# Ask an Expert: Menopause management

**Dr Sonia Davison:** So menopause gets a little bit cloudy now because it's the last period, but it's really the last egg that we ever produce, and it gets cloudy because you might be on the Pill until that last period or you might have a Mirena in situ. And so menopause sometimes gets lost. Natural menopause is what all women will do if they get old enough. And surgical menopause is when we remove both ovaries, that will launch someone right into menopause. The average age, however, has not changed. It's 51 years with a median of 50 to 52 years in Australian women, and we lose eggs. And perimenopause prior to that, the egg production is very variable and can last for about 10 years. So that's a really rocky time before menopause, which is just the last period and the last egg. And we lose that cyclical production of oestrogen and progesterone as well.

So the basic physiology here I've just told you, but the important thing to know is that premature menopause is menopause that occurs less than 40 years of age. And that's really important because some of these women may escape your attention, and because their oestrogen level is lower than it should be until the median age of 50, those women can have an increased risk of cardiovascular disease, cognitive decline, and even mortality if we don't treat them. So they are very important to recognise as a group, those women who have menopause less than 40 years of age. So just be on the lookout for them because sometimes they'll escape because it's quite convenient to not have periods and they might not turn up for your expert assistance, or my expert assistance, because you might send them to me.

So I grouped the symptoms around, so I'm saying 'around menopause' because we will touch on parts of perimenopause as well, and I think that is a very difficult time to manage because hormones are up, hormones are down, hormones are all around the place. Whereas menopause, there's just a flatlining of oestrogen, which sits there, typically at 20 picomoles per litre if you do a very sensitive assay. Whereas the average oestradiol throughout reproductive life in a woman is about 400. So there's a huge difference. And some women really notice a huge difference with menopause and that's what this is all about. We often get criticised because we medicalise menopause, 'Well, this is a natural life event. Why are you, sort of, medicalising it?' We medicalise it because women present to doctors and nurses and health practitioners with expertise in this area for advice about symptoms that bother them. And menopause is really about quality of life and bother. The cardinal symptoms are flushes and sweats. And every time I give a talk like this, I talk about beach towels because some women will sleep on beach towels.

That's how much sweat they sweat. And do you know what? You shouldn't sleep on a beach towel unless you're on the beach. You're allowed to sleep on a beach towel then. But what happens is that some women have a very vigorous experience with menopause and they can wake up 10 times. I had one today. Every time I think I've just cured everyone of menopause in Melbourne, there's another one that comes along. So flushes and sweats are the cardinal symptom. They can be associated with palpitations and they can be really bothersome and some women just do not sleep. So if you look on the right side of the screen, that top box, there's sleep disturbance. I think half of menopause is about women just waking up around 3:00 AM just not sleeping again, disturbed sleep, awakening many times and feeling hot and sweaty. But you might not have the sweats, but you still might have the sleep disturbance.

Many women will get vaginal dryness, dyspareunia and urinary symptoms. You should ask about it. They might be quite shy, but when you do ask about it, 'Yes, yes, I do have that. Yep, I've got that too.' And there are good treatments for these things. So it's important to ask about these things. Mood is very important. So if you have someone in their forties or around 50 who has mood disturbance, just think, well is this perimenopause? Is this going to be menopause. At the moment, I think we can call it pandemic, but you must have a think about this because again, we can intervene here and help. Often hormone therapy or other strategies will be very useful for the mood disturbance around menopause and perimenopause. So irritability, mood swings, ups and downs, teariness, they can watch an ad on TV and just cry, low mood and anxiety, and some women will just get one or other of these and it can be disabling.

