

## A Conversation with Dr Olivia Hum Webinar – October 2022 - Transcript

Lisette: Thank you very much, Dr.

Dr Hum: Excellent, hi there, so nice to be back here again.

I'm really sorry if anyone's heard my previous talks I did I think about a year ago, there is a little bit of duplication, but we're going to go.

So I know that people have been emailing beforehand with subjects that they wanted me to expand on a bit further.

So even if there are slides which all the same, you know, you can never learn too much about menopause. So just ignore those bits and have a cup of tea, but um, I just will share my screen.

Where is it? Here we go. There we are! So I've entitled it 'menopause, everything you need to know'.

And so it's been a really exciting week for us because we've also rebranded.

So I am a GP and a menopause specialist in Lewes and we've set up Women's Health Sussex over the last two years, which is a small private menopause clinic, and we're now beginning to sort of expand to other places in the country.

So we're coming to Kent, which is great, and then up into Cheshire as well as my Myla Health.

So I'm also on the Council of the British Menopause Society and involved in sort of national guidelines.

So there's loads of stuff happening in the background in this last amazing two years in which suddenly menopause has gone from something that no one knew anything about to something which was really in the forefront of a lot of the things that we do, which is fantastic.

And so this is a sort of bit about what we're going to go through today.

But again, please, if you could possibly save questions to the end, that would be brilliant.

And if you can put them in the chat or if you can ask me at the end, I don't know what Lisette wants, whichever one is better.

And so just to start with the definitions, so for many people actually, you know, what is menopause and what is perimenopause?

And again, it's all quite controversial actually. You'd think it was just one thing wouldn't you, but actually your menopause just means your last period.

And so this is what we call a retrospective diagnosis.

So we make it looking back. It was when you're a year after your last period, you're post-menopausal.

And the perimenopause and what the perimenopause is is also pretty controversial.

So the perimenopause used to be like a year before your period stopped, in which your periods start becoming irregular,

but we've actually realised that actually your body starts changing a long time before that.

So we see women in their late thirties and early forties who are already beginning to feel their hormones change and this is often - and we'll talk a little bit about this later on -

the average age in the UK is 51, but a lot of women have early menopause under 45 or premature menopause under 40.

And then this is - so anyone again who's seen my talk before will have seen this

I mean it's one of those things actually that you see this diagram a million times and you still don't quite get it.

It's really complicated. And this is why a lot of doctors don't know much about it either, because we sort of learned this about 20 years ago.

But it's really important when you get to talk about perimenopause,

If you look at the cycle and the first day is the first day of your period, and then what happens is in the follicles.

So the sort of pre-eggs in your ovary mature and they start making oestrogen and so often women will find the second week of their cycle is when they feel good and that's when their oestrogen level is high.

They suddenly say oh I can function, my brain functions, I sleep well, I feel brilliant.

I've got loads of libido. This is great. Then there's the LH surge, which is a hormone produced by the pituitary gland, and this causes ovulation.

After this, your oestrogen drops, it then rises a tiny bit and then goes down again, but at the same time progesterone is being produced.

And that is your premenstrual hormone. It's released to hold onto your womb lining until the end of the cycle.

And then it falls when the um, when it falls at the end of the cycle and your womb lining is shed.

And progesterone for many women is what makes them feel awful just before that period,

but also noticing before your period is that your oestrogen level has dropped really low.

So for many women in the perimenopause, that is the time they start getting symptoms - those two or three days before your period.

And the other thing that's really come out - so the menopause world is kind of divided into pre and post Davina basically.

So the first Davina documentary, not only did it start introducing concepts of perimenopause, but the other thing, it did just make people realise quite how much oestrogen does.

And so there are oestrogen receptors all over your body, not just in your temperature regulation system, but in your urinary tract, in your brain, your muscles, your joints everywhere, your heart, your blood vessels.

So this is really important to hold on to these ideas.

So in the perimenopause, what happens is that everything starts going a little bit awry.

So this lovely up and down cycle starts going all over the place.

And this is because your eggs start to run out, so things will go wrong.

So you will have a cycle in which you don't ovulate, for instance, so you don't produce enough progesterone and so the womb lining isn't held on to to the end of the month.

