**Transcript**

Hi everybody, I'm delighted to be here today to talk to you about all things menopause. I was saying to Chris earlier when I came to sort of make my mental notes for what I wanted to talk to you about today. There's so much that I want to tell you, and there will be a resources sheet sent round to everybody after this. And as Chris said, the session is being recorded so you will be able to watch it back.

So my job today is trying to give you a really good overview of the what, when and why of menopause. I hope that you'll go away feeling a lot more confident about understanding so many more aspects of menopause. And throughout my presentation today I will be sharing with you some of the resources that are free to access via Menopause Support that I hope that you will find helpful when you're supporting your Members.

So little introduction to me. I’m a well being consultant, menopause counsellor. My particular interests are in menopause and mental health. I have professional nurse training in menopause. I'm a member of the British Menopause Society and as Chris said at the start, I'm the founder of menopause support and also of the national make Menopause Matter campaign.

So I thought I would start off by looking at why menopause matters.

**Why menopause matters**

It matters because it's going to directly affect approximately half of the population, but it will undoubtedly indirectly affect the other half of the population to. Whether that's as a partner as a family member as a colleague, as a friend, etc.

Menopause can have varying impacts, so they can be on personal health and wellbeing. They can be on relationships on careers on finances.

And there are a surprising amount of hidden costs for those who are having really quite a turbulent time through menopause. And as far as the workplace is concerned, currently there are just under 5 million women over the age of 50 in the workplace. So consequently, that means that we're going to have more and more Peri, menopausal, and post-menopausal women in the workplace. It's the highest number we've had historically, and it is in fact the fastest growing demographic too.

So essentially a better understanding of menopause will allow all of us, if we're going through it directly to make better informed decisions for ourselves, but also hopefully it will allow us to have more compassion for others and be able to be more supportive. But in an informed way.

So, menopause is generally thought of as something that affects women, and it's true that the vast majority of people who will experience menopause are women. However, it's also important that we remember that there will be transgender and non-binary colleagues who will experience menopause too. For the vast majority, 3 out of 4 will experience symptoms, 1 in 4 will have almost no symptoms at all, but 1 in 4 will experience what they describe as debilitating symptoms, so severely affecting quality of life in some way, shape or form. And menopause symptoms can be different types for different lengths in different people, so it is very much an individual situation that they're going through.

I mentioned the British Menopause Society, which is sort of our professional society, mainly for doctors, gynaecologists and allied health professionals. And every few years the BMS run a survey and in the most recent survey that they ran:

* 45% of those who were surveyed said that they felt that menopause affected them at work.
* 33% said they felt less outgoing and were much less likely to socialize.
* 51% said that it had affected their relationships with their partners.
* 38% said of partners said they had no idea how to support somebody going through menopause.
* 28% said that they recognise that when they looked back not understanding, menopause had actually caused arguments within their relationships.

So, as I say, this can be wide ranging.

**What is menopause**

So what is menopause? Because we use this single word to cover what is essentially a transition that can take several years.

The first stage of this is something called perimenopause, and ‘peri’ means around the time of.

And again, that's a little bit misleading, because around the time of makes it sound as though it could be quite short term, but for the vast majority they will be perimenopausal by their early to mid-40s, and that perimenopausal transition can last anything from a few months to a few years. On average it's between four and eight years, so we can be talking about quite a significant amount of time where things can ebb and flow. So, symptoms can come along, but they can then recede. Then different symptoms might come up, so things can be changing on quite a regular basis throughout that perimenopausal time.

Menopause clinically is defined as the one day after somebody has had 12 continuous months without a period. So that's the clinical definition of menopause, and then everything after that 12 month and one day is categorised as post-menopause. And for the vast majority they will be post-menopausal by the time they're in their early to mid-50s.

With life expectancy being what it is, we know that for many they will live post-menopausally for some 30 plus years.

So that's the breakdown of the terminology.

* Perimenopause
* Menopause
* Post menopause

**When does it happen and early menopause?**

So when does it happen?

So as I said for many, the perimenopause will start in their early to mid-40s. Their menopause so that one day after that 12 month without a period is roughly for the majority around 51 to 52. These things can happen later and do, but it's important to recognise, I think, particularly when we are talking about supporting people in the workplace, that it can happen earlier too.

