Academy of PHYSICAL MEDICINE

# Women's Health

*With Dr Hannah Short*

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## TRANSCRIPT

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Steven :

I'm joined tonight by Dr. Hannah Short. Now, Hannah got her undergraduate degree at Oxford University. She finished her medical training at Cambridge University. She's a Diplomate of the Royal College of Obstetricians and Gynaecologists as well as the Society of Sexual and Reproductive Health Care; she has an advanced certificate in menopause care; she's a member of the British Society of Lifestyle Medicine and she's kind of a brainy person actually. She has a particular interest in plant based medicine and as you will have guessed from a slide behind me in women's health, particularly menopause. And Pre-menstrual disorders.

Hannah it's great to have you with us. Thank you for giving up your time. Before we go on, let me just quickly introduce the third person in the room tonight, which is Claire MacDonald. Now Claire is a very experienced osteopath working in Southwest London. She has an interest herself in paediatric care, but also, a considerable interest in women's health and I thought it would be nice if we had a third person in the discussions or to move things along this evening. But it's really your show, Hannah and the thing that puzzles me is that you are actually a GP and yet you have this interest in Obs and Gynae. Why are you not Obs and Gynae consultant?

Hannah Short :

Well obviously as a GP, we need to know about every, every aspect of health care, including paediatrics and women's health, care of the elderly, men's health. So we, we need to have a grounding in all of that. And actually I think I'd argue that menopause is more of an issue to be dealt with in general practice really than it is in obstetrics and gynaecology. And there's a bit of a myth that that gynaecologists are the only ones who know about menopause and HRT. But actually, to be honest, the vast majority of menopausal women are actually seen in, you know, general practice. And gynaecologists won't necessarily have the training in that area unless they've chosen to deal with this special interest. Not the same I am afraid actually for GPs. Often we have to have done a bit more further study maybe because it's of interest to ourselves or it just happens to be you know inspired by someone.

Hannah Short :

So I mean you can get experts in menopause and HRT, premenstrual disorders across the board, but primarily will generally be either a GP, a gynaecologist or somebody working in sexual health, but we all generally have done some extra training in that area. So wherever you're working doesn't mean that you're necessarily going to have a full knowledge, but everybody in there area should have a basic knowledge.

Steven :

When did you become a GP?

Hannah Short :

2016. I trained in medicine quite late, so, and then I started training in psychiatry before I switched to general practice. So

Steven :

I see. Right. So how long is the additional training, presumably this is where your diploma with the Royal College of OBS and gynae comes in. How long is that extra training to get that diploma?

Hannah Short :

So it's, it depends. It basically you have to, you have to have a certain number of hours and done certain number of cases and fulfill the curriculum and you generally do it alongside your day work, and so you've got time to complete it. It's not, it's not like you go away for a year and study and that's then so you have to make time in your schedule to go and do that. So actually I got this certificate from the British Menopause Society  which is affiliated with the RCOG and the active sexual reproductive healthcare, and that involves kind of going to work at a sexual health clinic, which was based up at the hospital and working alongside an experienced consultant there, and as well as doing quite a lot of book learning. So it probably took me around 18 months and you have to write a dissertation and things like that.

But that was on top of obviously having done the general practice training, and having, an extra training in obstetrics and gynaecology.

Steven :

We had a couple of other people on this show some weeks ago who are also lifestyle medical practitioners. And they said that actually getting their accreditation as lifestyle practitioners was harder than anything else they've done. Is that your experience of that discipline?

Hannah Short :

I mean, I haven't done for, I mean I, I did a one day course, in lifestyle medicine with the Royal College of GPs but I haven't taken the exams to be a board certified lifestyle position. So that's something that's slightly different. And so it's an area of interest and certainly we'll constantly kind of learn about myself, but I haven't taken further exams. I've done a nutrition course that was several weeks and that was kind of online distance learning, but I haven't, and I did the day at the RCGP, but I haven't taken those exams. So

Steven :

Your nutrition course was that centered around plant based nutrition?

Hannah Short :

Yes, it was from the Cornell University in the States. So they have an online course there. So, but I was funded to do that actually by my local CCG in my area.

Steven :

Okay. I mean, I don't want to make this evening's discussion about coronavirus, but I guess everybody's going to be slightly curious as to the extent to which your practice, your GP practice is operating at the moment and how you're operating. Are you doing it through video calls or are you being face to faces?

Hannah Short :

Well, we're going to the surgery, as normal, but we're trying to minimize face to face contact and so everybody is being triaged. So they will either have a phone call or we've got system could ask my GP where people can email in and then we have to make a decision as to whether or not they, they get a call or a video call and sometimes we will bring people down. , it really depends on the nature, but if it's an emergency or something that can't be assessed online, then we'll bring them down. Very occasionally there'll be something we can just send them an email reply or if they just need an extra prescription or something like that, then that's quite easy to sort out. So we are seeing people face to face. , but we're trying to minimize that for our sakes and for their sake as well.

Steven :

And has the womens health stuff being pushed to the back burner for the time being?

Hannah Short :

Unfortunately, I mean not, I mean we were trying to get the message out there that general practice is still open and that GP still want to hear from people if they they're concerned with they're unwell and they don't feel that they've got to wait because we are still there. , and a lot of this stuff can be dealt with let's say on online or over the phone. , but again, sometimes people need to be examined, but things like the contraceptive clinics, like the coil clinics I do, the implant clinics, they have all been put on hold, which is a real shame. , , yeah, I'm not sure if it's the wisest idea. I know we need to keep people safe, but yeah, there was already a back log with those and so we're making them and wait for longer for the rest again so.

Steven :

Yes. Telling people to stay at home and denying their contraception might come back to bite us at some point in the future.

Hannah Short :

Yeah, I think there is concerns about that and I know that they've, , things like abortion services are being effected as well. So I think it is it, yeah, it's kind of a short sighted thing, but I guess this is, we're at an unprecedented times so we don't really, I think we're trying to navigate things as we go. , I'm not quite sure when that stuff reopen and it might vary I suppose from practice to practice, but on the whole, unless it's an absolute emergency, we're not doing those procedures.

Steven :

So would you like to tell us then about the sort of the typical women's health problems that you see as a GP and before you go onto that? Obviously, the slant that we're interested in is osteopaths, chiropractors, physiotherapists is what is it that might present in our own clinics where we could offer some useful advice, even if it's only to go and see your GP or see somebody else, but you know, what might, what might present to us, someone coming to us with something they think is our problem actually turns out to be perhaps more your field feel.

Hannah Short :

Okay.

Hannah Short :

Well in terms of women's health, generally, obviously it's such a vast field so I see everything, but I guess my special interest area is female hormonal health and so primarily menopause, and premenstrual disorders. I think one of the key things for me about menopause and getting the message out is that it isn't just about hot flushes. , but there's no age that's too young for somebody to go through the

menopause, say to come to the first, the first part. , I think often I see women who'd been told that maybe they're depressed or, , they've been referred to cardiologists or rheumatologists because of symptoms actually ended up being hormonal in origin. So, obviously menopause relates to the time when, , you know, women's final period. And so a woman who is said to be menopausal is when she's one year after that final period, , and that is since the ovaries are no longer functioning as well, and they are no longer ovulating, the woman's no longer fertile, but there's obviously a build up to that and that is called the perimenopause.

Hannah Short :

And that can take several years. So it can be, you know, women can be in perimenopause for 10 years before she actually has her final period. Some women will be symptomatic potentially for that part or that whole time, you know, on and off, fluctuating symptoms. , and others or might not notice anything other than their periods kind of stopping. And maybe, you know, they might have an occasional Mileson it's like a mild hot flush, but they're not too bothered by it. , but a lot of women do suffer. , In fact 75 to 80% of them will have symptoms of the menopause. , and 80% of women will have hot flushes, but 20% don't. , and then they might well have symptoms there relating to mood swings, which is relating to the fluctuating levels of hormones means, especially in perimenopause or in especially your case, your area of work.

Hannah Short :

Things like muscle aches, joint pain, that can be really, really common. , and I think about 30% of menopausal women will state that muscle pain is a significant problem for them. , and it's, I think it's one that's under-recognized. Things like heart palpitations, you know, poor sleep, vaginal symptoms, so pain with sex, but sometimes just, just drying. That's all just feeling quite sore. , problems with urination, you know, like, or feeling is having like recurrent urine infections, things like that where they, or they might have samples sent off, they'll come back and they're normal. , but that can be a symptom of low oestrogen affecting the urethra. , I'm sure I'm going to be missing out things here, but things like migraines, essentially, any oestrogen receptors are throughout the body. They're in the gut, they're in the heart, they're in the brain, , or in the skin. They're, they're in the eyes so everything can be affected. , but like say in your, in your field of work, maybe it's going to be more the musculoskeletal side of things and, and say muscle pains probably number one things.

