only about half of UK health professionals seem to have had *any* training on menopause (which doesn't even guarantee that the half who've had training have had *enough*).

As WHC put it, "There remains widespread confusion and uncertainty amongst both doctors and HRT users." The consequence of this is "almost a generation of women who have mostly been denied the opportunity of improved quality of life during their menopausal years."

HRT in women with a family history of certain cancers

A minority of breast and ovarian cancers are caused by hereditary gene mutations and therefore run in families. (An even smaller number of cancers that affect men are caused by the same mutations.)

If such a gene runs in your family your risk is statistically increased, but that doesn't mean you will definitely have the gene; and even if you do have the gene it doesn't mean you will definitely get cancer. Neither does it mean that you definitely shouldn't take HRT. Let's look at different levels of breast cancer risk, as detailed by Breast Cancer Care:

1. General population risk (average or near population risk):

- Being at "general population risk" means you aren't significantly more likely to develop breast cancer because of your family history. Most breast cancers are not inherited and so do not increase the lifetime risk for other family members.
- If only one person in your family has been diagnosed with breast cancer, and they were over the age of 40 when diagnosed, you're likely to be at general population risk.
- It's important to go back to your GP if your family history changes – for example if another relative develops breast or ovarian cancer – especially if they are diagnosed below the age of 40.

2. Moderate risk (familial or raised risk)

- This means your risk is a bit higher, but you are still more likely to not develop breast cancer because of family history than you are to develop it.
- At this level you may have several relatives with breast cancer but no obvious pattern of the disease. These relatives will tend to be affected at older ages.
- Alternatively you may have only one close relative with breast cancer, but they were diagnosed with it under the age of 40.
- It's important to go back to your GP if your family history changes – for example if another relative develops breast or ovarian cancer.

3. High risk (hereditary or increased risk)

- Again the risk is higher but it still isn't certain you will develop cancer – not even if you definitely carry one of the relevant genes.
- You may be considered high risk if you have several close relatives (on either the mother or the father's side) with breast cancer, ovarian cancer or both over several generations – for example grandmother, mother and daughter – who are often diagnosed at a young age (i.e. below 40). If you have been genetically tested and identified as having one of the relevant genes you will be in this category.
- We'll come to the guidelines given to GPs shortly, but even if you are in category 3, "high risk," this doesn't mean that you are strongly discouraged from taking HRT: risks and benefits simply need to be weighed up on a case-by-case basis, according to factors such as your age, the severity of your symptoms and whether or not you still have a womb.



It's important to mention that women of Ashkenazi Jewish descent are around 5–10 times more likely to carry these genetic mutations.

Breast cancer and menopausal symptoms

There are women for whom HRT may not be suitable, either because of a family history of cancer or because they currently have, or have had, certain cancers themselves.

The majority of breast cancers are made worse by oestrogen ("oestrogen-receptor positive breast cancer"), and for this reason a number of breast cancer treatments target your ovaries to stop you from producing this hormone. These treatments can stop the ovaries from working either permanently or temporarily and can cause an early menopause, or menopausal symptoms for a

time. Even if you have already been through the menopause, breast cancer treatment may cause you to experience menopausal symptoms again.

If your cancer is sensitive to oestrogen, HRT is not recommended, as the oestrogen in it can make the cancer worse. If you are already on HRT when you're diagnosed you will probably need to stop taking it. Other sources of oestrogen, such as hormonal contraceptives, complementary therapies such as isoflavones (phytoestrogens), and certain foods (e.g. soya, which contains oestrogen) are not generally recommended either. The evidence on black cohosh is not yet conclusive: some studies suggest it may act like oestrogen in women with breast cancer, while others suggest it is safe; for the moment no clinical guidelines recommend it.

As in the case of natural menopause, some women going through chemical menopause find their symptoms quite manageable, while for others they can be extremely difficult to cope with – especially in combination with what they are already going through due to the cancer and treatment. Women in this situation may need extra support, both medical and emotional.

If you have had breast cancer in the past and you are struggling with menopausal symptoms in the present (especially if non-hormonal treatments haven't helped alleviate your symptoms), you will need to discuss this with your specialist cancer team. It isn't yet known whether HRT increases the chances of a cancer coming back and risks/benefits must be weighed up in the individual situation.