So for quite a significant number, their menopause will happen under the age of 40.

There is a condition called POI which is called premature ovarian insufficiency and POI or premature menopause, happens to approximately 1 in 100 under the age of 40, 1 In 1000 under the age of 30 and 1 in 10,000 under the age of 20. So the youngest woman that I have supported is 17, the youngest that we know of is 12 and that's very rare, but 1 in 100 is not so rare, so it wouldn't be unlikely that you may come across somebody who is in a very early or premature menopause. And there are various reasons why a premature menopause might occur.

The condition shortened to POI and is often described as idiopathic – In medical terms, idiopathic means we don't know, we don't understand why this has happened. Unfortunately for those diagnosed with premature ovarian insufficiency, of the vast majority of those will be told, we don't really understand why this has happened, and obviously for somebody who's going through a premature menopause in their teens, their 20s and even their 30s, it's probably not something that they've ever thought about before being diagnosed. It could well be something that they're older female relatives are not going through yet. It not only has emotional consequences as far as going through that early, but for many it could also have an effect on fertility. So that really does need very careful and professional counselling.

Other reasons why menopause might happen early could be things like an oophorectomy – the removal of both the ovaries at the same time. So that's called a bilateral oophorectomy, so most of the hormone oestrogen, progesterone and some of our testosterone is produced from the ovaries. So once the ovaries are both removed, being able to produce those hormones is vastly reduced.

When the hormones naturally start to fluctuate, that’s when the symptoms come along.

So having both ovaries removed at the same time will place somebody into a surgical menopause, and that can really be very challenging.

If somebody has a hysterectomy and the ovaries remain in place so the hysterectomy is having the womb and often the cervix removed too. That can actually make the menopause transition a little earlier than it might have been. So it won't be instant, but it could be a little earlier than it might have been, and then there is also medically induced menopause so that can be for things like very severe endometriosis, which is actually quite common, or it could be for a condition called PMDD - premenstrual dysphoric disorder, so that's a very severe version of somebody who experiences PMT or PMS around their monthly cycle. PMDD occurs because somebody has a very severe reaction to their own natural hormone levels changing.

So for some that can be really debilitating and it's quite often poorly diagnosed and so a lot of women will live with PMDD for many years before it's been diagnosed. If it is diagnosed one of the ways to treat it is to essentially stop the ovaries from functioning, so it's suppressing the ovarian function so that those hormonal fluctuations don't happen every month. But unfortunately, by doing that, that can mean that menopause symptoms can be induced. The same for endometriosis, ovarian function can be suppressed, but again, that can bring on menopause symptoms. So that's another set of challenges.

Other things that can induce an early menopause are treatment for a medical condition, so it could be for either breast or gynaecological cancer. Perhaps radiotherapy to the pelvic area. It's also useful for all of us to know our family history as far as menopause is concerned, because it's certainly not the case for everybody. But for some, if they have a family history where perhaps their grandmother, their own mother, has gone through menopause early. For some, that can be a pattern, so there are lots of different reasons why somebody might go into a premature menopause.

So premature is under the age of 40, and early menopause is defined as under the age of 45.

So just to recap, types of menopause can be:

* Natural, so the natural transition through perimenopause, menopause, and post-menopause.
* Surgical where both of the ovaries are removed at the same time.
* Medically induced. So that is really suppression of the ovaries or as a result of being given some kind of medication as probably part of treatment for cancer generally.

**What part do hormones play?**

I've mentioned the hormones a little bit, so I thought it would be useful for you to understand what the hormones actually do because it gives a really good indication of why the symptoms can be so varied.

So the hormones that we're looking at are:

* Oestrogen
* Testosterone
* Progesterone

You might be surprised to hear me include testosterone in there, but actually testosterone in women is produced in quite large amounts. A lot of it transfers itself into a type of oestrogen again, but throughout our lives, particularly in 20s and 30s, we produce quite a lot of testosterone. It has varying functions throughout the body.

The most important of those hormones is oestrogen.

Women have oestrogen receptors all throughout their bodies from the top of their heads to the tip of their toes. And when oestrogen level start to fluctuate, that's why symptoms can be very varied. Oestrogen is known as regulating the menstrual cycle, but it also does so many other things. It acts as a nourisher and a lubricant for the body, so it does things like helps to lubricate the eyes, the mouth being entire gut process the entire pelvic area and our joints.