Steven :

I see. So somebody just sent in a question. Melanie says that she has a patient, presumably a menopausal patient who she says has constant achy symptoms, achy joints and shoulders and lumbar spine, testosterone, progesterone and oestrogen not doing anything for her. Do you have any ideas what she should be suggesting or what she might, where she might point her?

Hannah Short :

Um, I mean it's quite, it's quite hard not having like the full history I suppose, and not knowing exactly what she's on and where she is I mean, sometimes, you know, if HRT has been given for that reason, , or was that part of the reason then want to see if you're on an adequate dose. , and actually you have to be quite careful with that, with HRT because you can have too much as well as having not enough. And that can sometimes mimic symptoms of low oestrogen ironically, not very helpfully. , so sometimes women who have or are over supplementing with the oestrogen and can end up having muscle aches. I mean, that's not so usual, especially not in the doses that are usually prescribed, but it is not impossible. , I mean, menopausal arthritis is, should really be a diagnosis of exclusion because around, around the time of menopause tends to be when there might be a flare up of autoimmune disease.

Hannah Short :

So you might see something like arising things like rheumatoid arthritis, it's associated with osteoarthritis as well. , and not that can be so many other things that can be responsible for, for muscle, muscle pain. , and so I think if something isn't responding to HRT, and you're sure that the person in question is adequately absorbing the HRT, it would be making sure you're having blood tests to check the levels of inflammation, that kind of thing. , I mean stretching exercises, things like yoga can be beneficial. , I mean, things I reckon sometimes magnesium supplementation. Vitamin D I mean, Vitamin D deficiency can, can often lead to similar kind of achy symptoms as well. Uh, and making sure that you're having an anti-inflammatory diet. So one rich in plants, , particularly antioxidants. , yeah, it's, it's quite hard without knowing the full background about a patient to be honest.

Steven :

Can I put Claire on the spot here and, and, and ask her what she sees in her clinic, which will give her concern in terms of, , women's health.

Claire MacDonald :

Yeah. So there's a couple of things Hannah the first one that just popped into my mind when you were talking about arthritis and rheumatoid arthritis, is there a link between the menopause and rheumatoid arthritis or is it just a coincidence that they happen at the same time?

Hannah Short :

I think it's probably more of a coincidence, but there is oestrogen and it does have effects on the immune system. , so oestrogen is inherently anti-inflammatory, and so when the levels of oestrogen dip or when there's, there's big kind of fluctuations as there is in perimenopause before the final period, that increases levels of inflammation. And it, and it may, I suppose it may have an impact if somebody's genetically predisposed that could be the trigger. So it's unlikely to be the full

cause, but it could be a trigger, but bearing in mind everything's kind of multifactorial, but certainly that we know that there's a rise in autoimmune conditions around the perimenopause and the osteoarthritis starts to emerge around the age of 50 often. , there's much more likely in women than it is in men at that stage. So I think there's certainly a hormonal element to it. And there is a good paper actually, which is, written by Fiona Watts is a rheumatologists, I think she's in Oxford and she wrote, she wrote a paper on, on menopausal arthritis and talks about it and then the links and everything on there. So, , we can send that over to you if you want.

Steven :

Yes, please. Yeah, it would be very helpful because we can put it on the website for people to download, which will be quite good. , earlier on you were talking about this, of the variety of things that could be done for a patient with, uh, with menopausal symptoms. How much of it is individual and to what extent does the NHS treats patients as individuals?

Hannah Short :

Well I think, you know, every clinical assessment should be based on that individual. We have guidelines for a reason. So, you know, whether it's about menopause or asthma or anything else, so you know, that there's a reason that we do certain things in a kind of stepwise way, but you always have to look at somebody as an individual, and things are never quite as black and white. In terms of how can we do that in the NHS, I think most doctors want to do that. But when you're a GP with 10 minutes, it's, it's very hard to do that in all honesty. , especially if it's an area you're not hugely familiar with. And that's why often people will stick to guidelines or hopefully go to the guidelines and try that. And then they may often refer on to a specialist if they can't get on top of symptoms.

Hannah Short :

I mean, in terms of menopause for most women, they won't need specialist referral. , so that was kind of important to bear in mind. And you know, menopausal symptoms, obviously it's a natural thing, and for most women when it isn't, it isn't it, it's not an illness, but it's important to know that there's different, there's different types of menopause. So obviously there's natural menopause which would normally occur around the age of 51. But any age from the age of 45 is a natural age to go through the menopause. There are going to be some women who go through menopause much earlier. They might have something called premature ovarian insufficiency or POI, which occurs below the age of 40. And it's not technically exactly the same as menopause, but to all intents and purposes, they may have similar symptoms and may not be able to conceive, but you can sometimes get a fluctuation and ovarian activity.

Hannah Short :

So occasionally these women with that diagnosis can still conceive. Whereas if you've naturally gone through menopause, you won't. But these, these women, they really, really do need to have HRT for protection of their long term health, their bone health, their heart health, their brain health and letting their quality of life. So they're kind of different because it's not just about symptom control, it's about looking after the long term. Then there's the women who have surgical menopause, so they have their ovaries removed and that can be for a number of reasons say cancer, endometriosis, premenstrual dysphoric disorder, like a severe form of PMS, , or maybe a prophylactic treatment that have their ovaries removed because they're positive for the BRCA gene. And again, they all need to be dealt with kind of differently. , and it's a decision and they were kind of more the people who would need to see a specialist.

Hannah Short :

People going through the natural menopause are between the ages of 40 or 45 upwards. If their symptoms are mild lifestyle, you know, , modifications might be enough to help, but the others they may, they may be okay with some HRT, others aren't going to be able to take HRT. And then it's looking at things like antidepressants in some cases that that can actually help with some of the symptoms. And there are complementary therapies. There's not that much evidence for them, but acupuncture, has shown some promise. Cognitive behavioural therapy can be helpful, especially if stress is a huge component because that can exacerbate things. There's some evidence of some herbal treatments and for phytoestrogen supplements like soya and red clover. So, , yeah, I've been, I've pretty kind of gone off on a slight tangent there, but it's, it's very important to treat everybody individually, but the guidelines are there for a reason, I suppose. So,

Steven :

Yes. I suppose my question was, I know you're into, I think bioidentical hormone replacement therapy and of course doesn't, doesn't recommend that whom we say doesn't recommended it can't sanction it because bio-identical compounds are not approved for use in a general practice.

Hannah Short :

That's not entirely true. But there's a lot of confusion around the term bioidentical. So bioidentical just means that the hormones are identical to the molecular structure to the ones we produce naturally, but there's, there is a difference between bio, unregulated bioidentical, which is available on the NHS and I'm sorry, regulated which is available on the NHS and unregulated, which is not, , the British Menopause Society, the Royal college of GPS and obstetricians and gynaecologists that don't advocate unregulated for obvious reasons because it's not been, , gone not gone through the normal safety testing and approval from the MHRA. But bioidentical, which we try and call body identical, which is the regulated form, , and has been approved from the MHRA is available on the NHS. So I think there's a lot of myths around that. The reason that we get concerned about the unregulated

bioidentical is, is more to do with the progestogen component of HRT. It's sometimes it's given through the skin in an unregulated bio identical, , treatment, and there's not enough evidence that it protects the lining of the womb from the action of oestrogen, which, , which is the main concern there. I'm not saying everybody who's doing, who prescribes the yet, unregulated bio-identical is a charlot or anything like that theres some very experienced people, who know what they're doing. But you don't actually have, you know, some people are doing it but they're not fully trained in that. And I think there's just a lot of concern, which is why it's not recommended.

Steven :

Claire any thoughts from you on these things?

Claire MacDonald :

Well, just talking about the herbs etc, or the natural approach. We've got one person who emailed in talking about a case study, their experiences, they have lots of hot flashes and mood swings. They took Sage tablets for five years, which controlled the hot flushes but did nothing about the mood swings. And she was wondering if you knew how Sage works.