“As in the case of natural menopause, some women going through chemical menopause find their symptoms quite manageable”

The Mirena coil

Although it isn't officially licensed as a treatment for the symptoms of menopause, the Mirena coil (which releases a version of progesterone) can lighten menstrual bleeding and therefore is sometimes offered to women in perimenopause who are struggling with very heavy flow. For some women this is enough to help them cope with perimenopause, or at least the earlier phases.

Because the Mirena coil elevates your progesterone and not your oestrogen, in some women it actually causes effects that look like menopausal symptoms: it can make your periods become irregular or even stop (which for some women is a positive) and it can cause mood swings, low mood and anxiety (not so positive). Some women also react badly to the coil, bleed more rather than less and experiencing more painful cramps.

As with most treatments, then, the success of the Mirena for perimenopausal symptoms seems to depend on the individual.

A couple of studies appear to have found a link between the Mirena coil and breast cancer, but the evidence isn't strong as the researchers didn't account for other breast cancer risk factors. It is not currently considered a risk by most prescribers, but if you are worried you should seek out information and make your own decision.

Non-hormonal prescription medications

There are other prescription drugs that can relieve particular symptoms of menopause. Most of them are not “licensed” for menopausal symptoms, meaning they aren't officially listed and recommended as treatments for menopausal symptoms (they are licensed for other conditions), but many doctors will prescribe them for menopausal symptoms because they know they can help.

This is a common practise among doctors and not a secret.

Clonidine for vasomotor symptoms

This is the only non-hormonal drug licensed for use for hot flushes in the UK. Originally a blood pressure drug, studies show that clonidine can help some women with these symptoms. At high dosage it can cause sleep disturbances in 50% of users, and if you want to stop taking it you must do so slowly as rapid withdrawal can cause rebound high blood pressure. It may not be suitable if you have low blood pressure.

SSRIs and SNRIs for vasomotor symptoms

These are drugs usually prescribed to help with depression and anxiety, but it has been recognised that they can also help with hot flushes in some women. These may have some side effects, including reduction in sexual desire – so if desire is already a concern for you, keep this in mind. These are not supposed to be prescribed for menopausal symptoms in the UK unless HRT is not an option.

Selective serotonin re-uptake inhibitors (SSRI): fluoxetine, paroxetine, citalopram, sertraline

Paroxetine 10 mg seems to be the most effective of these, and is now a licensed treatment for menopausal hot flushes in the USA.

Some studies suggest that fluoxetine and paroxetine may interfere with the way a breast cancer drug called tamoxifen works, so doctors in the UK won't usually offer these if you are on tamoxifen. However, according to Breast Cancer Care, more recent research suggests this may not be the case. If you are on tamoxifen you can discuss this further with your breast care nurse or specialist.



Serotonin noradrenaline re-uptake inhibitor/selective serotonin re-uptake inhibitors (SSRI-SNRI): venlafaxine

Venlafaxine is the preferred treatment for breast cancer survivors who are taking Tamoxifen. At 75mg there can be reduction in hot flushes with improvement in fatigue, mental health and sleep disturbance.

“Gabapentin (gamma aminobutyric acid) can improve hot flushes and sweats. One side effect is sleepiness, which some women appreciate”

Gabapentin for vasomotor symptoms and sleep

Gabapentin (gamma aminobutyric acid) can improve hot flushes and sweats. One side effect is sleepiness, which some women appreciate – but others find it makes them too sleepy in the daytime as well. You cannot drink alcohol if you are taking it – which might be helpful if you're trying to avoid alcohol as a hot flush trigger anyway, but not so helpful if the idea of avoiding alcohol triggers a hot flush.



Herbal treatments for vasomotor symptoms

Most medical professionals, including those of the British Menopause Society, will stress that a substance being “natural” doesn’t automatically mean it is safe. Of course, the very fact that plant and herbal treatments can be effective means they can also have negative or side effects, and that you can overdose on them.

If herbal treatments aren’t regulated by a medicine authority there may be a great deal of variation in purity and dosage – and therefore in side effects as well as effectiveness. Some herbal remedies can also “interact” with other medications (i.e. can stop other medications from working), or shouldn’t be used for too long, so it’s important to find out as much as you can about anything you take.