And then it also helps with things like heart and bone health. It also helps with things like brain health, long term, bone health, etc. It helps to keep our bones strong, helps to regulate cholesterol levels. And as I said, helps with brain, liver and heart health. It also helps to control what's called the internal thermostat. And that's essentially the thing that causes the hot flashes and night sweats when those hormones levels start to fluctuate.

As you can see, once oestrogen levels particularly start to change, those symptoms can potentially where they're going to occur, be very varied.

Progesterone again is known for helping to maintain a regular cycle and with a healthy pregnancy. But it's also it has other qualities, so things like it can really help with sleep patterns. It can also for some act as a calmer.

It's important to know that for many people, the first symptoms of perimenopause will be a broken sleep pattern and we all know how difficult it can be for us if we've had many nights of broken sleep. Both for our physical and our emotional health. So it's much more complex than it first appears.

And then testosterone. Testosterone is usually talked about as a male hormone, but females, as I say, produce testosterone too and testosterone is generally talked about with regards to libido, but again, it's much more complicated than that. Testosterone helps with motivation helps with optimism, helps with our outlook on life, how confident we feel in ourselves. From a physical perspective, it helps to support our bone health, keeps skin supple, turns fat into muscle, and helps with cognitive function too. So again, some of the things that you might hear people say are they're struggling with memory and concentration, so oestrogen has a part to play there, but so does testosterone.

They are the three key hormones that we're talking about.

**How hormones effect the menopause**

As we go into this perimenopausal phase, what starts to happen is progesterone levels start to drop, actually in some quite rapidly, and then oestrogen rather than being a gentle rise and fall on a monthly basis, in the same way that progesterone would be a gentle rise and fall on a monthly basis, oestrogen can start to fluctuate really quite rapidly. So rather than looking quite flat on a monthly basis, it can look much more up and down, and it can fluctuate not just on a daily but sometimes on an hourly basis too.

You might hear people say things like I felt fine a couple of hours ago, but now I just I just can't cope. I don't feel like I can carry on with what it is I was doing. I'm struggling etc. And of course that can be really anxiety inducing when you don't have control over not just your physical symptoms, but also how you're feeling too.

**What are the symptoms?**

So I've mentioned the word symptoms many times already, and one of the one of the resources that I wanted to highlight to you is the [menopause support symptom checker](https://menopausesupport.co.uk/wp-content/uploads/2020/11/MENOPAUSE-SYMPTOM-CHECKER-Nov-20.pdf), so you can find all of these things on our website, which is [menopausesupport.co.uk](https://menopausesupport.co.uk/). They're all free to download, print, share, and I hope that you will, because that's what they're there for.

Symptoms really breakdown into three areas:

* the psychological symptoms
* the cognitive symptoms
* the physical symptoms

So as far as things like the psychological symptoms are concerned, I think probably the most common symptom that I hear on a daily basis is increased levels of anxiety. Then things like low mood, perhaps feeling more emotional and that could be anything from more tearful all the way through to feeling more angry. That might be feeling that your moods are swinging around through the day. So these are all really common.

The cognitive symptoms, so particularly changes to memory and concentration which can be really troubling in the workplace.

And then physical symptoms, so I'm sure everybody has heard of hot flashes and night sweats and around 80% of those who experience symptoms will have hot flashes, but around 20% her symptomatic will never have a hot flush or a night sweat.

And then as I said, things like broken sleep can be really troublesome. But also things that you might not necessarily relate to menopause:

* changes to hair, hair thinning or drying
* dry eyes
* dry mouth
* burning tongue
* changes to gum health
* changes to gut and bowel health
* Very itchy skin is common
* Joint aches and pains
* Heart palpitations is a common symptom

There are all sorts of things that can be related to these fluctuating levels of hormones. And then there are symptoms that are rarely talked about, so they're the things that people find really quite embarrassing to talk about and there what we generally class as the genitourinary symptoms.

* increased urinary frequency or urgency, which again can be very troubling not just in your personal life but also in the workplace
* Increased urinary tract infections
* vulval and vagina or symptoms – dryness or soreness, irritation, discomfort. Which if you're a desk-based job where you have to sit down for seven or eight hours a day can really be troublesome and not just physically, but also emotionally too.