So you might start spotting. So often, however, that body will compensate for a long time and try and produce a regular cycle.

But what you'll notice is that your cycle might change and it might become shorter or longer.

So often I see people with 21 day cycles, so not only are their periods awful but they're happening every three weeks which is terrible.

Your periods might become really, really heavy and often the pattern is first two days bang, it all comes out and that's it.

But those first two days you can't get off the sofa because the bleeding is so bad.

And then eventually what happens is that they become more irregular and eventually stop.

The other key thing to note is that some women do not have a perimenopause, literally their periods stop, they have no symptoms, everything feels fine and they come and see me five years later for something else going

"have I been through a menopause?" And you're like, "Yes, you did, you lucky person. You haven't had any symptoms at all."

During this time, your blood tests are often normal, so there is absolutely no point in taking any blood test because we know you're perimenopausal by your age and your symptoms.

Blood tests don't add any guidance because often it depends exactly which point in the month you take the blood test.

And the other thing to know is that you can still get pregnant just until you've actually stopped ovulating which is a bit of a disaster for women who didn't really want that to happen.

And so, again, sorry if you've seen this one before but these cartoons - this was menopause, wasn't it, pre-Davina?

Menopause was about us in our forties and fifties, all becoming sort of fat and sweaty and and irrelevant.

And obviously, as we know, women in their forties and fifties are not, we're not going to ascribe to this any more.

So we are now spending a third of our lives post-menopausal.

We are economically productive. We are many of us are working.

We are having symptoms which are really damaging our work.

And so there's the Fawcett report of menopause which is the one to read, which has got all the stats about menopause and work. And a really big, so one in ten women who are working during the menopause have left a job due to their symptoms.

That's a pretty big stat. And that is something that, you know, which is really, really shocking.

And a lot of the women I see in clinic have either left the jobs or they cut down the hours or they cut down their level of responsibility because they're not sleeping.

Their brain is foggy, they're anxious, they've lost their confidence. And so as women do, instead they think, oh, I can't do this anymore.

So they shut down, they stop working. And it's really interesting to see how many women felt that menopause had had an adverse effect.

But also, to pick up on this, is that 50% did not feel it had had an adverse effect.

And part of the problem with the Davina documentary and all the kind of look-to-camera ooh isn't it terrifying, is that people have now got to thinking,

I'm now seeing women in their thirties who are absolutely terrified about what's going to happen to their body and actually for many women, menopause is fine.

So 10% of women get no symptoms at all.

About a third of women get severe symptoms. And most of us are sort of somewhere in between.

So it is not - for some women actually the end of periods and the end of fertility and the moving to a different time in their lives is a positive thing.

So we mustn't forget either. And then again, I'm sure you all know this and this is the big thing.

Another big thing that's come out in the last two years is, so when I was in medical school, it was all about - well I mean I had no training in menopause whatsoever - but it was all about hot flushes

And that was the only symptom, it was the only symptom anyone ever recognised as being part of menopause.

But for the women I see my clinic, both NHS and privately, it's not the hot flushes generally, although some people have awful hot flushes but it's not generally the hot flushes that is the problem.

It's the cognitive symptoms and this well, menopause week has been about cognition, and so it's about the brain fog and about the lack of sleep and about the anxiety.

And these all go in this great big cycle, which is that you get foggy, so you feel anxious that you can't sleep.

So you feel anxious so you can't sleep. And it goes round and round and round around in circles and everything feeds on everything else.

So often for the women that we see in clinic, restoring their sleep.

So Doctor Schaedel, Zoe Schaedel who is my partner at Myla Health is a sleep specialist.

And we see a lot of women for sleep. And often restoring sleep can really help with all the other symptoms or make them more bearable.

And then the other thing is the physical symptoms.

So migraine, we have Dr. Walker working with us.

He's a migraine specialist.

And so we see a lot of women with migraine, again, under the debilitating condition, really poorly treated and really affects people at work.

A lot [inaudible] a year due to migraine. Palpitations, really common. Joint pains.

I see it again, there's nothing written about this but if you talk to any menopause specialist, they will say we see a lot of women with joint pain.