One recommendation from the British Menopause Society is to **look for the THR logo** – which stands for Traditional Herbal Registration and is a sign of approval granted by the Medicines and Healthcare products Regulatory Agency (MHRA). If a product has this logo you can rest assured it tested and checked, with accurate dosage and proper product information:

The British Menopause Society tends to follow the official guidance offered by the **National Institute for Health and Care Excellence (NICE)**, which is a public body of the Department for Health in the UK and provides evidence-based guidelines for health professionals. NICE has looked into **the effectiveness and safety of some alternatives to HRT, reviewing the existing research and comparing each alternative to the effectiveness HRT and placebo**. This review showed HRT to be the most effective, and largely dismisses the evidence for most of the alternatives. Of course there are fewer studies (and none so large) on the herbal remedies, and not everyone sees Western medicine as the authority. Many women through the years have believed some of the following helpful, and there is some evidence behind each option, even if it doesn’t meet the standards imposed by bodies like NICE; we leave it up to each woman to decide what she thinks.

We will briefly cover some of the most common herbal options to give you a starting point if you are interested in these. We recommend you then do some more of your own research before taking anything.

If you currently have, or have survived, oestrogen-sensitive breast cancer, it is particularly important that you do some research / seek out expert advice about any herbal medication to find out whether it could aggravate your cancer, interfere with your cancer treatment, or increase the risk of a recurrence of your cancer.

If you suffer from any other health condition, or take any other medication, it is equally important to be sure that these herbal medicines will not interfere with your treatment or worsen your condition.

Black cohosh:

This is a North American traditional herb, and now very commonly used by women for the treatment of menopausal symptoms. Some clinical studies have suggested it can reduce hot flushes, and some women certainly feel it helps. There is no clinical evidence that it helps with anxiety or low mood.

There has been some suggestion it can cause damage to the liver, although the link hasn't been solidly established. There is also a question marks over whether it is safe for women with breast cancer (or whether it acts too much like oestrogen) and if it interacts with other medications. There isn't enough evidence yet to settle these questions, especially not where long term use is concerned. When recommended dosages and duration of use are respected, it seems that serious side effects are rare.

St John's Wort:

This herb has been in use in Europe for centuries. Is best known as an anti-depressant (some studies have suggested it may be as effective as prescription anti-depressants against mild depression, anxiety and seasonal affective disorder).

Other studies have also shown this herb to have some positive effects on vasomotor symptoms such as hot flushes and night sweats – possibly more so than Black Cohosh.

“There is some evidence that sage, valerian and vitamin E may all help in reducing hot flushes. Sage may also help with the mood disturbances of menopause”

It is safe and beneficial for women with breast cancer, unless you are taking tamoxifen, which is made ineffective by St John's Wort. (It's worth mentioning while we're here that St John's Wort also renders the contraceptive pill ineffective.)

The British Menopause Society, while recognising that this herb can be effective, have some concern over dose consistency and safety.

Sage, valerian and vitamin E for vasomotor symptoms

There is some evidence that sage, valerian and vitamin E may all help in reducing hot flushes.

Sage may also help with the mood disturbances of menopause. **Valerian** contains phytoestrogens, which presumably is how it helps with the hot flushes; it is traditionally used to help with anxiety and sleeplessness, too, making it doubly useful in menopause. However, it can cause drowsiness and shouldn't be taken in combination with sleeping pills, tranquilisers or strong painkillers.

Vitamin E, as well as potentially reducing hot flushes, may help with vaginal dryness and dry skin generally. **It can be found in foods such as** avocados, nuts and seeds, and plant oils like olive oil; there are also skincare products that contain it.

Sea buckthorn and ginkgo biloba for desire and sexual pleasure

There is some evidence to suggest that Ginkgo biloba can increase sexual desire. It has also been shown to be helpful with memory problems and mild anxiety. Sea buckthorn oil, meanwhile, may reduce vaginal dryness, itching and burning. This could be used as an alternative to local oestrogen. For both of these, as in the case of many treatments, you may need to persevere for some time before benefits are felt.