To help anybody who is struggling with those symptoms [we have created a separate symptom checker for the genitourinary symptoms](https://menopausesupport.co.uk/wp-content/uploads/2020/11/GSM-OF-MENOPAUSE-SYMPTOM-CHECKER2.pdf), and this has proved to be really helpful for people when they're going along to their doctor. It's something that they can either email over to them or to hand to them, if they have a face-to-face appointment, and I'm certainly aware of women that I've counselled who have actually left the workplace because of their symptoms.

And that's generally been partly because they didn't understand that it was necessarily related to menopause themselves. But it's also because they really didn't feel that they would have support in the workplace, and things are certainly starting to change in that direction. There is still an awfully long way to go, but you know, we are starting to see changes there.

So the symptoms essentially the potential effects are physical, cognitive and psychological and emotional and very often and I have spoken to women who have been experiencing perhaps a mixture of these symptoms and the great relief that they find where after having a conversation is being heard and being able then to understand what is actually going on for them. So that's really, really empowering for them. To understand and know what's going on, and not that it immediately makes it better, but then to know that there are things that they can do to help if they would like to seek support.

**Seeking support**

So around seeking help and support, some of the things that we hear regularly at Menopause Support are of women trying to seek help from their doctors, and incorrectly being offered blood tests to diagnose menopause. In the UK, [we have NICE guidance](https://www.nice.org.uk/guidance/conditions-and-diseases/gynaecological-conditions/menopause) and this is a really useful tool.

For a NICE guide, it's actually not too bad. It's only around 30 pages, but it's a really useful tool, and it's well worth having a flick through so that you know what individuals should be offered. If they do seek support.

It's written for doctors, but it's also written for the public too, but we have precised down some of the key points of the NICE guidance for you in a document, again in resources on the website called [10 things you and your doctor should know about menopause](https://menopausesupport.co.uk/?page_id=13769).

For Blood tests, if you're over the age of 45, NICE is very clear that there is no point in having a blood test because of those fluctuating on a daily basis hormone levels. You're literally taking a snapshot in time and that snapshot could look very different two or three days later. If you're under 45 then a blood test may be appropriate just to see if there's anything else going on – is there a thyroid issue that hasn't been highlighted, etc.

But for anybody who is in a premature menopause under the age of 40, it's really important that they have two blood tests, four to six weeks apart. If premature menopause is diagnosed, it's highly likely that they will then need a referral onto a menopause specialist.

In going to the GP, the GP should discuss with your members not just their symptoms, but all their treatment options. It's important to know what you should have prepared, and again we have done something which is called ‘[getting the best out of your doctors appointment](https://menopausesupport.co.uk/?page_id=13783)’ – there are 7 tips there for what you can do to make the most of your 8 or 10 minutes essentially.

As far as treatment is concerned, the first line treatment for menopause is HRT – that's hormone replacement therapy – unfortunately we see so many people who have gone to the doctor, and they're reporting either those psychological or those cognitive symptoms, or a mixture of both. And very often they're being incorrectly diagnosed as stressed, anxious or depressed, when in fact they are entering perimenopause. Unfortunately what's often going on is that they're being prescribed antidepressants rather than hormone replacement therapy. Now, that's not to say that antidepressants don't have a place for some people, but as far as perimenopause is concerned, it shouldn't be the first line treatment.

It's important that people know that if they don't get the help that they need, they should ask for a second opinion, and I think it's really useful for you to know that if your members are not getting the help they need, and you've signed, posted and supported them to get help, then there are British Menopause Society NHS menopause clinics. Sadly there are not enough throughout the country, but we do have them and anybody who needs to be referred to one, even if there isn't one in their local area, should be referred out of area. And you can find the information about those on the [British Menopause Society](https://thebms.org.uk/) website. The clinics were really designed for anybody with a complex medical history, so are premature menopause, those who have perhaps a complex medical history or anybody undergoing medical treatment. That’s what they’re there for.

And anybody who needs one, should be able to be referred.

Also important to know that for those people who absolutely can't take HRT or they choose not to, doctors can offer other medications. They can also offer what are called local oestrogens for those genitourinary symptoms. So if somebody is suffering from those, but they don't feel that they have any other symptoms, then they could just have some local treatment, which could be a cream or a pessary, etc.