Hannah Short :

I don't. I'm afraid we don't have any training in herbal medicine and I'm not sure looking at the literature that's there, we don't really understand the mechanism of action of how that works. I suspect it probably because there's no money to be made out of Sage and that's why the research isn't there. But, , which is I think is the problem with a lot of the, , the complimentary sides of things. But I do know that that Sage can be very helpful for you know, the hot flushes. , but yes, it might not have an effect on the other issues, and I think this is when it comes back to the part of the HRT tends to be the most effective treatment, but understandably, not everybody's necessarily feasible taking HRT. And some people may prefer to avoid it, but there's a lot of unnecessary, uh, what's the word?

Hannah Short :

A scaremongering I think about HRT. I think it's when people don't fully understand it, and why its prescribed and how it works and things. So how do you know who is suitable for HRT and who isn't? To be honest, most women will be the in most women who start HRT below the age of 60 and within 10 years of menopause. The benefits tend to outweigh the risks. There are some people who, who won't, , ideally have HRT or certainly not as first line. So, somebody who's had a hormone dependent cancer. So you know, an oestrogen positive breast cancer for example. , and, and certainly other cancers interesting like melanoma and this has got an association with oestrogen. , and then so you have to be a little bit careful and then say, yeah, there are ones where ideally that wouldn't be the first choice, but it's rare to say no, you know, people can never ever have it.

Hannah Short :

And even patients who have had breast cancer, , who are really, really struggling sometimes if they have had an informed discussion with their doctor, may make the decision to have, say a low dose of HRT if their quality of life is severely affected. But this is when it comes back to the individual. So, some women are completely, you know, blindsided by the menopause where there's other who seem to sail through it. , and it's sometimes hard to say who's going to be affected, but certainly some women end up suicidal because of their symptoms. And so it has to end up being a very much a, you know, an individual decision.

Claire MacDonald :

For sure. Some people are asking about, talking again, just as you mentioned about the safety of HRT and tablets, talking about tablets versus gel.

Hannah Short :

So the safety of HRT was kind of called into question with the trials that were done in 2002, so women's health initiative.

Hannah Short :

So, so obviously going back a while, but a lot of it, there's still a lot of overhang from that. And it was just to deal with studies that, we're looking at the safety of HRT kind of long term. And they stopped the study because they felt there was a higher incidence of heart disease and breast cancer in these patients. The problem was that they were testing a particular form of HRT, one that's derived from mare's urine so it's called Premarin, it's an oral form of HRT and they started it in women who the average age of 63 which is over 10 years older than most women would be when they would start HRT ordinarily a lot of these women already had pre-existing conditions, diabetes, a lot of them were quite overweight, some of them had already had these illnesses that were developing as well. So basically this trial was stopped because they said too many women developing complications on this HRT therefore HRT isn't safe and they extrapolated the data and said that this applied across the board including to women of naturally menopausal age as well as younger. We now know from further studies and also that it has been scrutinized and criticised for the way the report was presented that's not the case and as I have said earlier women who are below the age of 60 and within 10 years of menopause starting HRT at that point, generally the benefits outweigh the risks. So in fact it is thought to be heart protective if you are below the age of 60 when you start it is more to do with the length of time at that you haven't had oestrogen for, so that's why we talk about the 10 years thing, so if you start it before then you are generally thought to be cardio protected we know it protects bones. In women who have had their ovaries removed before the age of 45 it is definitely thought to protect the brain and reduce the risk of Alzheimer's so again you have to put everything in context with the patient and also the HRT that we generally prescribe here is not Premarin we don't tend to use the equine oestrogens in the UK so much anymore.

Nearly all the oestrogen which is prescribed here in the UK is plant based and derived from Yams or soya. In terms of the risk of HRT, if you take the tablet form, there is a very small risk of blood clots it's probably little bit less than the Pill but it is still there, but they can be avoided if you have a patch or a gel, or a spray and in which case through the skin as it avoids the passing of the tablet through the liver.

So if a woman has migraines, if she's overweight, if there's a family history of blood clots, then I would, you'd always go for a transdermal oestrogen. Micronized progesterone or Utogestan is probably the safest form of progestogen from that point of view as well. And that's a natural progesterone. So yeah, again, it very much depends on what you're using.

Steven :

Hannah you sent through this useful infographic about the risks of breast cancer, which I think is one of the ones which is high in peoples list of concerns about HRT. I've sort of chopped it around so that we can show it on the screen better but it kind of is quite a useful way isn't it of relating normal risks to what would happen if you were actually on HRT?

Hannah Short :

Yeah, I think breast cancer is probably the number one reason really why women are reluctant to start HRT, even if they really feel that they would benefit from it. And it's not, I don't want to say everyone should be on HRT. It has to be an individual decision. But I think it's a shame if people are really, really struggling and that they've got this in the mind that if they take it, they'll have, they'll develop breast cancer because the fear is very strong in some people. And I think a lot of it's to do with irresponsible reporting in the media. So I think breast cancer is a common disease unfortunately. One in eight women will develop it at some point. The biggest risk is being a woman and getting older, which we can't really do much about. , I think this slide really just puts it, I suppose into context.

Hannah Short :

So in the group of women age 50 to 59, so an average menopausal age range, there'll be 23 cases of breast cancer per thousand in the general population each year. I'm sorry over the next five years. If you take traditional old fashioned HRT, it's thought there may be an extra four, 27 in that thousand over these five years, which is similar to, you know, the risk of being on the pill, but the risk actually, for breast cancer is actually higher in women who may drink a glass of wine a day or, and if you're overweight, that's the biggest risk factor of all. If you can kind of see from that line at the bottom, as you can see here, if you stop smoking, if you exercise regularly, that hugely reduces your risk. And actually what I found is that sometimes women who have started on HRT and ultimately probably reduce their risk of breast cancer because they're then feeling better so that therefore able to kick sleep, you know, take exercise because maybe they're sleeping better, they're not aching as much.

Hannah Short :

Their mood is better. People who exercise then they're much more likely maybe to change their diet a little bit. I'm not pretending it's easy, but I've just, I've seen this in practice a bit and you know, there was one, one patient who she said she felt so much better. She started park run, now she's enjoying running. So she doesn't want to drink before her park run, so she's not drinking alcohol that much anymore. Now she's watching her diet. She's therefore lost weight, so she stopped her, you know, she's, she's actually reduced her risk hugely by starting her HRT. I mean this slide is very slightly out of date because there was a paper published in the Lancet, I think last summer, which caused some controversy about breast cancer risk. And we're saying it was worse than we thought, but essentially this still stands in terms of the relative risk factors.

Hannah Short :

The only thing is that in women who are on oestrogen only, so they're the ones who have had a hysterectomy, it looks on this, they might have a reduced risk of breast cancer with just oestrogen only and namely, but we think actually that it is still lower than doing combined, but it may not be reduced in the way it appears here. It may have a neutral effect and potentially there may be a small increase after time. But again, breast cancer risk depends on the type of HRT as well. So the body identical HRT tends to have a lower risk than the traditional tablet form of HRT. And it's the combination of the progestogen and the oestrogen, not just the oestrogen.

Steven :

Just remind me why you would pick combined as opposed to oestrogen only is that?

Hannah Short :

You have to have progestogen if you have a uterus. So if you still have a womb, most women will need progesterone because the progesterone protects the lining of the womb from the actions of oestrogen, oestrogen thickens the lining of the womb. So it's just women who have had a hysterectomy who can have oestrogen only.

Steven :

Okay. You mentioned migraines earlier on, and I'm not sure I was aware that migraines were associated, presumably reasonably strongly with menopause. You know, the mechanism for that, I thought that the cause of migraines was quite a mystery.

Hannah Short :

Well, I think it probably still is a bit of a mystery and there's multiple things that can trigger migraines, but we know that obviously there's a connection with the cardiovascular system and vascular spasm and oestrogen affects our

cardiovascular system and can cause cardiovascular instability in that sense. It tends the women who tend to struggle or those who are often have had menstrual migraines throughout their life. Although I do see some women who've never really had headaches and suddenly it will develop in perimenopause and it seems to be to deal with the fluctuating levels of hormones, and whether that's affecting the cardiovascular system in that way. So basically with these women if HRT can be used, but you often need to start at a very low dose,  instinctively patches would be better because they give you a kind of very stable background or something like the Marina coil cause it gives you a stable background of the progestogen. There's a very good podcast called Heads-up, which is on the National Migraine Centre website about hormones and migraine, which is worth listening to with a Professor Ann Macgregor and she's got a whole hour on there talking about it. And so yeah, Heads-up podcasts, woman's migraines she talks about it all and it's very interesting.