Probably about 50% of the women I see - aching. stiffness, poor recovery, after exercising.

Some people really, especially postmenopausal, really debilitating pain, multiple investigations, no cause found, all goes away once they're on HRT.

And then the next thing is the genitourinary syndrome menopause, so this used to be called by vulvovaginal atrophy. We don't call it that anymore.

Largely because it is a horrible term, but also because it's not just about dry, and again, hot flushes and dry vagina are the only things that people ever think about.

But actually we see a lot of women with UTIs that aren't actually urine infections.

It's just a burning and stinging when you pee. Painful sex and what it does, what menopause can do to your sex life, we'll talk about a bit later, but it's a really common problem.

Itchiness. So women think they've got thrush and they self diagnose, they treat themselves over the counter. It's not, it's actually dryness.

And remember, if you have thrush before your period, remember that oestrogen drop, it's probably not thrush. It may well actually just be the oestrogen drop causing vaginal irritation.

25% of women will have no flushes at all. And many women we see have already been started on other medication including anti-depressants.

Um the fan on my laptop has just started going off pretty loudly.

Is that, can you hear that Lisette? Is that something that, no, is it okay? Good.

Right. So sleep. This is Zoe's slide. So again, what we were talking about, there's lots of things that impact sleep.

And the most common pattern we see is you drop off to sleep in the evening because you are absolutely knackered.

You go to sleep on the sofa, you go to bed, you wake up at two in the morning, bing, brain's on, hot, cover on cover off, rest of the night, oh my god, can't sleep. drop back to sleep at 5am, alarm goes off at six.

And then so you are permanently knackered and that does not help your brain fog.

Remember that there is, if you look at men in their fifties, they also have an impact on the sleep so some of this is due to aging and not to menopause.

As we age we sleep less heavily, but definitely we know about 40 to 60% of women during menopause have disturbed sleep and it is also associated with low mood, unsurprisingly, and low libido also unsurprisingly.

And then let's look at the non-hormonal treatments. So the treatments that we're looking for when we're looking at menopause and how to help people, we've got to not forget about things like lifestyle.

So lifestyle, we know that diet, exercise, eating a healthy sort of Mediterranean balanced diet, avoiding processed foods and too much sugar can really help.

We know that cutting down on alcohol really helps, but we also know that there are some non-hormonal treatments and these are the treatments that we use for women with breast cancer.

So women with breast cancer have been largely left out of this conversation.

So a lot of this oh HRT, it's so brilliant. it'll you know do all these claims that are made, which some of them which aren't true which I'll go through, has left a whole lot of women who can't take HRT feeling very, very left out.

But in fact, there is lots that we could do for women who can't take HRT.

St John's Wart is really good. It's a kind of mild. It's a herb but it's a mild anti-depressant and anti-anxiety.

We've got medication that we can use for hot flushes. There's a lot of interest in CBT and there's good evidence for this.

It's going to be included in the new NICE guidelines, and it isn't only for low mood, it is also for sleep and for hot flushes.

We know that there is, there are oestrogens in some foods, things like soy and seeds and linseed.

We know these can help relieve symptoms. And then sage is the one thing that I've seen some women say really, really helps.

But then the next thing obviously is HRT. So these are all the different types of HRT.

And the reason that GPs find HRT very confusing, although honestly the learning curve has been massive and I've spoken to hundreds of GPs now in Sussex and around and so people are really beginning to get the hang of this.

But the reason it was so confusing at first is because there were a million different preparations and they all kept going out of stock. So just as you got the hang of one, it would disappear and you'd have to get your head around another one again.

And we weren't prescribing it very much. Up until two years ago, I probably saw about one woman a month for HRT and it was usually me trying to persuade them to go on it and them going

"Nope, I don't want it because it's going to give me breast cancer."

And now I've gone to probably seeing ten women a day and I've just been at a training course with lots of GPs over the last few days and they're all, most female GPs especially, are seeing about the same increase in the number of people they're seeing.

But actually we really now only prescribe a very few different things and what we do now is the first thing is to go through the myths and these are myths that firstly I've heard from women, especially before, before Davina, but also that we used to say to women, so we used to say,

don't take HRT, it might make your menopause worse. If you've had a bad time on the hormonal contraceptive pills, so women who are very sensitive to progesterone, you'll have the same thing with HRT, and we know that isn't true.