Some doctors can refer for talking therapy, so generally that's going to be CBT – cognitive behavioural therapy – that can be helpful for anybody who is experiencing extreme anxiety around their symptoms. It's not going to stop the symptom happening, but it can help to control how we manage them. There is also the NHS referral around the menopause clinics

Preparing for an appointment, we advise that the best way to prepare for an appointment and this, again, is in our ‘[getting the best out of your doctors appointment](https://menopausesupport.co.uk/?page_id=13783)’ resource:

* book a double appointment if you absolutely can.
* Ask to see your GP or nurse who has a special interest in menopause.
* Have an idea of what the NICE guidance says you should expect.
* Keep a diary of symptoms and any changes to menstrual cycle.
* Complete the symptom checker before you start the appointment so that you've got all those notes in front of you, and you can absolutely get the best out of it.

**Questions were asked between 32:25.810 --> 39:17.310 on the video. You’ll find the questions and answers at the end of this transcript.**

**Menopause at work**

So menopause at work, and you lovely people supporting your members. I just wanted to give you an update on some of the most recent information that we've had around statistics of menopause in the workplace.

The [Chartered Institute of Personnel and Development (CIPD)](https://www.cipd.co.uk/knowledge/culture/well-being/menopause) which many of you I'm sure will be aware of. They did a really comprehensive survey, and in that survey it told us that:

* 59% said it had a more negative impact on work, so their menopause symptoms had a more negative impact.
* 65% said they found it more difficult to concentrate, so going back to those cognitive symptoms.
* 58% said they experienced more stress. So again, we're looking at those psychological symptoms.
* And then we also know that quite a significant number consider actually leaving the workplace. Around one in four will actually consider leaving their job. And when we go back to who experiences menopause and how they experience menopause, that correlates with the 1 in four who experience really debilitating symptoms.

The most common symptoms that the CIPD reported in their survey were hot flashes, sleep disturbances, night sweats, and psychological symptoms.

The reasons that people didn't want to declare that they had taken sick leave from work due to menopause were mixed. 45% stated privacy, which of course everybody is entitled to. 34% said that they were too embarrassed to say that it was related to menopause, and 32% said they felt that their manager would be unsupportive.

While we are seeing things improving the workplace, we certainly have a significant way to go before everybody feels that they can raise menopause as a reason for taking time off or why they're struggling in the workplace. And we also need to ensure that all of those line managers feel that they're knowledgeable to be able to support.

The most common potential challenges that we hear of and see when we speaking to women are:

* Reduced engagement
* Reduced job satisfaction
* Managing time
* Their emotional resilience
* Their ability to complete tasks as effectively as they would have previously
* This higher sickness absence
* And this increased desire to actually leave the workplace altogether.

So for anybody who has not come across the CIPD hub on their website, it's called ‘let's talk menopause’ and it has an absolutely fantastic range of resources. It's really well worth taking a look at.

In terms of you supporting your members, I think it's important to remember that so many previously have essentially suffered in silence in a way that they would not be expected to for other health related issues. And I think in many ways what we're currently all trying to do as far as menopause is concerned, is very akin to the work that's been done on mental health. It's about actually normalizing the conversation.

I think it's also important to understand the employers legal duty to make reasonable adjustments where needed. And of course, understanding the employers and line managers have varying degrees of understanding of menopause. Some of them will have had a partner who's gone through it. Some will have had some kind of professional training, but many have no experience whatsoever. So being faced with somebody who's experiencing it, who has gone to talk about it can be equally challenging on that side too.

Communication is absolutely key.

If you are speaking to somebody who has approached you for support and I would say as I'm sure you do in all your conversations, empathy and understanding is absolutely key. Just remember that that individual might have been trying to start that conversation for many weeks or months. Giving somebody the opportunity to explain in their own words and also being prepared for some silences and sometimes some tears too.

In the days when I could go into workplaces, I would often finish a presentation and there would be a line of people to talk to me and it was always the two or three people at the end of the queue that I wanted to make sure that I got to because they'd hung back for a reason. They'd hung back because they knew that they were going to be emotional.

It's also important to remember that everybody is different, and everybody is experience is different, so you know it might be a different set of symptoms experienced in a different way. So the depth and breadth and length of the symptoms can be different, and it can have a different effect on everybody.

Your awareness and understanding will absolutely make the difference.