Steven :

Is the association just with migraines or with other forms of headache as well?

Hannah Short :

No, there's other headaches, I think it's women who might have experienced occasional migraines in the past. They seem, they sometimes become much more common. But to be honest, sometimes the people's migraines disappear completely at menopause, it tends to be perimenopause that's major problematic. But other women might develop headaches and I suppose it's a little bit like women who have premenstrual disorders which I know we haven't really talked about yet, but they can have similar symptoms in the, in the lead up to that into the period as well.

Steven :

Right. Claire do you want to ask a few more questions before we move on to premenstrual disorders?

Claire MacDonald :

Sure, Helen has asked, can HRT help in the control of autoimmune flare ups?

Hannah Short

Sometimes, but sometimes it can worsen them. And I think the key thing is that you have to start very, very slowly. So I think there's a lot of hormone sensitive conditions out there, say like migraine, like endometriosis, like autoimmune conditions. If you often go in with a normal starting dose of HRT, that can sometimes trigger a flare and actually what you need to do is build things up very, very slowly. There was a lecture at a conference I went to last year on Lupus. They were saying that actually it can be used but you need to be quite cautious and you just need to

kind of increase an increased dose gradually and start a lower dose, maybe effective initially and just build on it slowly.

Steven :

You have started there talking about building up gradually, we've had a lot of questions, you know about what happens when you stop HRT, do you end up with menopausal symptoms or do you bypass them all together? Do you have to come off it gradually?

Hannah Short :

I mean I think I would recommend it. Women might choose to come off HRT stopping gradually, just because effectively obviously it is a medication and your receptors are used to receiving that medication. And I think I often liken it to if you were a coffee drinker and you suddenly stop your three coffees a day, you're going to get a headache. Although eventually that headache will go. If you suddenly stop your HRT, you suddenly will probably get rebound symptoms. It doesn't necessarily mean that your symptoms are still going to be there two months down the line. It's often a reaction to drug withdrawal.  So, the way I normally do it is to reduce the days quite gradually, and then stop. And if the symptoms persist, into weeks, weeks, it is likely they would have been there anyway. But for a lot of women, especially if they've been on it for a few years, they might have dissipated but symptoms can, can take seven to 10 years is the average length of time is, is around seven years, to be honest.

Hannah Short :

For women to suffer menopausal symptoms, around 10 to 15% of women will have symptoms ongoing unfortunately. And some women who might need HRT lifelong, but they're, they're probably in the minority, but there is no arbitrary time limit for stopping. But it doesn't delay the menopause. I think some people think it is going to push you to go through it the other end or whatever. And that's not the case. But yes, if you suddenly stop your treatment, you might have, you and your receptors are going to be screaming where's the oestrogen? But

Steven :

So I'll just ask one supplementary before I let Claire jump back in again. So given all that, how do you judge when to stop HRT?

Hannah Short :

I mean, traditionally, it was always try for five years and then try and come off at five years. But again you need to be guided by the individual, but I think five years is a reasonable time,  if somebody wants to try coming off it, because a lot of women, nobody wants to take stuff unnecessarily and so maybe at five years you'd try reducing the days and see how you go with that. Women who are in a surgical menopause for example, might need to stay on a very, you know, low dose life long,

even if they're in their seventies or sometimes there's some women in their eighties, nineties, you still take HRT because they struggle otherwise. And I don't think we should be denying women that say. And certainly I've just realized, I haven't mentioned the vaginal HRT, which can kind of really, which is separate to this systemic stuff we've been talking about, but that can be used kind of lifelong and they don't need to have any concerns in terms of long term health risks because it's so local that treatment. And that's not going to happen. That say, you know, there's vaginal oestrogen, vaginal cream, there's a Silicon ring with the oestrogen impregnated in it. I mean, that can be very, very beneficial for women who suffer with recurrent UTI or severe vaginal symptoms as a result of menopause, and you don't need to take systemic HRT alongside, although often people do. And there's no reason to stop that. And actually that's something that won't get better without the oestrogen.

Steven :

Yeah. Claire would you like to jump in?

Claire MacDonald :

Yeah, sure. With the perimenopause in HRT, are there any benefits in taking HRT before the menopause has properly started? So you've been through that year or no periods, but you might be in that 10 year potential perimenopause. Can you take HRT then?

Hannah Short :

Yes. I mean, to be honest, that's generally when it should be started because that's often when women are most symptomatic. So it's a bit of a myth that you shouldn't start it until your, you know, and until you know, you've had your menopause. So there's two types of HRT. There's cyclical HRT where you would have a withdrawal bleed, a bit like being on the contraceptive pill. Then there's continuous combined, which is what we call a no bleed regime as well. But there's no point putting someone on a no bleed regime if they're still having periods because they're likely to have problems with breakthrough bleeding, which just compounds everything. So yeah, that's, I think it's frustrating. I do see people who have been told they can't take HRT because they haven't been, they're not menopausal. And it's like, well no, you can start it in the perimenopause. And to be honest, the younger somebody who's having these issues, the sooner they should probably seek help, especially if they're very young actually. If they are below 40, we need to make sure it's nothing else is going on that it's not a thyroid disorder or anything which can have similar symptoms.

Claire MacDonald :

Yeah. We run some menopausal workshops at our practice and one of the questions is frequently asked is how do I know when I'm in the perimenopause if

you are still having periods? How do I know that, you know, we've been grumpy and my husband is because of that. Or just being grumpy. And my husband.

Hannah Short :

I mean I guess you don't really, in terms of, I suppose it's looking, it's like when I speak, when I see someone in my menopause clinic I will take a full history and then including everything else that's going on at home, looking at their lifestyle, working out what's going on there as well, because it's also important, because I suppose especially in forties and fifties is often a very busy time for people's lives. It's often when people have got maybe still have children at home, they may be looking after elderly relatives. There's often at a time when people are in the mid, you know, good point in their career, probably got quite responsible jobs. There's often lots of life stress as well. So I think it's number one looking at a tool of that and seeing has anything else changed? I mean I do see people who are very, you know, high-flying careers and suddenly they feel like they can't cope and they just wonder what is it that's changed.

Hannah Short :

I said that would be a time to kind of maybe may be consider it. But I think it's important to say HRT is, is I think the most effective medical treatment for, for menopausal symptoms. But lifestyle is really key as well. So I, and actually depending on how you look after yourself and you're trying to prioritize things like sleep and exercise and a good diet and that's going to have an impact on how well your body deals with the HRT and even drive some of the benefit from it. So, I mean if people drink, I mean lots of women and men will have a glass of wine or something when they get in after a hard day's work to try and relax them. But that's probably one of the worst things to do cause it affects your gut house, the gut microbiome, which has a direct effect on everything.

Hannah Short :

But it has a direct effect on how you, your body will deal with hormones on excreting hormones and metabolizing them generally, and it may even affect how well HRT works. So in, in eat, making sure you eat fibre rich diet is really important for kind of similar reasons because it, because of the kind of the enzymes that it produces in the way it can break down products and, and, and, yeah. So every, everything is, is, is kind of related, but it's so it's just looking at all is very important.

Claire MacDonald :

Yeah. So relating everything back to lifestyle and the changes you can make that to make whether you go and HRT effective or not.

Hannah Short :

Yeah, yeah, definitely.

Steven :

So regarding that, identifying the starts of the menopause, I gather from a question that's coming in anonymously that there are differing opinions over the value of blood tests?

Steven :

What's your view on testing through that means?

Hannah Short

There's not really, I mean, that's, there's quite clear guidance on it. They're not needed if you're over 45, because essentially any woman age 45 will be in the perimenopause and so perimenopause, the reason that it's not that helpful, to be honest, is that the numbers can change from one day to the next because you're getting a big fluctuation or your levels are going like this. And it's just the snapshot. It can be important in younger women if you're trying to rule out an early menopause or because if you're, if the levels of normal need did normally take two blood tests to, you know four to six weeks apart, if they're abnormal, then you think, okay, maybe there is something hormonal going on here. If they're not, then it'd be maybe needing to look elsewhere. So that, but for diagnostic purposes in most women at the age of 45, it's not, they're not going to be that helpful. It can be helpful in terms of treatment in women who don't seem to be responding to treatments, or women who have had say a surgical menopause or who've been, who are, who are young to make sure they're getting an adequate oestrogen from that treatment. But I don't, do blood, tests that often. And the Nice guidelines on menopause are quite clear about, we don't test for menopause.