Ginseng

Ginseng has been shown to have some positive effects on vasomotor symptoms and to fortify sexual desire; it may even be beneficial to heart health.

Soya products, isoflavones, and red clover (phytoestrogens)

These are food and plant substances that contain phytoestrogens: naturally-occurring compounds that are similar to human oestrogen, but weaker. A great many food and plant substances contain phytoestrogens, but soya products are particularly rich in them. Isoflavones are the type of phytoestrogen found in soya products but also sold as dietary supplements. Red clover is another plant rich in these and also sold as a dietary supplement.

Among some ethnic groups these substances already form a large proportion of the diet, and perhaps because Japanese women, for instance, are known to report fewer hot flushes, this adds to the perception among Western women that increasing their intake of these substances will help.

Some studies do show benefit to menopausal women (and, indeed, to women at other stages of life), while others do not. It may take some months before benefits are felt.

It is possible that red clover may decrease the effectiveness of the contraceptive pill (and perhaps even other hormonal contraceptives). It may also interfere with painkillers and NSAIDs such as ibuprofen. If you are taking this supplement along with another medication you should seek information and advice.

Are phytoestrogens dangerous for women with breast cancer or endometriosis?

As suggested in the section on HRT, some breast cancers are aggravated by oestrogen, meaning that women suffering from these cancers cannot usually take HRT. What we do not yet know for certain is whether plant oestrogens are also a risk factor in this way. Some studies have suggested that they are; others have suggested they may actually have a *beneficial* effect on women with breast cancer. It depends on the type of cancer (women with HER-2-positive tumors, nothing to do with oestrogen, are advised to avoid phytoestrogens) as well as the type of phytoestrogen (concentrated extracts are associated with more risk than those consumed in their natural form

within certain foods). Some data suggests that pre-menopausal women at high risk for breast cancer should be more cautious. The greatest benefits appear to be in women who have been consuming higher levels as a part of their diet from an early age.

Endometriosis is also sensitive to oestrogen, and some sources advise women with this condition to avoid all soy products. There are, however, studies that suggest phytoestrogens do not increase the risk and severity of endometriosis, but may even reduce it.

One possible explanation for the unexpected benefits in women with oestrogen-sensitive conditions is that instead of increasing her over-all oestrogen levels, these plant versions of the hormone can actually bind to a woman's oestrogen receptors and block her own more powerful hormone from having its effect.

This is only a theory, however: it's clear that we do not yet know enough about the workings of these plant oestrogens in the

“Some breast cancers are aggravated by oestrogen, meaning that women suffering from these cancers cannot usually take HRT”

human body. If you have any type of breast cancer, or endometriosis, you should probably seek out expert advice before upping your intake of phytoestrogens.

Cognitive behavioural therapy (CBT) for vasomotor symptoms

Few women want to be told that all they need to do is take a more positive attitude in order for their hot flushes and anxiety to disappear, which seems to imply that it's all in our own minds and somehow our own fault. This certainly isn't the approach we take at Bristol Menopause. However, while it is the biological reality of low oestrogen levels that triggers hot flushes and anxiety in menopause, we do recognise that it may be possible to adopt techniques for managing these unpleasant experiences.