We use a different type of progesterone now.

We used to think that HRT delayed the menopause, so we used to say, don't take HRT, it's just going to delay it.

So you'll come off of it and you'll go through the menopause again.

And that was what we thought. But evidence shows now that that's not true.

So what we think now is that your menopause symptoms have a sort of finite time.

So you'd say it takes, the average is about five to seven years. Whatever you do in that time is not going to alter that five to seven years.

So you can go for five to seven years and just push on through if you want to, or you can take HRT and mask it for five to seven years and then come off.

If you're lucky, your symptoms will then have finished and would have gone.

If you're unlucky, you might be one of those people who were going on for ten years. And so your symptoms will come back.

We know it's not addictive. It doesn't work on the pleasure centres in your brain.

So you can come off it again when you want. It's absolutely up to you.

Breast cancer, we'll talk about. But then the other thing is and this is really prevalent in Lewes where I work and in Brighton as well, is this whole feeling that kind of taking HRT means you're sort of copping out, you're not suffering well enough and you are not letting a natural process go on.

And that's fine. If people don't want to take HRT, that's absolutely brilliant, but what we need to be really careful about is judging other women for their choices.

And women are very bad at doing this. We just have to look at the narrative around childbirth and around breastfeeding, this whole like 'you had a caesarean to save your life and the life of your baby, therefore you are not a proper woman because you have not experienced childbirth'. You know, we need to stop judging other people.

So just because someone you are sailing through menopause with a supplement and a bit of yoga, that's brilliant.

But your best friend might be having the worst time ever, and it might be completely damaging her job and her relationship.

And if she wants to take HRT that is fine. So there's no kind of moral failing on taking HRT.

There's no prize for suffering through this. It's great if you don't want to take it but if other people do, then there's no need to judge.

We do see quite a lot of that. And the other thing is 'I've been told I can't take HRT' but it is happening less and less and less.

But we see, in every clinic I see someone who's been told they have HRT but actually can, usually with a few provisos or proper risk benefit discussions.

Keep an eye on time. Right, so nearly everyone can have HRT.

And the reason I've put almost is because actually even women with breast cancer, we are now moving towards talking a lot more about risk benefit balance.

The problem with breast cancer, previous breast cancer, it is very tricky and we just don't know, we don't have the evidence but we are beginning to, that guidelines allow us to have a proper conversation about the risks and benefits.

There are some very few other [inaudible] you are actively having a heart attack.

But even then after a heart attack, we think it's relatively safe. You can have HRT if your periods haven't stopped and if you've got endometriosis.

Someone asked about family history of breast cancer, I'll cover that on a different slide. And you can have HRT if you've got normal periods and normal blood tests.

So this is my sort of really easy how to look at HRT.

So HRT. The first step is oestrogen and this is what you need to make you feel better basically.

It relieves your symptoms. We give it via your skin, which is called transdermal HRT, and this is safest.

It does not have an increased risk of blood clots, unlike oral HRT which does. And we usually use Estrogele, that's the green bottle in the bottom.

So Estrogele disappeared just as we got everyone started on it, it then disappeared for about a year.

That seems to be back now, we're starting to get it again. But I know many women had an absolute nightmare, sort of destabilising their menopause or treatment on it.

Lenzetto, I saw the rep yesterday. I'm informed that that's coming back in and we like Lenzetto.

It's much easier to apply than Estrogele but the problem is it doesn't go up to quite as high a dose so we don't use it quite as much.

And then we've got the patches and the patches have not gone out of stock apart from each Estrodot which is the little teeny patch which we like.

Estraderm is massive so often falls off. People don't find it very good so Evorel is the one that's been available that a lot of people are using.

And that's easy, so oestrogen and you just take it every day or you've got a patch, you change it twice a week.

And so that then fills in in the perimenopause, remember those sort of ups and downs.

So instead of your oestrogen level going up and down, it just goes like that. So that's lovely stable oestrogen. So that's easy.

However, if you have a womb, you need a progestogen.

So a progestogen is an artificial progesterone.