Steven :

Okay.

Claire MacDonald:

Yeah. So there's a couple of questions that will relate back to the musculoskeletal aspect, which is really interesting for us. Vannin asks, do you have any experience of progesterone worsening benign joint hypermobility?

Hannah Short :

Yes. I mean, I'm aware that it does that and so patients with say benign joint hypermobility certainly can do. I think not, can again be quite, quite tricky in my, maybe in those patients that they'd be recommended to potentially see their GP and think about something like the Marina coil, which although it's obviously it's a progesterone, it's a much lower dose and it's, it's a little obviously T shape thing that sits in the uterus and protects the lining of the womb, but it's going to give you a steady state of progesterone cause I think it's the fluctuating hormones as well as the rise of progesterone in,  you know, before the period that that can, can worsen

joint hypermobility. So that is if they wanted to take it. But obviously some women might normally not want to take any if they have had a bad experience before, but it might be worth speaking to somebody who's a specialist in that area. But yeah, I think it's well documented that the luteal phase of the menstrual cycle, so the two weeks before is, is definitely can come worse than symptoms in inpatients with hypermobility.

Steven :

I guess that also leads us into this next question, which is of interest to several people. How much choice does a woman have or with a type of HRT that she gets? Apparently gels, patches and all HRT will have different risks and attractions. But GPSs presumably are keen to drive people down a specific route.

Hannah Short :

I think you know, that there are guidelines on what you would try first. I think it very much depends on the individual practitioner that somebody sees. I mean, if you're seeing somebody privately, then it's probably a little bit easier to kind of have a choice about what you take. If you see a GP who hasn't got that much knowledge or experience, they, it's going to be a little, maybe a little bit trickier I suppose. I think it's reasonable to ask, and in terms of, especially in terms of gels and patches are available on the NHS. I mean, albeit there is a bit of a shortage of patches at the moment. I think it's reasonable to ask because they're obviously they've got a lower risk of blood clots for one thing, and even, I don't know, a lot of the women who need HRT can, you know, lots of them may have something else which might predispose them to that. So yeah, I think, I think it's always worth always worth asking. But it's hard because you know, people, often doctors are used to prescribing things in a certain way and they will, they'll prescribe this cause they've always prescribed this. But I think most doctors hopefully will be amenable to a bit of a discussion. If you've got a reason for why you want something in particular.

Steven :

You made it sound there that if someone were to come and see you privately, your adherence to Nice Guidelines might not be quite as acute or otherwise?

Hannah Short :

No, no, no. I mean, the thing is what I do in private practice is what I would do in general practice. I still work alongside the, the Nice Guidelines. It's not about the nice guidelines, it's, it's just in terms of what if you've got longer with somebody or somebody is with you, then you've got more time to discuss. I mean, I do, honestly, I tend to prescribe the same whether I'm in general practice or private practice apart from stuff that you can't prescribe on the NHS, but most of this stuff is available on the NHS. So yeah.

Claire MacDonald :

Yeah, we have, as you said, lots of questions and a lot of them are about other conditions associated potentially with the menopause, tendinopathy, people talking about especially with shoulders, asthma, thyroid, breast cancer and other joint pains.

Hannah Short :

As I think I said when you mentioned autoimmune thing earlier, say thyroid or Hashimoto's thyroiditis is pretty common in the general population, and it's obviously thought to have an autoimmune you know, role there. And so we do see that there is, that there is a link with, or at least thyroid disorders often seem to emerge around peri-menopause. I don't think, again is necessarily triggered by it, but everything is connected, and so each trend affects the thyroid gland and, and, and kind of vice versa. And actually women with thyroid disease need, if they are on HRT need to be managed in a particular way. So they, they certainly should be on a, on a kind of a transdermal preparation. So a gel or a patch,  cause they often need higher levels of oestrogen to have the same effects.

Hannah Short :

It's better to have it through the skin because otherwise if you take oral HRT it can increase thyroid binding globulin which will affect obviously the thyroid gland. So, yeah, so there is, there, there is an association and it can be a bit tricky sometimes because some of the symptoms can overlap with thyroid disorder and menopause. So that may be a time when blood tests are necessary, especially if somebody has got a strong family history of it or they've been borderline in the past. Asthma, there does seem to be an association with new onset asthma in women in their mid forties, which we think has a hormonal element. I mean we do sometimes see kind of an asthma in pregnancy, so we think oestrogen is related.  I think again, it's to do with this inflammation that you say your body's in a state of heightened inflammation when you're in the menopause.

Hannah Short :

And so that predisposes people to more inflammatory conditions. It might be related to histamine. So obviously histamine is produced as part of an inflammatory reaction, but we naturally, our bodies naturally producing histamine any way. It's in some of the foods that we eat and fluctuating levels of oestrogen affect levels of histamine. And that can certainly trigger kind of asthma type symptoms in some people as well as other symptoms like brain fog and other things. So that's again where sometimes other stuff other than HRT is going to be beneficial. And I'm often recommending like a dairy free diet can be helpful, cutting out processed meats and smoked meats and fish, alcohol, I mean that's a whole other topic really. But yeah, there's certain, the role of histamine so it certainly seems to play it play a part here as well.

Hannah Short :

What was the other thing you said? The tendinopathy? I mean I was contacted by a runner who was asking me because she, she developed for the first time during, during perimenopause, but unfortunately there's so little research out there so we don't, I don't really have much more information, I'm afraid it does seem to be associated, but I, I don't really, you know, understand the full pathophysiology of that. It's an area that needs to be much more researched I think because, you know, so many people do struggle with, with muscle and joint pains and tendinopathies at this time and on shoulders like you've mentioned.

Claire MacDonald

Yeah, absolutely. We've got another case history that's come in, so I'll just read that through if that's okay. So a patient with bilateral hip pain, very low blood pressure every morning, she fell and broke loosely on one occasion. A sense of the air being very thin every now and then, one period a year for three years, no mood swings or loss of energy and occasional hot classic flushes, inflammatory markers all check, nothing abnormal detected. And 24 hour heart monitor, nothing abnormal detected. Two years later, hot flushes became unbearable. So they were always proceeded by this sense of the thin air. And then brief sensation of pins and needles in both hands. Patient had blood tests taken privately, no oestrogen or no testosterone at all. HRT given all the symptoms stopped. And the question is, is this a normal picture and what should we be asking to get a clear idea about patients like this? So we refer to blood tests,

Hannah Short :

It's not a typical picture, but then I think, because as I said earlier, the oestrogen hormone receptors throughout the body and we're all individuals. So everyone can be affected very, very differently. And I think it's what we need to think that, well I suppose it's what you guys are pretty quite good anyway at a just doing complete holistic overview and not narrowing somebody who comes in and not just put them down to this is a gynae patient or this is a thyroid patients and actually just looking at the whole person. I mean often with these things, it does end up being a bit of a diagnosis of exclusion. I think if someone is having hot flushes but it doesn't fit the typical picture, you should certainly be checking or referred for like hormone levels that would make sense.

Hannah Short :

So it seems to me, I think with that history with the one period a year and the occasional hot flushes, I think it would have been important to do her FSH, her oestrogen again and things like that as well as checking things like thyroid and prolactin and everything. But it did sound like a little bit of a tricky case, but I think we do, I see patients quite frequently with pins and needles and things like that and blood pressure instability and that can often calm down on HRT as well. So, but it wouldn't be an indication for starting it. So we've really, you know, we're often still guided by, you know, hot flushes, staffed it or whatever, but Nice Guidelines are

very clear about the mood changes in menopause that HRT is recommended over anti-depressants, but there's lack of clarity really about the others. So sometimes I think sometimes it would be missed that case because it's not, it's not particularly easy to say.

Steven :

Is there any typical patterns to the pins and needles you mentioned because obviously that's a common symptom in musculoskeletal cases.

Hannah Short :

Often hands and feet, its often the extremities. Yeah.

Steven :

Okay. And also you mentioned well Claire mentioned testosterone. What's the role of testosterone? And somebody asked whether that is actually available on the NHS guidelines.