The next column where you see 'somatic' there over to the right, that word is 'formication'. It's a sensation of crawling like ants under the skin. It can be very, very disabling and they can get restless legs and just not get comfortable. It's a very difficult symptom. But some will get muscle and joint aches and pains and they, again, you'll think, 'Ooh, they've got some sort of amazing arthritis or muscle condition'. but it's just menopause. And again, they may respond very well to hormone therapy, and they may come to you and say, 'I feel old.' And then you can ask about these things. Weight gain around the tummy is very common and they'll worry about weight gain on hormone therapy too. So we'll talk about that. Headaches or migraines are very common in perimenopause, and bloating. And you'll see there, there's lots of different symptoms I haven't talked about, but I always ask about them and just do a little bit of a tick list when they present, and then a tick list when I've given them some form of strategy to try and alleviate these symptoms.

So this is the 20/20/20 rule. 20% of women have few or no symptoms. They may not come to you for screening, they may just escape. You might not check their blood pressure or their blood sugar or their cholesterol or what have you. And 20% have severe symptoms. They're the beach towel type symptoms and they're the ladies who might be suicidal or might just really struggle with mood. So everyone else is in the middle, but 60% of women will have four to eight years of symptoms which can really decrease quality of life. And as I said before, menopause is about quality of life and bothersome symptoms, which we have good management strategies for most times. And some women will still have symptoms in their sixties and seventies and you'll think, why are they on hormone therapy?

But really they do have symptoms that persist if you try and stop it or lower it. So I'm going to talk to you now about Eva. Eva is 52 and she's single. She's a social worker and works full-time. She comes to you because you are her trusted health practitioner and she notes that she's had low mood, anxiety, lethargy and sleep disturbance and she feels hot. She has drenching night sweats and frequent flushes. Her periods ceased a year ago and were quite erratic for 12 months prior to that. And she's worried about her bones. Nothing stirs a woman up to make her more afraid than the word 'osteoporosis', I think. Her mother has osteoporosis and fracture and that's a real, sort of, prompt for women. They don't want osteoporosis and fracture having seen what their mother might have gone through. So I'm going to incorporate lots of management options in the things that we discuss now.

They're not actually targeted specifically at Eva. You can make your own mind up what you might offer her as we go along, and then we'll go back at the end and see what Eva's experience was. So I think it's really important to get the diagnosis right. You don't need to test FSH and oestradiol if it's a typical lady of around 50 with symptoms, or in her forties, get the diagnosis from the history, not the other way around. And you don't need tests. Unless you think it's something funny or premature menopause, then it is important to do some FSH and oestradiol testing. Then it's about symptom control. So that's the thing that the lady will come to you with, the bothersome symptoms, but that's your sneaky way of nabbing someone at midlife and trying to do a midlife check.

What are the problems they've got now and what are the problems they're at risk of in the future? So it's a really, really, really good opportunity to do a really good history, their own history, but a family history of things like VTE, osteoporosis, cardiovascular risk, stroke, diabetes, et cetera. Because I'm always planning for the future when I'm seeing the lady with her symptoms in the consultation. So we treat symptoms when they're bothersome. And that's usually why a lady will come to you, they want advice. They don't want to be patted on the hand, they've come with something, they've taken time out of their day to see you or, at the moment see you from home or wherever, but they've got bothersome symptoms and they're worried by them. So lifestyle measures are very important. I'm going to go through those. Hormone therapy is also an important part of this as well, for some women.

HRT used to be the name, 'hormone replacement therapy'. We now call it 'menopause hormone therapy' to specifically say that this is hormone therapy we use around the time of menopause. So 'MHT' I'll be using. And vaginal oestrogen is part of that as well. There are non-hormonal options which are applicable and relevant and are useful, and there are non-medical options as well. So I'll go through those too. So these, I think it's nice to know, but women are usually doing them by the time they get to you. So avoiding overheating, and sometimes I've written letters for the workplace where the workplaces were clearly too hot. Police women are difficult with their big gear that they have to wear and they can get very hot. So they need to be mindful of menopause in their big outfits that protect them.