The one thing that I hear regularly on a daily basis is it's so nice to talk to somebody who understands. It's such a huge relief to be able to talk to somebody who understands what an individual is talking about. I would also say encourage your members to make a plan if they're going to be approaching their line manager, with or without you, it's really important to have a plan because it's so different for everybody.

So just to give you a couple of examples, couple of women that I've counselled, one who had dreadful, hot flashes and was having many a day. But because of her working hours was having to travel on the tube at rush hour and had got to the point where on a couple of occasions she'd nearly fainted. But in her mind her times were fixed, and they were the time she had to be in work.

And leave work, and by the time she got to talking to me she was so stressed that she was actually considering leaving. We talked about what simple adjustment would make the difference for her and she said I can cope with the hot flashes when I'm at work, but I can't cope with the idea of fainting on a tube train journey.

So we did a really simple thing and she put to her employer that she would like to be more flexible in her working times. Could she come in either a little bit earlier or little bit later? And could she do the same going home. The employer was really welcoming and really supportive of that. They kept a really valuable member of their team, she kept her job.

The other one is something that again doesn't get talked about very often. Are things like experience seeing changes to periods during menopause. It's often as perimenopause progresses that periods can change. They can become lighter, more infrequent, but they can also become heavier. And for some people that will mean flooding. In a workplace situation that can be embarrassing, distressing and anxiety inducing.

So in this example, a woman who worked in a busy collective office, she was a long way from the toilet facilities. She had nowhere to keep a clean set of clothing and sanitaryware. She was in a position where she was, to try to alleviate her stress, she was going backwards and forwards to the loo very often. That made her stress worse because she had got it in her head that her colleagues were noticing how often she was going backwards and forwards.

So again, really simple adjustments we put to the employer that her workstation be moved so that she could be closer to the facilities that some lockers were installed so that she could keep anything she needed there and again, that relieved her anxiety. She could go come and go as she pleased, and she had no more stress over what was going on.

It wasn't comfortable for her to be experiencing, of course, but it really relieved the stress for her and she stayed in her job.

**The law and menopause**

Just very briefly, I just wanted to mention to you. I'm sure you're aware of these strands of law, but regarding menopause, there are two essentially strands of law that can relate to perimenopause and menopause. They are the Equality Act 2010 and the Health and Safety at Work Act.

Employers should be looking at things like:

* Risk assessment
* Temperature
* Ventilation
* Can they change uniforms? Uniforms can be really troublesome for anybody who's employed in perhaps the NHS or the fire service, the ambulance service, etc. The materials in those clothing.
* Access to toilet facilities can be such a simple one to change
* flexible working
* having line manager support and knowing that that support is there
* Access to a menopause champion – so something that I have been championing with the organisations that I work with is for them to essentially create a menopause champion that's very often somebody in the workplace who has been through a tricky time themselves and actually volunteers for that position to be the go-to person.
* Offering a quiet space. So either a quiet break space, or a quieter environment where somebody can work, particularly if they're struggling with cognitive function.
* Simple things that can be done around sleep disruption are allowing somebody to have more flexible time in their working. So perhaps working from home a little bit more. Around cognitive function, as I said, maybe a quiet space, access to a restroom.
* Being able to take more flexible breaks, so knowing that that's an option.

So I think as far as how can you go about supporting, it's really about having as much knowledge and information about menopause as you can. If somebody approaches you being able to offer that space that they clearly need to be able to talk about it, to talk about how you can then support them as far as their employer is concerned.

And I think it can be difficult, because if somebody hasn't recognised menopause in themselves and but you feel that you have, that's a difficult conversation to have. And I think you know, sort of, if you're pretty sure, then there's nothing to say that you couldn't mention ‘have you thought that it could be related to hormones?’. You don't even have to say the word menopause to start with and then just see what the response is.

It's not easy and we can't always assume that everything is menopause, but particularly for those who, as I said, we expect almost everybody to be perimenopause or by the time they're 45. So if you've got somebody who is struggling and they haven't mentioned it, then you don't have to start with the word menopause. You could just say do you ‘do you think that it could potentially be related to hormones?’

I'm really aware that we have officially around 6 minutes left, but I’m happy to stay on a little bit longer.