Hannah Short :

It is available. None of it's licensed, we used to have a patch who've been Trinza patch, which was specifically for women, but I think it was stopped for commercial reasons, not for safety reasons. So a lot of women won't need testosterone replacement, but there are certainly some women who will benefit from it, so it's sometimes recommended if women are struggling with libido, despite having adequate HRT and looking at lifestyle, but it's not just about libido, it's also about energy, about muscle to reduce the risk of sarcopenia, things like that. Especially in the younger women. It can help headaches and it can help with some of the urogenital symptoms. So it's often needed in the women who have picked the POI, so the younger menopause or if they have surgical menopause because obviously they're not producing any of their own.

Hannah Short :

Having said that, there are some women who have a natural menopause and they might still require it and I think that that you would consider it at that point if they, if they're not you know, if they're not getting better with and that they've got adequate oestrogen and there's nothing else to read to account for it. There is a good fact sheet on the British Menopause Society about it and talking about what's available on the NHS, what's available privately. We stopped testing at the moment. Normally you'd check your bloods after around six weeks of starting on it to check your in normal female physiological range. And we stopped that just because of the COVID-19. But it doesn't, it's still, there are women who can still start it and especially if they're young and you're using the prescribed dose.

Steven :

So a separate question is asked whether you prescribe testosterone for anyone with reduced libido.

Hannah Short :

I mean, I have prescribed it and that's one of the indications for it and again, it comes back down to it individually. If I've, I mean, I see patients who will say they haven't no libido, but it doesn't bother them. So if it doesn't bother them and they're otherwise well, I don't necessarily need to give them testosterone, but there are some people where there you know, it's, it's really upsetting them. It's causing difficulties in their relationship. Especially if they've had a healthy high libido previously and often people talk a lot, they've lost parts of themselves. So it's very important to always, I mean, I was asked about sexual health and how things are, how things are there because that's important. And women are often not afraid to bring it up to be honest. So but it isn't, it isn't just about that. I'm not thinking about that's, that can be enough in itself, but it's, it has a role in other areas as well.

Steven :

Sorry Claire. I held the conversation there a little bit over to you.

Claire MacDonald :

That's fine. It's great. Jane B has asked, is it true that taking HRT would continue to maintain uterine fibroids?

Hannah Short :

Yeah, again, have to be a bit a little bit cautious with fibroids, but yeah, it does. You can certainly have HRT, but fibroids are oestrogen dependent benign tumors. So if you have a big dose of HRT that could, I suppose worsen fibroids, but I have had patients on HRT with the fibroids. Key thing is having stable levels, but starting low a bit like with these other, you know, home independent things I mentioned earlier

Steven :

We talked earlier on about taking people off HRT Hannah, somebody sent in a question about the effect on bone density. We thought you talked about taking them off and hoping that their symptoms have gone away. If someone comes off HRT in their sixties, is that going to affect their bone density then?

Hannah Short :

I mean potentially, I mean obviously the oestrogen it's going to help whilst it's there and I think it continued for a little bit, but it's, it's not going to be, you know, protective long term, but I suppose it will have maintained their bone density to a degree that it wouldn't be maintained before. I mean, in terms of HRT, you actually only need very low doses of HRT to kind of maintain your bone density. But if you're wanting to build bone in somebody who's got osteopenia or something, you need slightly higher doses. And that's when it becomes important in younger women. So if

somebody is gone through menopause at the age of 30, you need to make sure they've got a decent dose so they can actually build bone. Cause often these women will actually have osteopenia at that point.

Steven :

Any alternatives that you suggest to HRT for preserving bone density?

Hannah Short :

Well obviously strength training, exercise, always recommend that. Weight bearing exercise. I just think that's so important. Obviously not smoking, eating a diet, there's actually a good paper that was published recently about the importance of gut health and microbiome and for bone health as well. Actually saying that some probiotics might be helpful in terms of maintaining bone, bone health if taken during perimenopause, don't know if you saw that. It was, it was kind of in the media probably a month or so ago, which was really interesting and that because you get gastrointestinal increase in permeability around menopause and that, that seems to have a knock on effect. But if you can support the microbiome that can help with the bones. I mean obviously there's the traditional, Alendronic acid and things, but it's not something I generally prescribe.

Hannah Short :

I think if they've been told they've got osteoporosis that you'd recommend, but otherwise I think it's a lot of lifestyle, not drinking too much alcohol. Interestingly, not having a lot of dairy because I don't know if you've seen the milk report that was asked about milk can health and that can actually worse in bone health if you have, you know more than say a glass of milk a day. Although I've, I've seen one woman who was drinking six pints a day because she thought it would help her bones. Obviously evidence is actually, if anything, it might increase the fracture risk. So trying to get your calcium from other sources, so fortified soya, leafy greens, nuts, seeds, beans, all of that stuff, because it's not just calcium that's important and stuff like magnesium, boron and iodine, they're important. I do actually recommend, Vitamin D supplements and iodine, to be honest to most patients because a lot of people are deficient in both of those things.

Steven :

I don't think we've spoken to a single practitioner who hasn't recommended vitamin D to be honest. So particularly in the non sunny months in this country, which is pretty much most of them.

Hannah Short :

Well, most people are deficient aren't they? I think, but Iodine is really important and it's one that's hugely overlooked. It's really important for bone health. Most countries Iodide is their salt and we don't do that here. There's Iodine ironically in milk but it's not, it's only as a result of cleaning the vats, and or cleaning the cow udders. So it's

not a natural component of milk. But that might be where a lot of people might get some iodine, or from seafood or seaweeds. But it's unreliable. And a lot of people still are inadequate and I wonder if that's why there's a bit of a problem with thyroid disease in this country. So 150 micrograms of Iodine in should be sufficient, because I'm too honest, a lot of people just don't have enough so, but you don't want it to overdo iodine because you can cause problems with your thyroid if you overdo iodine.

Steven :

I think you've probably answered Robin's question earlier on about the impact of an early menopause on osteopenia, but he followed it up by saying what do you consider to be early menopause? Is that anything before the age of 45?

Hannah Short :

So early menopause is before the age of 45, premature is below the age of 40. There are some girls in their teenage years who will have a very, very premature menopause. That's what I said earlier that no, you're never too young. I see patients who are told you can't possibly be menopausal when they're in their twenties and having night sweats, and you know, sex is painful and everything else, but then they're found out to be.

Steven :

Psychologically that must be devastating.

Hannah Short :

Yeah, I think it is, and especially when you're kind of at that point in your life where you're just starting your adult life and people are taking contraception to prevent them getting pregnant potentially, and you, and you think that what you've been told you may never get pregnant. I think there's a connotation with being menopausal and being old. I hope we can kind of change that narrative because, and there's, you know, across the spectrum, obviously most women are going to be late forties onwards when they're menopausal, but even at that stage, you're not old. It's still just early middle age at that point. so we need to change that, but there is a charity called the Daisy Network, which supports women with premature menopause so if you have anybody, he's who's kind of going through that they're worth pointing out to.

Steven

So, okay. Your turn Claire, I've hogged the conversation again,

Claire MacDonald :

There's actually a question but just before we come on to that, is there anything that can be done with hormones to, to stop that early menopause to, you know, enable you to still have children or..

Hannah Short :

At the moment we can't stop that happening. I mean there has been some talk about STEM cell and you know, and egg donation and things like that, but actually we've not found a way to kind of stop that. But sometimes I think I said earlier, very occasionally women can still conceive but it's pretty rare if you've had a diagnosis of POI. There are options like egg donors and sometimes IVF is successful but quite rarely, but egg donation does, it does sometimes work. So again, the Daisy Network is a good place to go to find out more about that. So it's not impossible, but, and it's, it's one of those hard things because you don't want to kind of completely dash people's dreams and hopes, but then you want to think it's not entirely hopeless because I have seen women, who have fallen pregnant when they were 40, but they were diagnosed at 30 with POI, but it's not, it's not common, but it can happen. Egg donation is it's something that some women do consider.

Claire MacDonald :

Okay. And then somebody was saying about late menopause, any reasons or issues for people who don't have their menopause until they're in their sixties?

Hannah Short :

I mean that's quite late. I think I've never really seen a case with somebody who's in their sixties with menopause. I've seen some women in the very late fifties, which is the much later age. I think it's no, not really issues but obviously there bones and stuff, their heart they might have a better outcome in terms of their bone health and everything. They're likely to have a slightly more increased risk of breast cancer. But again, looking at the heart disease is what kills most women in this country and so actually there's, as long as there's no other issues and it's a late menopause and not actually postmenopausal bleeding that's restarted after time, then I don't think there's too many other concerns from that point of view because you're, if you're still producing oestrogen and your bones are still being protected, your heart's still getting some protection, your brain's still getting some protection. So no, I think it's just more probably the inconvenience and people who must be frustrated.