To dress in breathable fabrics is very important. To avoid alcohol excess, and some women just can't drink alcohol around menopause, they just have too many symptoms. Avoiding spicy foods. Now someone asked about healthy diet, that's very important. So healthy diet is part of menopause management. Avoiding weight gain is part of menopause management too. There is no one right strategy with diet and symptoms, just having a healthy and balanced diet, avoiding saturated fats, avoiding all the bad sort of things, but it's about moderation, and also regular exercise. And those who do tend to be larger with a bigger fat mass have a lot of insulation and therefore might be hotter and have more flushes and sweats. That's another thing to consider. And another thing which is very easy to put in two words is 'stress management'. We're all stressed out at the max at the moment with all the things we do and looking after others, but that's very important in terms of controlling menopause symptoms too, and getting a handle on them.

So when we're looking at hormone therapy, it's waxed and waned from the nineties when we used to offer hormone therapy almost universally at menopause without really thinking about it a lot. There's a more rational approach now from the studies from 2002 which really turned hormone therapy around, and our knowledge around. But the international menopause societies and other expert societies say that the benefits of hormone therapy far outweigh the small risks in healthy women around the time of perimenopause and menopause. And you can see various consensus statements and guidelines, and often I will state that very clearly to the lady who's in front of me. There is an increased risk of breast cancer after five years of use, but it does depend on what hormone therapy you use, and that's not really relevant for oestrogen-only treatment in the biggest study of hormone therapy. And multiple trials support a safe window for prescribing, and also a window of opportunity.

If you give hormone therapy around the time of menopause, you actually probably are lowering risks of osteoporosis and bone density decline and risk of cardiovascular decline. So there's that window of opportunity. When we're looking at timing of initiation, within 10 years of menopause. But some women will have menopause at 57, just remember that. But also less than 60 years of age. So sometimes a woman will come to me at 61 and say, 'I want hormone therapy.' And I say, 'Well do you have symptoms?' 'No, I'm worried about my bones.' 'Yes, your bones aren't too bad, I don't think hormone therapy is for you.' So it really depends on the woman. And you did ask about duration of treatment. There is no set duration, there is no safe duration. We just try and use what's appropriate for woman at the lowest dose that will control her symptoms, and the safest option for her, and I'm going to go through those later.

But younger women are more likely to be symptomatic and have lower background risks for those things you don't want, VTE and stroke and heart disease, and are more likely to get a cardiovascular benefit and a bone benefit. So I love this slide. It was done by the US Endocrine Society some time ago, but they tried to look at all the big studies of hormone therapy and just really look at the risks for those women who are likely to be prescribed hormone therapy. So up to 60 years of age or within 10 years of menopause. And if you see something to the right of the vertical line there, those things are things that got better. So you'll see up the top, flushes and vaginal atrophy definitely got better, with the black line which was oestrogen-only treatment, and the white line which is oestrogen and progestogen. And if you look on the lower part of the slide to the left, that's where things get worse, where there's a higher risk.

And you'll see really in the scheme of it all, there's a huge improvement in symptoms, but really the risks are a blip on the radar. And when women are really getting anxious and worried about this, I will show them this slide just to show them this is the perspective, this is really what it means in terms of risk. But the next slide is the bottom part of the slide just blown up a bit to amplify that. And again, we're still looking at the same timeline, 50 to 59 years of age or within 10 years of menopause. You can see to the right there for both types of hormone therapy, fracture risk, diabetes risk went down and overall mortality and coronary heart disease went down. And that's really interesting. I don't know why diabetes risk goes down with hormone therapy, but it's a very interesting finding.

You can see there with breast cancer that the oestrogen-only bar on the right shows a protective effect. But on the left there's definitely a risk for breast cancer, which came about in the biggest study of hormone therapy, WHI, which there was an increase in risk of breast cancer, a slight increase, after four to five years of use. So you do need to tell women about that. But if you're looking at the biggest risks down the bottom, it's cholecystitis, smaller risk of stroke and VTE, which is really with oral hormone therapy. So again, I do show this to some ladies and it is a useful tool, and useful for you, I suspect, in terms of looking at those overall risks. So when you are prescribing hormone therapy or thinking about it, just make sure there's no contraindications to it. Any hormonally sensitive cancer, whether it's breast cancer, ovarian cancer or other, will be a problem.