**Takeaway messages**

I think three really simple things that every employer could do really quickly would be:

* To create a menopause champion
* Create a menopause support group within the workplace
* Make whatever menopause support they have, make that pathway clear for everybody in the organisation so that those who are struggling don't have to essentially fight to find it.

My top tips for you would be remember everyone is different. Please share what you've learned today and encourage your members to seek help, whether that's from their GP or their employer. Keep the lines of communication open.

Signpost, and as I say, the most important thing that somebody who is struggling has reported to me is that having a supportive ear is so valuable to them and has often not only helped them personally, but also help them to stay in their job. And I really hope that you have found this helpful, and I have a few more resources for you.

We have one which is called ‘[understanding menopause for partners](https://menopausesupport.co.uk/?page_id=13696)’, because of course for a lot of people they will not just be in work relationships, but in personal relationships too. And this can be helpful to share with those who were going through it directly. For those who are supporting them at home.

We have a [couple of FAQs](https://menopausesupport.co.uk/?page_id=2651). One is frequently asked questions about all things menopause. The other is around oestrogen and progesterone specifically.

And then we've also done a resource sheet around under [understanding the psychological symptoms of menopause](https://menopausesupport.co.uk/?page_id=13759). Because they are really common and can be very troubling.

And then I've just got a couple of books to share with you. For anybody who wants to learn a little bit more about this subject.

The Haynes Menopause Guide is a really good introductory book. And then for anybody who wants to know a little bit more, there is the Complete Guide to Menopause. These are all on your resources sheet. And for anybody who is looking for perhaps something where it is looked at in a really holistic way. There is the Natural Menopause book, and I have to sort of claim some allegiance with this because I wrote the mental health part of it. But really good book with a lot of really useful information in there, from a medical herbalist.

I hope it's been helpful to you and if you have any questions, I'm really happy to stay on for a little while. Chris to make sure that we get them all answered.

**Questions**

**Q**: *What are the risks of developing breast cancer through HRT?*

A: There is a fantastic infographic that you can download from a website called Women's Health Concern. Women's Health concern is the patient arm of the British Menopause Society and they have a fantastic infographic on there so the breast cancer risk around HRT.

The breast cancer risk of HRT has had a very chequered history over the past 22 years. That's because 22 years ago there was a piece of research, a big piece of research, that was done as part of the WHI. So that's the Women's Health Initiative study and the Women's Health Initiative study was really looking at the health of older women.

What they were looking to do, was to look at whether HRT improved health long term.

Unfortunately, whilst it should have been a study that was done on those women who were in their 50s, many of the women who came into the study were in their 60s and 70s. The women in their 60s and 70s were being given exactly the same HRT as the women who were in their 50s. That's not something that would be done. It wouldn't be a one size fits all, essentially.

The study was released, and it prompted all sorts of scary headlines, particularly about HRT and breast cancer.

We know that approximately 1 in 8 in the general population will experience a breast cancer in their lifetime. We also know that it is one of the most treatable and one of the most diagnosable cancers, but one of the things that we know about breast cancer is that the risk increases with every decade of life. Now, having those women in their 60s and 70s in that cohort of the study really skewed the results.

It's also fair to say that the type of HRT that was used in that study is not generally prescribed today. It was what's called a synthetic progestin that was prescribed, and it was an oral HRT and oral oestrogen.

Today we have what are called ‘body identical’ plant-derived oestrogen and progesterone. So they are very similar to the oestrogen and progesterone that we produce naturally.

For women under 50 using HRT, there is no increased risk above baseline. Once women get over 50, we know that with the body identical plant-derived, there is research French research that shows that over a period of five years, there was no increased risk. In fact, no increase incidents above baseline.

However, menopause specialists still believe that there is a small increased risk with some of the synthetic progestins. So currently what they called the gold standard of treatment is to have body identical oestrogen, which can be a gel, patch, spray, or in fact many of the tablets are body identical oestrogen, and then a body identical progesterone.

Obviously, it's really important to say that things like lifestyle also make a difference. Things like taking two and half hours of regular exercise a week, watching the amount of alcohol that you drink, we know that those who have a BMI over 30 have an increased risk not just of breast cancer, but cancer generally.

So it's about looking at the individual, their family history, their own history, their lifestyle and then at looking at tailoring the hormone replacement therapy to each individual. But as I say, currently it's the body identical oestrogen that is seen as gold standard.