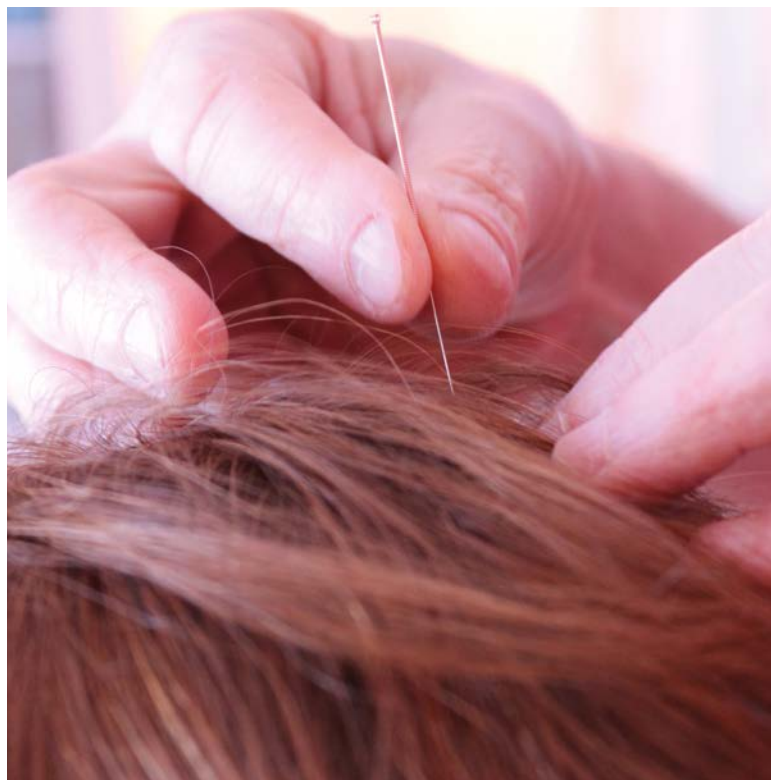
The British Menopause Society recognises that CBT can help with low mood and anxiety in menopause – and even with hot flushes and sweats, or at least their management. The North American Menopause Society (NAMS) recommends a CBT approach that combines relaxation techniques, sleep hygiene and learning to take positive healthy attitude to a menopause challenge. CBT is now a recommended treatment option for anxiety experienced during peri- and post-menopause. A CBT approach which is theory based can improve hot flush perception and reduce stress and sleep problems. There may well be two-way interactions between mood and hot flushes as 10% of women are more likely to be depressed during the menopause. There is a fact sheet (written by Professor Myra Hunter, Kings College London) on the Women's Health Concern website which provides guidance on cognitive behavioural therapy almost in a self-help format for women to access themselves.

Acupuncture for anxiety and hot flushes

There does seem to be some suggestion that acupuncture can help with anxiety and hot flushes in menopausal women, although NICE declare it no more effective than "a high placebo effect". Any effect at all might be welcome, however! You may want to let yourself be the authority on what works for you.

Magnesium for bones, muscle aches, mood, metabolism, sleep – and more

Magnesium is needed for a great range of processes within the body, including muscle function, calcium absorption and the metabolism of carbohydrates. It can help with muscle aches as well as anxiety, low mood and sleeplessness, so many swear by it as a remedy for women in menopause. It is recommended that you try to increase your intake via foods that are naturally rich in magnesium as we generally absorb minerals better this way, but supplements are also available – and some women find it really helpful to take magnesium baths.



WHAT YOU CAN EXPECT FROM YOUR DOCTOR

If you are considering asking for treatment, or if you want advice around your symptoms, you may want to go to your doctor. While there are some brilliant GPs as well as specialists out there who are very attentive and helpful to women who are struggling with the effects of menopause, we often hear from women that GPs (including women, unfortunately) are under-informed or dismissive when it comes to this topic. Some are reluctant to offer HRT (especially reluctant to offer the safest but most expensive form, patches), whether this is because they have an exaggerated impression of the risks or because they disapprove of it on principle. It may be helpful to go prepared if you want help from your doctor: if you know what you're entitled to in terms of treatment and advice, you will be in a stronger position. **For this reason we have summarised the guidelines around menopause which the National Institute for Health and Care Excellence (NICE) has designed for NHS professionals, so that you can get some idea of what your doctor is supposed to offer you.** GPs don't always seem to be very up to date on these guidelines, so it can be helpful to inform yourself and remind them!

- It can also be a good idea to keep a diary of your symptoms
- Some find it helpful to print a list of symptoms, tick off the ones they have and show this to the doctor

The NICE guidelines given to NHS professionals

Diagnosis

Your doctor should

- Diagnose you with perimenopause **if you are 45+** and experiencing "vasomotor symptoms" (hot flushes) and irregular periods (no lab test needed)
- Diagnose you on symptoms alone if **you have no uterus**
- Offer you an FSH test (2 tests within 4-6 weeks to confirm – ideally taken on 3rd or 4th day of your period) **if you are 40-45** with menopausal symptoms, including a change in your menstrual cycle
- Offer you an FSH test (2 tests within 4-6 weeks to confirm – ideally taken on 3rd or 4th day of your period) **if you are under 40** and menopause is suspected
- Not use an FSH test if you are on the combined pill or high-dose progestogen
- Diagnose you as post-menopausal if you have gone 12 months without a period (as long as you are not on hormonal contraception and there is no other reason your periods could have stopped)
- Take into account that it can be difficult to diagnose menopause in women taking hormonal treatments (i.e. for heavy periods)