Steven :

I know I was intrigued earlier on because you mentioned the connection between menopause and UTI and I wondered what that connection was. But Zoe has sent in a question asking whether you can recommend a natural alternative to HRT to prevent those UTIs.

Hannah Short :

So the connection is that obviously there's oestrogen receptors around the urethra and then the bladder and they can become quite inflamed and irritable so they can give that sensation of UTI without there actually being an infection. But equally because the skin is more friable and fragile and irritable, you can again be more likely to develop them. You need to develop a GTI. To be honest, oestrogen is going to be the main thing. You can, as I said, you can have a topical oestrogen. You don't need to take full on HRT. You can have a local thing which isn't really absorbed systemically. So there's all these vaginal preparations I talked about and pessaries and there's even actually a non, it's termed a non-hormonal. I think it's still somehow works in hormonal way and that, that you can kind of take that in theory isn't oestrogen.

Hannah Short :

But I say things like there is some evidence that probiotics can kind of make potentially help. I guess the usual of using vaginal moisturizers, using a lubricant, especially for intercourse and stuff that provides a kind of barrier. It can make things less uncomfortable, but also it does provide a barrier to any bacteria that are there. But if somebody's really struggling with these symptoms, they're not getting better, that it's a treatment sooner rather than later. And there probably has to be quite good reason for something not to want oestrogen because even women on breast cancer treatment and Tamoxifen are often taking the local vaginal oestrogen.

Steven :

We actually had a question from somebody, Ellie, in fact, you asked about Tamoxifen was interested in your thoughts on how that affects menopause?

Hannah Short :

Well, obviously, I mean, Tamoxifen is you know, trying to kind of block the actions of the oestrogen anyway, so it can produce menopausal type symptoms, but it isn't necessarily going to kind of impact your menopause. It's only given to premenopausal women. I mean, sometimes women might find when they stopped there Tamoxifen that they've gone through the menopause. Was there a specific question about that or..

***NOTE***

**After the broadcast Dr Short asked us to clarify what she had said about Tamoxifen:**

**Tamoxifen can cause a temporary medical menopause as its mechanism of action is to block oestrogen receptors. However, there is no good evidence that it leads to an earlier permanent menopause after treatment has been completed. Tamoxifen is given to both premenopausal and postmenopausal women for the treatment of oestrogen-positive cancer; in premenopausal women it can**

**decrease bone density, but in postmenopausal women it can improve bone density. This is because it is a SERM  and its effect on bone is driven by the relative oestradiol concentration in the patient.**

Steven :

No, just what was the impact of Tamoxifen on menopause?

Hannah Short :

I haven't actually seen any research on that specifically, but obviously it's normally given to you when you're premenopausal. So, if you wouldn't be, you wouldn't be given Tamoxifen if you were  postmenopausal. It's trying to switch that off really.

Steven :

Right. Okay.

Claire MacDonald :

One person is asking. How often should we see a gynaecologist? In Australia, people will go, the women go once a year. Would it be good practice to have a check up every couple of years?

Hannah Short :

Well, I mean, we don't really do that routinely here do we? I think, and it's something that we've been talking about. There's a lady called Davina. I can't remember her surname, which is embarrassing, isn't it? But she's got a petition up to try and get it regularly, I think she's from another country. And she said, well, normally you would have a yearly check up with a gynaecologist. I don't think it's necessary to see a gynaecologist for that. You could see a GP who's got an interest in women's health, you don't necessarily need, see, I think other countries have a very different healthcare system to here.  I think in a way it would be good practice to, to see someone and have a chance to check and make sure things like contraception are okay. Have you got any menopause or symptoms? Any, you know, any unpleasant vaginal symptoms, things like that, it's, it's a good chance to check through or, I think it wouldn't be a beneficial thing. It's just whether we have the capacity for that in the NHS. So, yeah, in theory I think having a One Stop women's health clinic and, just cause I think right the way from puberty to menopause, I think it would be a benefit even from talking to younger women about preparing for pregnancy or preventing pregnancy, preventing STI, all of that stuff. Unfortunate it doesn't happen but.

Steven :

But how common are breed are you Hannah, because you've said go and see a GP with a special interest in women's health. I mean, are there lots of them around? Does every practice have one?

Hannah Short :

Most practices will have a woman, have a GP who has an interest in women's health and not have necessarily interest specifically in the menopause, but they, they would probably be more likely to know, but most practices should have a GP who's interested in women's health. So we should be able to do and deal with a basic review.

Steven :

Okay. Anonymous question about how HRT affects hair loss, possibly sent in by my wife with concerned about me, but..

Hannah Short :

That's one of the difficult ones because it....

Steven :

Hannah we seem to have lost your microphone.

Hannah Short :

Hair health can respond to HRT, but it's certainly not something that's gonna happen overnight and it's not always the answer. I think we still don't have all the answers to the puzzle essentially. Again, alcohol's often implicated with them and it's not, it's not the main cause at all, but alcohol can worsen hair health and hair loss, but again, that goes back to looking at everything including lifestyle and things and you know, not to make sure you're not smoking and dish, and make sure you are de-stressing. I suppose it depends on the degree of the hair loss as well, because hair loss can be associated with, you know, things like thyroid disorder as well. So it depends if it's very severe hair loss than it might be time to kind of have a thyroid check, but sometimes if women do have a low dose of HRT it can take a while to build up but sometimes hair loss may stop and hair health can improve.

Steven :

Okay. Claire..

Claire MacDonald

There's lots of no alcohol advice going on here.

Steven

I'm going to ignore that!

Claire MacDonald

Emily's asked being on the Marina coil would that do a similar job to HRT when a woman is perimenopause

Hannah Short :

No, not by itself, it can be part of HRT. So in HRT you need progestogen and the oestrogen, but it's the oestrogen that tends to on the whole, the hormone that's responsible from previous menopausal symptoms. But the Marina coil is a very good option for women who are perimenopausal because it provides contraception, which is still needed. And it can provide the progestogen component of HRT. But it's not going to be enough in itself to, to hold these symptoms for most women.

Claire MacDonald

So it's the progesterone that's in the coil?

Hannah Short

Yes, it is. Yeah. But it's an option for the part of HRT, but no one's fitting them at the moment, unfortunately.

Steven :

I love this next question. It's about what is described as the anti-aging wonder drug DHEA which seems to be prescribed a lot with the bioidentical hormones. And what are your thoughts about those? Hannah.

Hannah Short :

We don't have enough evidence to prescribe it, at the moment, generally for menopause, but we can prescribe it now on the NHS for vaginal symptoms and for painful intercourse. So there's, there's a new product that came out last year, which has been used in the US, Germany, Spain and Italy actually, and that's been quite successful, so it's not, wouldn't normally be a first line drug here, but it is available on the NHS. I've had some success with some patients who haven't responded to the Vagi foam, which is an often like a pessary tablet you'd use, and like cream things. But this, this one called Intrarosa can be very effective, but that's the only licensed form of the drug we have here. In the States though, you can buy it over the counter! But I think that there isn't enough research to recommend it on the whole here at the moment.

Claire MacDonald :

Somebody else is asking are the effects of surgical menopause equal to natural menopause. Do women get the same symptoms?

Hannah Short :

They're certainly not equal. It's a whole different ball game because you have part of your endocrine system removed, say symptoms can be much more severe and they're going to be quite sudden, so you, if you're post premenopausal before you have your ovaries removed, you're then post-menopausal straight after that. You're not producing any of your own hormones. You know, you might have small amounts from your adrenal glands, but it's not going to be enough really. So often women might need a slightly higher dosage of oestrogen, and they're often the women who might need testosterone as well. The symptoms can be similar, so the things like the, you know, the hot flushes, mood swings, migraines, joint pain, but some of them can be more pronounced and especially things the migraines and the joint pain.

Steven :

We've got more questions about headaches Hannah. I'm asked whether you can advise anything for chronic migraine sufferers around perimenopause, menopause, specifically in someone with a lifelong migraine headache, but worse coming up to and through menopause. Is there a role for HRT for that symptom if that's the main problem, symptom or should headache.