Progesterone is that hormone that's around in the second half of the cycle that holds onto your womb lining.

But in the context of HRT, we know that the oestrogen makes your womb lining thicker and the progesterone thins it out.

If we give you oestrogen on your own, your womb lining will grow and that will leave you at risk of womb cancer.

So we do not give oestrogen on its own unless you've had a hysterectomy, whereupon we can do it.

If you've had a period in the last year, you take it for half the month and you shed the womb lining every month.

If you've not had a period over a year, if you're post-menopausal, you take it every day.

And the one that we're using now which has been a real game changer with HRT is this stuff called Utrogestan.

And this is micronised progesterone. This is body identical HRT, it is identical to your normal hormones. It is derived from plants and it's got a very low level of side effects.

But for many women, especially if you're having terrible perimenopausal periods, the Mirena coil can work absolutely brilliant.

It provides contraception, it provides half your HRT and if you are lucky, it will also stop your periods.

So that is not an option for a lot of women, they don't want it, but for the women who do use it, it can be absolutely life changing, especially if you've got heavy periods.

And then the next stage is sex and libido.

So this is sort of my area of interest. So most of the women I see, I would say about 95, 96% of them, when you ask about libido, they just sort of shake their heads and look a bit rueful.

And most women have it, it is an almost universal thing, especially in long relationships, you are feeling, you know you're not sleeping, you feel awful, your body is changing,

you've got six million things on your list of things to do, and sex is definitely for a lot of women right down at the bottom. It's really different from men.

So I spent years working in sexual health and I really think that for men, if they're tired and anxious and stressed, then sex is a release.

It's something that makes them feel better. When women are tired and anxious and stressed, sex falls very far down the list of things to do.

So you can see how if you look at the different stages of libido, how menopause might affect it.

So desire is the psychological aspect of libido.

And this is the kind of feeling, the thinking that you might be wanting sex.

And again, if you're tired, stressed and anxious, you're not going to be feeling like sex.

The arousal is the physiological. It's what happens to your body when you feel desire.

And for that, what changes then is the changes to your body.

And so for many women, the dryness and the itching cause actually sex to become really really uncomfortable.

And for a lot of the women I see haven't had sex for two or three years. They don't really know what to do about it.

They feel like they just, they feel desperate about it, it's really affected the relationship with their partner and they can't, they don't want to.

They say to me, I'm 48. I don't want to never have sex again. And the thing is, is that actually this is really, really treatable.

So vaginal oestrogen is incredibly safe. And we used to be told again right up to a few years ago that you could only use it for two years.

It would make your womb lining thicker and you had to then stop it.

And so what I'm seeing in my clinic is a lot of women who've stopped it and are now in their sixties and have now really irreversible changes to the vulval and vaginal skin.

Because what happens is that the collagen goes, the skin gets tighter, and eventually you do get to the point where it is actually very difficult for you to have sex.

And once we get to that point, it is very, very hard to go back, although there is still lots of things we can do.

So vaginal oestrogen is very safe. It can be used even if you've had breast cancer and it needs to be used lifelong.

The problem is with the other, so the other changes of menopause.

The symptoms will get better as you get older but if you left it, they would get better.

But for the vaginal and vulval symptoms, they often don't get better. They carry on getting worse.

So they do need to be treated. You can treat them without oestrogen, you can use a moisturiser.

So YesVM is one we use. It's a vaginal moisturiser, you can get on Amazon.

Replens isn't quite as good as it gets a bit clumpy, which is a bit unpleasant.

So Sylk is another one that we use. And then the other thing is actually HRT can be really effective. Although we often find with women, is that they've got systemic HRT.

So oestrogen that goes in your patch or your gel into your blood is not quite enough.

So for a lot of women, I will give them oestrogen as an Estrogel or an oestrogen patch, but also give them vaginal oestrogen at the same time.

And that is safe because we know so little vaginal oestrogen goes into your bloodstream.

We know that this is really safe. And so as well as their, so what we can see this Vagifem which if you look, that's the little blue applicators.

So Vagifem is like a little vaginal tablet which you put on the applicator and you put into the vagina.

And Vagifem has got a lot of single use disposable plastic.