VTE, so thrombophilia in the family or their own past VTE event, there will be caveats here. So sometimes we get around these and if they've had an injury or a car accident, they had a clot after that, well, yes, there's a reason. Undiagnosed vaginal bleeding, we don't want to let that be undiagnosed. We want to get onto that before we look at hormone therapy, if we do. Active liver disease, uncontrolled hypertension and cardiovascular disease risk or existing disease. You do need to ensure screening's up to date and you are very good at doing that as a group, I know that. And I usually start with a mid-range dose because we've got to think that most women when they're initially presenting will have been used to, have been exposed to a fair amount of oestrogen, which has just sort of sunk into its boots.

You can use a low dose and some guidelines say that, but I think that we'll lose some women who will say, 'Oh, this stuff's just not effective', and they'll just abandon treatment. So I start in the middle and then I can go up or go down depending on their symptoms. And use it for the shortest duration for symptom control, and sometimes that will also be for bone. So there's lots of different ways of giving hormone therapy. So I'll just take you through those briefly. But low dose therapy, you're exposed to less, so less effect on breast cancer risk, less effect on thromboembolic risk. Transdermal, in the studies of transdermal hormone therapy, there's been no increase in thromboembolic risks, that's important to know, and less effect on stroke risk. So when a tablet of oestrogen goes through the liver, it tends to make proteins and those proteins, we think, factor in with those risks of VTE and cardiovascular disease risk.

Oestrogen-only has less effect on cardiovascular disease risk and less effect on VTE risk, and also, you saw from those slides before, less effect on breast cancer risk, but it also has less effect on colorectal cancer risk reduction. Combined hormone therapy does have a protective effect there. And not all progestogens are equal. And more and more we've learned since that big study, WHI, that the progestogen is very important in terms of risk, particularly breast cancer risk. And those progestogens that are more like natural progesterone do tend to be less involved with risk, whereas those that are more synthetic, or more testosterone like, are associated with more risk. And I'll go through that in a minute, seeing that your questions are already coming. So what do we consider when we're giving hormone therapy? I firstly look at, are they likely to bleed?

So we're going to go through that in a minute. So the sequential use, if you do think they're going to bleed, more about convenience for the woman, or continuous use if you think no, they're not going to bleed at this point. Oestrogen-only versus combined oestrogen and progestogen or localised, that's PV or vaginal oestrogen. Risk factors, symptoms, their need for contraception if they're perimenopausal. The cost, so that's a big issue at the moment. PBS is probably favoured for some. And premature menopause, we do favour a higher dose of oestrogen and we do favour hormone therapy use of some type, it can be the Pill, up until the age of expected menopause, at least 50 years. So if they're perimenopausal or if they're just recently postmenopausal, when you give hormones back, a uterus will want to bleed again, just with the hormones going in. So it can become very inconvenient if you try and give them continuous hormone therapy.

You can try it for a little bit, but it's most likely that they're going to bleed. So it's probably kinder to just give a sequential array of hormone therapy so that they will have a regular withdrawal bleed. The bleeding is less likely if they're more than a year after menopause, and it is common in the first three months. So this is my sneaky trick. I usually will say to the lady, 'I'm going to see you three months after I initiate hormone therapy', because most of the problems will be ironed out within that three months. They might get initial breast tenderness, they might get a bit of fluid retention, they might have a little bleeding, but usually by three months those things will settle. And they also, if a lady forgets her patch, for example, she might have a higher risk of bleeding. So you do need to tell them if they're on a patch, for example, twice a week, they do need to be very regular.