Hannah Short :

Sorry, cat walking through!!!

Speaker 1 :

I was hoping, I was hoping the cat was going to make an appearance. So is there a role for HR T for that or if it's the main problem or should headache migraine problems be treated separately, for example, with usual preventive meds or onto Botox as guided by Nice?

Hannah Short :

Again, I think it's, it was very individual and I think I was saying earlier, the thing with migraine, if it's a hormonal trigger and it seems to be getting worse, then it might be that there might be hormones, might be part of the solution, but you, what you want is a very stable hormonal background and that can be quite hard to achieve. So something like the Marina coil because it just gives you a hormonal acronym that can be in place for five years. Patches, oestrogen patches but starting very low dose. So normally oestrogen patches of a normal starting dose is 50 micrograms. So sometimes I've started somebody on the equivalent of 12 and a half, so a quarter of a patch and then built up.  It really depends how severe the migraines are, but that can be effective, if you go in with a straight one with the 50 dose, that might be too much.

Hannah Short :

The other one that can be, that you can use sometimes, there's, I sometimes prescribe a double dose of progesterone only pill called the desogestron, which it's kind of off license. but it's, it's kind of what a lot of us think. It just provides adequate

protection for the lining of the womb, and often prevents ovulation and that's what you're kind of trying to do. If you can give that and then have an oestrogen patch as well, that can often help with the headaches. Other than that, I think magnesium supplements can be beneficial, and in Nice, it's a bit willy on that and whether or not it is, but it's some patients I find that it can be helpful, and B Vitamin complex especially B2 can be very helpful. You might still need to take things and stuff as well. But 'd refer, go back to the Heads-up podcast I mentioned, with Ann McGregor and there's a whole episode on that. And so just Google Heads-up, and it is season two, I think it's the first episode, but it's really worth listening to.

Steven :

We'll make sure that's recorded on the website as well. Someone has asked why you think there are differences in menopausal symptoms in different cultures? Apparently in Japan they don't have a word for menopause and report far fewer menopausal symptoms. Is it diet related?

Hannah Short :

I mean I think there is a difference I think in, in parts around the world. I think sometimes it's because people don't choose not to report them because I think in more recent studies they women do suffer with menopausal symptoms in other cultures. But it does seem that there's a low rate of things like what we would consider traditional symptoms here, like hot flushes. We think it may be more to do with the diets and things, especially consumption of soya. So in traditional kind of, I suppose Japanese culture, people might have two to three servings of, you know, what's the word? Well, minimally processed Soya on a daily basis, and so they're getting a big dose of, I say flapping switch. You're kind of like the plant based oestrogens and that seems to affect things you know, in quite a positive way.

Hannah Short :

There's a lot of myths around soya as there is around HRT. The evidence generally is that it can be quite beneficial, and including for patients who have had breast cancer, it's associated with a reduced risk of oestrogen positive breast cancer interestingly. So we think soya acts as something like a CERN, so selective oestrogen receptor modulator, so it can block the actions of oestrogen in some tissues and enhance the actual actions in others. So that's might be why, it might be okay in breast cancer sufferers, but can also do things like help with the hot flushes and sometimes help with bone health potentially as well.  Soya also affects the gut microbiome and women might actually derive more benefit from taking soya supplements or extra soya if they've eaten or soya and those who eat a plant based, are more like to drive benefit from soya.

Hannah Short :

So again, it's one of these things where everything's connected, but certainly those people who have more soya in their diet or plant based oestrogens, there's

association with them having reduced, you know, reduced level of menopausal symptoms.

Steven

Do you see this in this country, different cultures or different groups of the populations with a different set of different symptoms.

Hannah Short

To be honest, I suppose where I kind of work. I think quite a lot of people I see are just white Caucasian, so it's quite hard for me to say here. I think if I worked in, in London or something, I'd probably see a wider breadth of people from different cultures.

Steven

I was thinking along the lines of vegan, vegetarian diet.

Hannah Short

There was a paper I appreciate sharing that they still have a more of a plant based diet tend to suffer fewer menopausal symptoms and that might be to do with the reduced inflammatory load.

Hannah Short :

So we know that animal protein increases things, inflammatory markers in the blood. I generally advocate more of a plant based diet, but even if people can't feel they can go fully done that route. I think just add as many plants as you can, increasing your fibre intake is going to just be hugely beneficial. Try to minimize meat to specialty meat and dairy and stuff from factory farms. So if you are going to have meat in your diet, make sure it's from a better source. I mean I don't particularly advocate but for me generally, but if you are going to then make sure you know where it's from, and kind of minimize it. And try and shake things up a bit. I always try to encourage people to include beans, lentils, things like that in their diets to help with bone health, for heart health and everything else.

Claire MacDonald :

So you mentioned probiotics a few times and how effective they can be. Are there any specific probiotics that you recommend?

Hannah Short :

In terms of the bone health that you were talking about or just?

Claire MacDonald :

I think you mentioned it in bone health and you mentioned it for UTI. So I think with the question is really related to brands or you know, what, which ones do you specifically recommend?

Hannah Short :

So they're the one that in the paper that was talking about bone health, I can't, I don't know if the brand is available in the UK that they used in the study, but it is available from Europe. So I'd have to forward that on. But the particular ones for with like women's health and the genito-urinary region, there is a brand called OptiBac, they do a women's health one. They can help either if people are developing UTI, it can actually help with the antibiotics as well, but they can also be beneficial by themselves. They are quite helpful that they might be able to advise if there was one that might benefit bone. But this is quite a new study about the bone health and the microbiome, but I'll see if I can find the reference and send it across.

Steven :

Valerie sent in a question Hannah, about someone who hasn't had a period for months and then starts bleeding again? Should they seek help? Is that something they should be concerned about?

Hannah Short :

If it's more than 12 months, yes, they need to see that doctor because it may be nothing, but you need to rule out things like endometrial cancer. So if it's more than 12 months, or you've have been on HRT and if you haven't bled for more than six months and you suddenly start bleeding, then you do need to see your GP.

Steven :

What would be the mechanism? Why would it start again?

Hannah Short :

If you've got a thickening of the lining of the womb, a build of the lining of the womb, and sometimes if it gets too thick, then sometimes it comes away and causes a bleed. So sometimes women are prescribed HRT inappropriately so they might be given oestrogen only and not given the progesterone then that can cause that to happen because the progesterone in theory should be maintaining the lining of the womb, minimizing the thickness. Very occasionally mistakes are made and people are just given oestrogen, and then that can cause changes to the lining of the womb, but certainly needs to be investigated.

Steven :

Okay. Sharon asks if you're already taking Alendronic Acid can you also take iodine?

Hannah Short :

I can't see why not if you're taking it in a natural way kind of. If you're just taking some supplements and you're not having tons of seaweed or something else as well.  I don't think there's any interactions with that. It's just, it's a very tiny dose of iodine that you need. So I mean, I often recommend the Veg 1 supplements which is, it's a vegan society supplement, but it's, it's kind of cheap and cheerful, but it does have the 150 micrograms of iodine, it's got some B12 in it. Everyone over 50 should be taking B12 whether they are animal products or not.  It's got vitamin D in it, selenium, B6, but it hasn't got a whole load of other stuff than it's, it's just, it's just got small number of Vitamin's that can be beneficial. So,

Steven :

And one final question because we're just about out of time, somebody who's asked where the collagen metabolism is affected by oestrogen fluctuations and could that contribute to tendinopathies do you think?

Hannah Short :

Oh, well that's a good point actually, because collagen is affected by oestrogen certainly. And that may well be the mechanism. So, yeah, Liz Earle did a feature on this because I wrote something with her about it but I think it was more about the face that was rather than, you know, to deal with tendons and stuff. But certainly collagen, it's is affected and actually HRT I think can help with, you know, maintaining good collagen in areas that aren't affected by the sun interestingly. So then maybe that may be how it can potentially help tendinopathy but I looked at this and the research and there is very, very little research on it again as there is with all of this stuff.

Steven :

Hannah that's been fantastic. Thank you. I'm always astonished by how much GPs and other doctors can hold in their heads and you're doing all this without referring to notes and anything like that and answering all these questions. But anyway ,but thank you. And, and we're particularly grateful for the contribution of your cat. That was very enjoyable as well. And we did have a lot of other questions asked of us, about gynaecological issues and so on. And I'm hoping that you'll agree to come back again in the future at some point.