So we're trying to move away from that to something called Vagirux. We're trying to get that on the formulary, which is cheaper but also has a reusable applicator.

And there is also something called Imvaggis which doesn't have an applicator at all.

The other thing that's really useful that we use for women who can't be bothered to fuff around with all the pessaries is something called an Estring.

And this is about this big, it's like a little ring and it's flexible and you pop it inside the vagina and it stays there for three months to give you a good high dose of oestrogen.

And then you just change it every three months yourself. Or for older women, we sometimes get the practice nurse to do it.

So it's really good if you're finding everything a bit fiddly.

The other thing is there's an oestrogen cream, you're supposed to load it into an applicator but often to women who are very, very sore and dry, we just use it just rubbed over the outside and rubbed remember around your urethra and your clitoris as well.

So again, we find lack of sensation is a real issue. We also find that a lot of people get this sort of burning and stinging when they pee, which is repeatedly diagnosed as a UTI but actually has never grown anything on a sample.

So this isn't a UTI. This is the lack of oestrogen to the neck of the bladder which is causing stinging when people pee.

So testosterone. So any of you who are on social media will know that there is a great big 'everyone needs testosterone campaign' going on out there.

Unfortunately, this is not borne out by evidence at all.

So testosterone doesn't fall dramatically at the menopause. It starts declining when you're about 30 and declines through your life.

But the levels of testosterone in your blood are very poorly related to libido.

So actually some women have loads of testosterone.

It's like women with PCOS, they've got lots of testosterone and they don't walk around with an amazing libido.

And ditto a lot of women have no testosterone at all post-menopause and still are happily having sex and still are feeling desire.

So the levels are very poorly correlated with symptoms and the only evidence there is for it is for women in libido in postmenopausal women, not for brain fog or energy or cognition.

And actually, if you look at the trials that looked at things like brain fog and energy, it was about equivalent to placebo.

So there is an enormous placebo effect of testosterone. And even with the placebo effect, I must admit from using it, so initially I totally drunk the Coolaid, I was like brilliant,

everyone should have testosterone. And then they started prescribing it and found that actually, for quite a lot of women, it really makes no difference.

And so about I think probably about 20% of women that were using it for libido do find a bit of an improvement, but that's not to negate it because actually 20% of women improving, that's pretty good.

And so for some women, it could be an absolute game changer.

They feel it's the sort of missing bit of their HRT. They add it to the rest of their HRT and they just feel fantastic.

So it's definitely worth a try for women who are on a maximum dose of HRT.

So the key thing is that oestrogen is very good for libido and it's also good for, because libido in women is multifactorial.

There are many components that influence libido so often actually getting oestrogen right.

Most of the women I see in my private clinic for testosterone, many of them are inadequate oestrogen.

So the first thing we do is sort out their other HRT, make sure their vagina is comfortable and the sex is comfortable, make sure they don't actually essentially hate their partner because if that happens, there's nothing I can do.

Just, you know, there's my professor who I trained under in London always used to say "no amount of hormones will make you fancy your husband".

And I that's so true.

So actually, if you don't fancy your partner, however many hormones they give you is going to make absolutely no difference.

So there's a lot going on with libido and it would be lovely if we could just solve it with a hormone but obviously we can't. So there are different types, you can get it on the NHS but it is unlicensed so GPs do not have to prescribe it.

And many aren't confident because although it sort of looks quite simple, it's actually quite complicated.

There's no real consensus on how you prescribe it and what do you do in the blood tests, you get a blood test and it's really high, and I get these e-mails all the time from GPs who are really trying to do this but then they kind of do a level and it's five times the upper limit of normal - now what do you do?.

You know so it's, I saw the other day someone who had been prescribed it by a GP who'd been trying to be helpful but accidentally given her double the dose.

And she said for about three weeks she felt absolutely brilliant and was just phoning her husband, saying get home from work now baby.

And then got terrible acne and suddenly thought, wait a minute, something's really going wrong here.

And realised that she was on double the dose. So she felt great for a few weeks but then started getting the side effects.

And so these, the side effects which are things like acne and hair growth, you do get if you're on too high a dose.

So we need to monitor the blood test which is quite complicated.