And I tell them to put it on Monday morning, take it off Thursday evening and change it over, just three and a half days very regularly. The Mirena was one of your questions. The levonorgestrel IUD. It's a really excellent strategy for perimenopause. It provides contraception, it mostly provides bleeding control and it is a very good progestogen for hormone therapy purposes. And so you can watch someone in perimenopause and as soon as they're having bothersome flushes and sweats, if they have a levonorgestrel IUD in situ, we can just add any type of oestrogen and it's very easy and they're less likely to bleed. So that's one of my favourite perimenopause strategies, and very convenient. Not for everyone, but convenient. So we've talked about the likelihood of bleeding. If they're more than 12 months after menopause, it's very likely that you can use continuous oestrogen throughout the month and continuous progesterone throughout the month, and we'll go through various options for that later, and there's some really good information that guides you about that.

But sequential use is usually progestogen for 12 to 14 days per month, and they would expect to have a bleed after that time. It doesn't matter in the first few months if they don't, and if they don't know where they are in the cycle, I just say day 1 to 12 or 14 per calendar month, that's when they have the progestogen and they should have a withdrawal bleed after that. It doesn't really matter if they don't, some women will not, and that's also quite convenient for them. But if there is new bleeding at any point, you need to be worried about it, and a gynaecological ultrasound would be appropriate, and referral to a gynaecologist if you are worried about that. So don't ever let bleeding go without actually sorting that out. So if a woman has had a hysterectomy, she only needs oestrogen-only, and we'll talk about that a bit more down the track with endometriosis.

And if they've got a Mirena in situ, they only need oestrogen-only. Women who've undergone an endometrial ablation may still have some pockets of endometrium left. You don't know when they're still left there. You try and get them all out, but it might be left. So they do need a progestogen if they're on oestrogen, that's systemic oestrogen, because they might develop pockets of endometrial hyperplasia. So that's very important. But women with endometriosis who've had everything cleaned out, they still might need a progestogen because that's very important in some women to stop endometriosis from coming back. So even though they might've had a hysterectomy, they might also need the progestogen still. So that's an important sort of caveat there with endometriosis. So vaginal oestrogen, vaginal oestrogen is very risk-free. In hormonal cancers like breast cancer, that's a little bit different, but if the woman really only has vaginal or urinary symptoms, vaginal oestrogen is a really good option.

And there are various options out there. There are creams and there are pessaries. They do need to use it regularly and not many are very good at using it regularly. That's twice a week or a little bit more if they need it. And it is safe for long-term use. If a woman has had breast cancer, I will usually use a vaginal moisturiser first, and I think I'm going to go through that later. And then I possibly will use Ovestin because that does not go through into the bloodstream as oestradiol, as does Vagifem. But sometimes you will need to use Vagifem and it might be a specialist decision, but just always ask for advice if you're not sure. Systemic hormone therapy is for the body symptoms, flushes, night sweats, insomnia, cognitive symptoms, mood, joint aches and pains. But it will also help genitourinary symptoms, but it might not do it for two or three months.

So you might use vaginal oestrogen and systemic hormone therapy and later on the track you might not need the vaginal oestrogen anymore, just depends on the woman. So perimenopausal women will potentially need contraception. So have a think about that. And they will need a sequential regimen of hormone therapy or have bleeding issues. And we've talked about Mirena, you can give the talk now, I've given you a good heads up with that and you know about it already, I know. Postmenopausal women can use continuous combined hormone therapy, so that's pretty easy. So there's lots of types of hormone therapy. I'm immersed in this every day so I know the products, but I know you are doing lots of different things and it's hard to be an expert in lots of different things when lots of other things are going on, and I know you're considering other things.

But the PBS thing is important for some, the oral versus patch or gel versus vaginal oestrogen can get people confused. And there are combined products as well that have the oestrogen and progesterone, or a combination of separate oestrogen and progesterone products. So it does get overwhelming. And some products at the moment, as I'm sure you are aware, are not available, such as the Estradot patches, Angeliq was out for a while, Estalis is now out, which is amazing that I'm still practicing and not retired instantly due to pandemic. But I've got to do this and I've got to keep helping you and the ladies. So hormone therapy is not contraceptive. You've got to tell ladies that, and there can be some surprises there. And there's some lovely resources that I'm going to show you later, particularly that AMS guide, the Australasian Menopause Society Guide to equivalent doses.