**Q**: *Does the contraceptive pill delay the menopause*?

A: It's an interesting one. For the for those who are using the combined contraceptive, doctors should be encouraging anybody who is using the combined contraceptive to be changing their contraception at around the age of 50. But the mini pill, so that's progesterone only, that can be continued.

Some people who have been on the combined contraceptive for some time do feel that once they stop it and change to something else there, then they start to feel symptoms. Now it's fair to say that the combined contraceptive is oestrogen and progesterone, so it would make sense that if you're on the combined pill that actually hormone symptoms are not as prevalent.

But I do think again that it's an individual situation. It's not sort of a blanket situation.

***Q:*** *How would you have this kind of conversation specifically as a man? It might actually be more difficult to have that conversation as well, are there any top tips for men where introducing menopause into the conversation might be a bit more uncomfortable?*

**A:** I think it is tricky, because until you feel comfortable in your knowledge, it is a difficult one. And of course, as I said before, we can't assume that somebody is going through menopause. We have to think, OK, could it be something? But remember that this is a member approaching their rep, so remember that they're approaching you for support. You're not jumping in both feet.

First, you know they're approaching you. It’s about individual conversations, considering the circumstances. And it's whether or not you feel that that person is going to be open to you sharing what you've learned. You might be able to simply ask had they thought that there could be other things going on.

Initially not using the word menopause is a good way to go. So do you think there could be other things going on? Do you think that this could be hormone related in any way? Even that might kind of get the light bulbs going on, and then if you do feel that you've got enough knowledge yourself, then you could have that initial conversation. But equally you could signpost to people like ourselves, Women's Health concern, British menopause society etc.

And of course, then it depends what the employers got in place.

It’s important not to overstep the boundaries and start diagnosing and offering the solutions though, but to point to the medical professionals.

**Q:** *Does menopause increase symptoms of osteoarthritis, and is that true? Is it a myth? And how can you tell?*

**A:** We know that oestrogen acts as a lubricant for the body. We know that oestrogen helps with our bone health throughout life. So if somebody is already diagnosed with a condition, certainly going through menopause can exacerbate that.

If there are people who have experienced PMT, the condition I mentioned PMDD or have experienced post Natal depression, we're also aware that the hormone fluctuations during perimenopause through to post menopause can in some people exacerbate those symptoms as well.

So if somebody experienced those, we know that that can be exacerbated and those people, obviously they would need to be sharing that with your reps, but if they do share that, I think it's important that they're also signposted very clearly towards a medical professional.

***Q:*** *Is there any evidence or some kind of medical certainty around why some people experience symptoms yet other people don't? You know what kind of factors influence that?*

**A**: That's a brilliant question, and one that I actually asked to probably one of this country's most world-renowned menopause specialists very recently. And the answer is, I'm really sorry to say, they don't know. They don't know why some people experience worse symptoms than others, or why some people go through the entire transition with almost no symptoms. And the only thing that really happens for them is that their periods will stop.

So sorry I don't have an answer to that because when I asked him he doesn't have an answer to that either.

**Final thoughts**

When I started raising awareness about menopause, which was back in 2015, it was a very lonely place to be. And that was because even in 2015, people didn't want to say the word menopause out loud. They certainly didn't want to, you know, talk about it on TV and radio and things. But things are definitely moving in the right direction. We are going the right way. You know, doing this session with you today. Amazing.

Having so many people join and knowing that there are going to be so many people who watch. We are going the right way, but I think for anybody who's ever thought particularly in the position of, you know, being a Union Rep, how do I start this conversation or how do I bring this into the conversation? I would always say gently, does it.

If somebody is seeking you out for support that's the first step is that you now, hopefully know, a little bit more about all things menopause, and perhaps where it's relevant you can start to at least signpost in the right direction. It is always tricky. You know it's very different for me. People come to me because they know what I do.

Your remit is very much wider than just menopause, but I think you know the thing that is the most important and the most valued by individuals is having that supportive ear. So it might be that that first conversation is just a general conversation, and then that's followed up. But I think by each of you individually keeping the door open, it adds that layer of support and genuinely that can make all the difference to somebody's life.

**Resources**

Resource sheet mentioned by Diane [is available for download](https://accord-myunion.org/assets/files/events/MenopauseResources.pdf).