Discussion

- Your doctor should tell you about all the possible symptoms of menopause – including the effects it can have on your mood, vaginal discomfort and sexual desire – in such a way as to encourage you to talk about these symptoms without embarrassment.
- They're supposed to tell you about the various treatments, including HRT, and non-hormonal alternatives such as clonidine. They're also supposed to tell you about the possible benefits of CBT (cognitive behavioural therapy) as an alternative to medication in managing your symptoms
- Give you information about contraception – whether you are in perimenopause or in the phase immediately post-menopause
- If you are likely to go through medical menopause due to surgery or treatment, they should tell you about the symptoms and the effect on your fertility BEFORE your treatment happens. They should also refer you to a healthcare professional with expertise in menopause.

Treatment for the symptoms of “natural” menopause

Your doctor should

- Offer you HRT for “vasomotor symptoms”, having discussed short term (up to 5 years) and long term benefits/risks
- Consider offering you HRT for “low mood” as a result of menopause (even if you aren’t experiencing hot flashes)
- They aren’t supposed to offer anti-depressants (SSRIs / SNRIs) or clonidine as treatment for hot flashes alone, unless there’s a reason you can’t take HRT, or HRT isn’t working.
- There is “no clear evidence” that anti-depressants will improve low mood as a result of menopause unless you have been diagnosed with depression. They should explain this to you... it doesn’t mean they can’t prescribe these for you if you want to try them.
- Consider offering you testosterone supplementation if you are struggling with low sexual desire and HRT is not helping with this.
- Offer you local (vaginal) oestrogen to help with vaginal dryness, discomfort, pain (including vulva rubbing on underwear as well as pain during sex), itching, burning, unpleasant changes in discharge, recurrent vaginal infections like thrush or BV, and bladder problems/infections.
 - Even if you are on systemic HRT
 - Even if systemic HRT isn’t recommended for you due to risk (local vaginal oestrogen is unlikely to raise your total level of oestrogen and produce the side effects/risks that can come with systemic HRT). The advice of an expert should be sought in such cases.
 - Continue this treatment as long as needed for your symptoms
 - Increase your dosage if it isn’t relieving your symptoms
 - Tell you that adverse effects are very rare, and advise you to report any unexpected bleeding to your GP
 - Warn you that symptoms often return when treatment stops.
 - Advise you that other vaginal moisturisers and lubricants can also help, either in combination with vaginal oestrogen or alone.
- Explain the risks and possible benefits of alternative and unregulated therapies such as St John’s wort
- Discuss with you the importance of keeping up to date with nationally recommended health screening (e.g. cervical smears)

“For each treatment you are given you should get a 3-month review appointment to assess how well it is working for you”

Review and referral

- For *each* treatment you are given you should get a 3-month review appointment to assess how well it is working for you (if all OK at 3-month review, you should be seen annually thereafter – but if at any point the treatment isn’t working or you are experiencing adverse effects you should be seen)
- If the treatments given are not improving your symptoms, or if you have “ongoing troublesome side effects” you should be referred to a healthcare professional with expertise in menopause
- If there are reasons (contraindications) you cannot take HRT, or if there is some uncertainty about which treatment option would be best for you, your doctor should consider referring you to a healthcare professional with expertise in menopause

Managing menopause in women who currently have, or have had, breast cancer

- If you are diagnosed with breast cancer pre-menopause, your doctor should offer information and counselling about the possibility of early menopause and menopausal symptoms associated with breast cancer treatment.



- If you are diagnosed with breast cancer while already experiencing menopausal symptoms and taking systemic HRT, your doctor should stop this treatment immediately.
- our doctor is not supposed to offer/continue alternative treatments including soy (isoflavone), red clover, black cohosh, vitamin E or magnetic devices either
- Certain antidepressants (SSRIs) can relieve menopausal symptoms, particularly hot flushes, and these can be offered to women with breast cancer – unless you are taking tamoxifen.
- If you have had breast cancer in the past, systemic HRT (including combined HRT) shouldn't automatically be offered when you begin experiencing symptoms of menopause
- If your menopausal symptoms are severe, and if the risks have been discussed, your doctor may offer you HRT even if you have had breast cancer in the past. This is supposed to be restricted to "exceptional circumstances."