It's a brilliant sheet. And the Jean Hailes information sheet and the menopause tool is really useful there in looking at different doses and different types of hormone therapy in different situations. So we will look at a picture of that soon. So oral versus transdermal, it really depends on the woman, what she will manage, her risks and her family risks. So oral is convenient. Some ladies like taking a tablet, they'll remember a tablet better. It's daily dosing, it's reliably absorbed. But they may have more nausea because it's going through the liver, effectively, and they may have more fluid retention and breast tenderness. So I do use oral oestrogen, I use all the hormone therapy types. It depends on the woman and the situation. There is no one wrong form of hormone therapy, just, it's important to understand that, There is an increase in risk when we give oral oestrogen.

But if you're thinking of a typical woman at 50, her overall VTE risk is about one in 10,000. Oral oestrogen will, sort of, make that about three in 10,000. So it's not enormous, but it is a risk for some. Transdermal is quite convenient. There is a patch twice a week. There is a patch you use once a week. There is a gel that you use daily, two gels. And it does avoid the liver, so it's a lower effective dose and it goes straight through into the bloodstream. There's less tendency for weight gain, breast tenderness or breast enlargement. No increase in VTE risk from the studies that we've seen to date. Some find the gels messy and some find that they have an irritation to the patch and if they're getting an irritation they won't be absorbing it reliably. So I will always try and switch to something else at that point.

So I alluded to this before, but the progestogens are very different and you'll see, on the left there, we do now have micronised progesterone which can be administered orally or vaginally, usually orally for hormone therapy, but it's exactly identical to the progestogen that our bodies made from the ovaries. Progesterone, it's the same. Typically in the past we used to use more of medroxy progesterone acetate and cyproterone acetate, but you'll see there down the bottom dydrogesterone is very similar to natural progesterone. And the two down the bottom, dydrogesterone and drospirenone, are very similar to micronised progesterone and they're quite safe progestogens. I'm not saying the others aren't safe, but they in studies have been associated with more risk of breast cancer and other problems. But as I said before, there's no one wrong form of hormone therapy. It's just the risks are a little bit different and different in different situations.

Tibolone is a very interesting product. It's more like a progestogen and it splits off into three isomers that are like oestrogen, progestogen and testosterone. So it can be quite useful if libido and wellbeing are low. And if a lady comes along with lowered mood and libido and not much in the way of flushes or sweats and if she's got some bone thinning, I'll always think, 'Oh, I wonder if tibolone would be a good option.' It is not on the PBS, so it's expensive, it's about $70 a month, and it's only appropriate if they've really finished bleeding. So more than a year after that last period. It is low dose and it doesn't increase breast density. It does have a low VTE risk. So sometimes I will use this just in considering family history or other VTE. And there is a slight increased risk of stroke from the sixties.

So you just need to be aware of that because some women love tibolone and want to stay on it forever. But we do need to sort of think, in the sixties, well, is there another option or do we need hormone therapy anymore? But it's quite good for bones. And there was a study called LIFT which showed that it was quite good for older women, even at low dose, for bone density. Duavive is very hard to get at the moment and I'm not sure if that's going to continue, but it's a combination of a conjugated oestrogen, which is Premarin essentially at lower dose, and the SERM, the selective oestrogen receptor modulator bazedoxifene. So it's a different concept, it's giving oestrogen, but instead of adding a progestogen, it's giving an anti-oestrogen at the same time, which in theory works very well. And there's some nice studies, quite a lot of studies actually, that say that this is very effective.