And then somebody also submitted a question to ask about what was bioidentical HRT.

So this is really confusing and everyone is really confused about this.

And that's because the terms bioidentical and body identical are often used interchangeably.

And then we also add some confusion by using words like regulated and compounded.

So, regulated bioidentical HRT or what we call body identical HRT is the stuff that we prescribe.

So it's oestrogen and progesterone which are derived from plants. So it's oestrogen as the gel patch or spray are all body identical.

And the progesterone which is the Utrogestan is also body identical. These are identical to your natural hormones.

And these, whatever the other clinics that peddle the other stuff will tell you, are totally prescribable on the NHS for the cost of an NHS prescription but they are also regulated.

They are, we know what is in them because they are made in a lab or in a factory where we know each preparation will have the same stuff in it.

Then there's compounded bioidentical HRT and there are some clinics which do this.

And so it was, this was the Marion Gluck Clinic which is a clinic in London which first started this. And they do this random test called the Dutch test, which takes all sorts of random things,

and then people presenting have no idea what any of these things mean and they don't have testosterone, which is really annoying because it's the one thing we do actually need.

They claim that you can diagnose and treat people to create a personalised hormone regime, but from a lot of people that I've seen with it, they just end up on oestrogen and progesterone like we give but it's really, really expensive.

So it's like 400 quid a month or something.

But the real issue with it is not that we have no idea whether it's safe or not because it's classified as a supplement, not a drug.

It's the fact that we, the progesterone that we use to protect the womb lining, this is in trials.

We know that this is enough to protect it, to stop you getting womb cancer.

However, the compound the bioidentical clinics often use, firstly the progesterone cream, which we know for some women doesn't absorb at all, and for others absorbs very variably.

Or they use other types of progesterone, but they haven't, because we don't know what's in any of this stuff, we've got no idea whether it is enough to protect it.

So it's not only that it might not work is the fact that it may be dangerous, which is why the BMS doesn't recommend it. And if you look, if you want to read a bit more about it as a consensus

statement, which is a consensus statement from all the sort of experts in menopause about bioidentical HRT.

So this is so again, as you can tell, despite trying to be on the fence about it, I am actually quite, I, yeah the claims made about it often aren't true.

The other thing is the claims made on the websites of things like oh, the other menopause specialists give stuff made from horse urine. That's this thing called Premarin.

We don't use Premarin anymore, the stuff that we're using is the body identical stuff.

So the other good things about HRT, again, this comes out of Davina, is the fact that HRT has also got health benefits.

However, this does not mean that everyone needs to take HRT to avoid getting these things.

So although it does reduce your risk of osteoporosis while you're taking it and potentially after you've taken it, that doesn't mean that it's the only way of preventing osteoporosis.

And again, it reduces the risk of heart disease and stroke if you start it before [inaudible] but again, it's not the only way to reduce the risk of heart disease and stroke.

We know that it's associated with a reduced risk of bowel cancer, but what it is not associated with is a reduced risk of dementia.

And this was a claim that was made on the Davina program and by many online social media sites.

But this isn't true. There's no evidence for this. All we can say about dementia is that we don't think it increases the risk of dementia.

It might reduce the risk of dementia, but we can't say this from the evidence that's available, and to do the trial would now be impossible because we'd have to randomise people into HRT and non-HRT and then follow them for 30 years and no-one would want to be in the non-HRT group.

So it would just be a very difficult trial to do.

And again, so breast cancer, so 5 more minutes then we'll answer some questions. But, and again, someone asked about genetic risk of breast cancer.

So the key things we say about breast cancer is that, yes, so it's the progestogen that increases your risk of breast cancer, not the oestrogen which is really weird. So oestrogen only HRT actually reduces your risk of breast cancer.

HRT with an artificial progestogen, so the Mirena or things like Everol Conti or Everol Sequi, does increase your risk of breast cancer but not by very much.

So if you look at this really good infographic, you'll see if there, and yeah we've got to remember that we've all got a risk of breast cancer just by being women.

So in over 50 in five years, 23 of us will get breast cancer anyway, whether we took HRT or not.

What we're looking at is additional cases. So about four additional cases out of a thousand women on people taking an artificial progestogen with their HRT.