HRT for women with a family history of breast cancer (who have not had breast cancer themselves – "no personal history")

If you are older than 35 and being considered for HRT, your doctor should ask you if you have a family history of breast cancer. (The same should apply if you are older than 35 and considering using an oral contraceptive pill.)

- If you have a family history of breast cancer and you are considering taking, or already taking, HRT, your doctor inform you of the increase in breast cancer risk according to type and duration of HRT.
- The advice you are given about HRT should be specific to your situation, varying according to your individual clinical circumstances (e.g. whether you are actually experiencing symptoms and how severely; whether you have osteoporosis; how old you are)
- If you are considered "at risk" of breast cancer, HRT should be restricted to the shortest duration and lowest dose possible. Oestrogen-only HRT is lower risk, therefore preferable – but this is only suitable if you don't have a womb.
- If you are considered at "moderate risk" or "high risk" of breast cancer, and have an early menopause (whether for natural or medical reasons), your doctor should inform you the benefits and risks of systemic HRT.
- Even if it is confirmed that you carry/are likely to carry a *BRCA1* or *BRCA2* mutation, if you have both ovaries removed (a procedure known as a bilateral salpingo-oophorectomy) before the average age of menopause, you should be offered systemic HRT up until the average age of menopause (51 or 52). This should be combined HRT if you still have a womb, but oestrogen-only if your womb has also been removed. (When HRT is stopped, the symptoms of menopause should be managed in the same way as symptoms of natural menopause.
- If you are considered at "moderate risk" or "high risk", it is *generally* recommended that you should only be offered systemic HRT if you are under 50 years of age.
- Alternatives to HRT should be considered for specific symptoms such as osteoporosis

HRT and "risk-reducing gynaecological surgery"

- If you are having "risk-reducing gynaecological surgery" (surgery to remove ovaries, fallopian tubes, womb or breasts so as to reduce an elevated risk of cancer) you may be able to take HRT, but careful consideration should be given to the type.

Do you need a woman to listen to you?

If you are struggling with the emotional and psychological impacts of menopause and would like to talk to a woman, you might want to contact **Womankind, Bristol Women's Therapy Centre**. They offer a helpline service for women experiencing any kind of emotional distress, and also provide women in the Bristol area with free or affordable professional counselling.

Helpline: 0117 916 6461 or **0345 458 2914**

Website: www.womankindbristol.org.uk

Email: helpline@womankindbristol.org.uk

QWIM: Quixotic Women in Menopause, a Facebook support group

A friendly, informative discussion group for women experiencing menopause.

Facebook: www.facebook.com/groups/QWIMclub/

Bristol Menopause Socials:

Women of a Certain Stage run pop up Menopause Socials in a cafe or other location near you. Join the group for support, to be re-assured you are not alone, share your stories and top tips and be around like minded women, all preparing for or going through a similar journey. These events are always free to attend. Join in for some or all of it, just pitch up and be yourself. More info at: <https://www.womenofacertainstage.com/events>

If you would like some more information, some helpful sites are listed below:

- British Menopause Society fact sheets: <https://thebms.org.uk/publications/factsheets/>
- Menopause Matters: www.menopausematters.co.uk
- NHS Menopause page: www.nhs.uk/conditions/menopause/
- Menopause Doctor: www.menopausedoctor.co.uk/menopause

This guide was put together by Bristol Women's Voice.

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We are a charity working to make women's equality in Bristol a reality.

We make sure that when key decisions are taken in the city women's voices have been heard and their concerns acted upon. We work to increase awareness of women's rights and to make sure services meet women's needs. We bring women together to share ideas and experiences, support campaigns and celebrate success so that together we can make Bristol a showcase for women's involvement, empowerment and equality.

We invite all women to get involved

– become a member of Bristol Women's Voice by signing up on our website and have your say in shaping the future for women's equality in Bristol.

CONTACT US

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