It's lower dose hormone therapy than the standard Premarin. We don't need the addition of a progestogen and we do need to wait for one year after menopause. It's not on the PBSs, as I said, it's hard to get, and it may be a good option for those women. I've got quite a few on it because they couldn't tolerate their other progesterones and we went through all of those. So that could be a niche role for Duavive. I've talked a little bit about this before, but micronised progesterone is called 'Prometrium' and it's a capsule form of progesterone. It's body identical. So some women may come along to you and say, 'I want bioidentical hormone therapy. I've read lots about it, it's natural, it's easy, it's risk-free' et cetera. And you'll say, 'Well that's good. Here's some information from Jean Hailes about bioidentical hormone therapy. And here's some information from the Australasian Menopause Society, which says that there are pros and cons of bioidentical hormone therapy, but we can actually use body-identical pharmaceutical-grade progesterone, which can be added to any oestrogen product.'

A continuous combined dose is just a hundred milligrams every night. Sequential is two capsules per night for 12 to 14 days per month. But don't take it with food, because that does increase the absorption and it's important to take it for night because it's quite calming for mood and it's good for sleep. And some of my ladies do come in and I'm surprised they're taking it in the morning. It is a cost consideration. It may be a good option if other progestogens haven't been well tolerated. And there's a lovely study called E3N, which is a French cohort of more than 80,000 teachers. They weren't all on hormone therapy but they were followed over time, and what they did, it was the biggest study of cancer in Europe, they looked at their breast cancer risk and they looked at their hormone therapy use. And what they found was that the women on micronised progesterone and oestrogen did not have an increased risk of breast cancer within five years of use, but the women on synthetic progestogens had a slightly higher risk of breast cancer.

So given that, it's very, sort of, compelling to think, well, we should use this if we are looking at hormone therapy. But it's the inconvenience of requiring two hormone therapy products, because you need to add a separate oestrogen, and it might be a cost consideration. And one lady said to me, 'I just can't have capsules', and I thought, 'You can have that capsule.' She went and bought them and she said, 'I can't have the capsules.' So women are very unique and I've seen almost everything. So you can't ever criticise. You've just got to go with the flow and find an answer. So what type to choose? If you are worried about weight gain, breast tenderness or those metabolic factors or VTE, I'll always try and use transdermal patch or gel. There are special scenarios and that Jean Hailes menopause foldout tool is really good here.

Scalp hair loss, I like to use the product Angeliq, which is also not on the PBS, but that can be quite useful. It's a low dose hormone therapy, it's quite safe. And low libido, tibolone may be a good option there. I do start at the middle dose, I've talked about that already, and then you can titrate up or down when they come for review. If a woman has an adverse experience on a hormone therapy or is very anxious or has had an adverse experience on the Pill before, I'll always try and use the lowest dose just to increase confidence. I just don't want a side effect to happen and them to abandon what might be a really good strategy for them. And as I said before, we do favour a higher dose of oestrogen and premature menopause until the age of 50 years at least, unless we can't because they've had a sensitive cancer or something like that.

And we often will talk about testosterone in those ladies as well. But that might be another webinar down the track, I suspect. Probably not enough time tonight, but I will, I'm going to say a little bit, don't worry, don't go away. So potential side effects, and you must say these when they, it's a big consult, the menopause thing, it's a big thing. You've got to say a lot and women are worried and you've got to reassure them. That's why I think a lot of people do refer off to someone like me and I do it all in 45 minutes and then it's all done. Bleeding or breast tenderness, very common in the first three months. So just reassure them that it should settle and it usually does. If bleeding doesn't settle after three months and they're early postmenopausal, I would always consider a change to a sequential regimen, or if, really if it's bothersome or flooding or whatever, or if they've got adenomyosis or something like that, a Mirena, I'll try and push them in that direction.