With the micronised progesterone, we think probably there is no increase for the first five years. After that we don't know, there's no data. But the other thing is looking at the other stuff.

So drinking a glass of wine a night increases by five women in a thousand over 5 years, and being overweight doubles your risk of breast cancer and doing lots of exercise significantly reduces it.

So we've got to take things into context. So in the same way that crossing the road increases your risk of being hit by a bus.

But we weigh up the risks, the benefits of crossing the road before we do it.

And it's exactly the same about taking HRT. In terms of family history, so again, that's been a real worry for women who've seen a family member go through breast cancer.

But actually, the good thing to know if you've got one and one only relative with breast cancer over the age of 40, you're not considered to be at any higher risk.

You are put in the low risk group along with all the other women who've never had breast cancer in the family.

There are some families who have a high genetic risk and we know who those families are generally.

And you will know these are the young cancers, lots of relatives with cancer, and these are the women who go to the genetic breast cancer clinic and then they're given a risk category.

Even they can have the HRT but it's probably a good idea to see a medical specialist to talk about your individualised risk benefit balance.

So how to get help? So after you've seen this, so many of you I'm sure are on HRT already or managed to get help.

It is really difficult. It's difficult seeing a GP at the moment.

The demand has just increased enormously after COVID and we are really, really struggling to cope.

But there are a lot of women, a lot of GP's around who know a lot about menopause and if you've tried a year ago and it wasn't a great response, you may well find that they've been on one of mine or Zoe's courses since then and know absolutely loads about it now.

Ask the receptionist. They always know, they're always perimenopausal women.

They know exactly who they want to see. And then the other thing is that what often happens is that people will often phone up desperate on a Monday morning.

So Monday mornings are a really difficult time to go and see a GP because we are really really busy.

We've got lots of disasters that have happened over the weekend but actually things like e-consult if your GP does it is a sort of way of saying, look, I'd quite like an appointment in the next few weeks, I don't mind waiting for the person that knows about menopause.

And I know it's different at different surgeries.

It's always really good to kind of just educate yourself before you go in, especially if have a feeling your GP doesn't know very much about it.

If you look at our website, we've got a symptom checker that you can download and there are about 25 different symptoms on it.

And essentially it's quite a good idea because often what happens is that when it's time you get to see the GP or speak to the GP, you're so knackered and tearful and anxious and feeling awful, that you don't manage to get your point across and what you actually want.

So sometimes just helping, having things written down in front of you, going right, here

I've got 23 different symptoms so I either have 23 different menopause symptoms or I am menopausal and I would really like to have a trial of HRT just to see if it helps my symptoms.

But any of you who have got complex medical conditions, there are NHS menopause clinics, just not in Sussex. We are working very hard on this. It is really difficult.

Getting the funding has been really, really hard. We might do one day. At the moment, however, there is a clinic at the Chelsea Westminster in London and I send my NHS patients up there to be seen up there.

And these are for people with complex medical conditions; history of breast cancer, really strong family histories, that kind of thing.

If you are going to go see someone privately, make sure you have someone who's had the BMS advanced certificate, and that is on the British Menopause Society website and these are the registered menopause specialists.

And there we go. So mylahealth.co.uk is our website. We've got a few sort of sheets about things like testosterone and stuff on. Then there's Balance, which is the biggie, which has got loads of amazing information.

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

So all that information is very evidence based. And then Menopause Matters as well is the sort of, is the kind of menopause journal basically that's got loads.

It's got a brilliant forum, which every question you ever have is answered on there.

So that's me, so that's the website and Facebook page. On Facebook,

I put lots of just any update stuff on women's health, and that is my email address.

Lisette: There we go, so I will stop sharing. Thank you so much, Dr Hum. That was really fascinating and interesting and very quick, but there was so much information in there. So it was fantastic.

And I was saying earlier that I did attend your session last year, but actually my symptoms now are different from what they were a year ago and things that I was really plagued by then have now been sorted out with HRT, and then other things kind of crop up that I wasn't expecting.

So that was really, really useful.

I know there were some questions in the chat and I know people probably have a lot of questions that they want to ask as well.

So what I'm going to do now is just stop recording.

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