The initial VTE risk does increase with oral oestrogen/progestogen, we've talked about that, and it's not a huge overall risk, but it will be relevant for some. So breast cancer is really the biggest barrier, I think, to any lady with bothersome symptoms taking hormone therapy at menopause. So this is the typical things you need to talk to them about. Between one in eight and one in nine Australian women will develop breast cancer over their lifetime, but those women aren't all on hormone therapy. When you think of women in the breast surgeon's office, they haven't all been on hormone therapy. So this is one part of the equation. For example, having two alcoholic drinks per day increases your risk about the same as having hormone therapy. So that's an important thing, especially during the pandemic where lots of my ladies are having lots of alcohol and they've got family histories of breast cancer too.

But the major risk factors are having a family history of breast cancer and having dense breasts. And having a family history of breast cancer doesn't mean you can't use hormone therapy, but I always tell those ladies, if you get breast cancer on hormone therapy, it's probably going to be about family history and less likely to be about hormone therapy, and we need to make a very careful decision about whether we do it or not. But dense breasts is another big risk factor. They're much higher than hormone therapy is. So from the largest hormone therapy study to date, that's WHI, combined oestrogen and progestogen did increase their breast cancer risk after four to five years of use. And you have to consider that those women were on average age 63 and they were using Premarin and Provera, but the women on that study who had a hysterectomy and were only on Premarin had a decrease and went to seven years and were protected against breast cancer.

So we thought then that it was about the progestogen and therefore the studies since then have really concentrated on the progestogen. And as I said, different progestogens have different effects on breast cancer risk, with those more natural or progestogens like natural progesterone having a lesser risk from studies to date. You do need, I always make a little note in my thing if I'm prescribing hormone therapy, I always say, 'Pros and cons of hormone therapy discussed,' and I tick VTE, bleeding and breast cancer risk, just so I know I've done it and anyone else will know I've done it if it becomes an issue, it's very important to note that in your notes. So you know my tendency for review at three months. If they're bleeding, flooding all the time, they're having headaches, they hate it and they're nauseated and vomiting, of course you see them before that, but I always tend, and I don't have many appointments left, so three months is usually reasonable, review them at three months, discuss the negatives and positives.

Try, I love doing a menopause symptom score and there's one of those on the Australasian Menopause Society website under the information sheets, there's 30 there, and the 'What is menopause?' sheet will have a menopause symptom score. But there's also, guess what, an excellent one on the Jean Hailes website as well. And I often will do that at the start or before treatment, and then I do it at the end of treatment or at the three month mark to see what the issues are. And I think that's a really objective way of doing it. I adjust the dose if we need to, and then if I do change the product, then I'll also review them in another three months, just because we've changed things. But then I'll usually review them every six months and I'll look at the reasons behind hormone therapy every year.

And it's also a good time to make sure the screening's up to date, and most scripts will only last six months anyway, so it's a good way of getting them back and making sure that they're doing the right thing. Ceasing hormone therapy, that's a real trick and some of your questions reflected that. I do, I will just try and definitely think, 'Why is this lady on hormone therapy?' when I'm seeing them and when I've seen them for a long time. I trial a dose reduction at some point to see if their symptoms recur. And often the lady will want to do that. So if they're on, for example, an Estradot 50 patch, I'll try and use a 50 patch early in the week and a 37-and-a-half patch later in the week to see if they can manage that. I do it very slowly. I'll do that for two to four weeks, and then we'll go just to the 37-and-a-half patch. There's lots of ways to do that.

If they're on the gel, you can miss alternate nights, or whatever, on the gel. There's no set way of doing that. The study suggests that weaning gently or going cold-turkey had the same effects, but I think it's kinder, and my ladies seem to do better, with a very gradual reduction in hormone therapy dose instead. And as I said before, no ideal duration of hormone therapy use. It's just from the studies that we are looking at a slight increase in breast cancer risk with combined hormone therapy when we get to the four or five year mark. If we get there. And most women will only use hormone therapy for about, maybe two years for when their symptoms are most bothersome. So some women cannot have hormone therapy, they've had a stroke, they've had heart disease, they've had breast cancer or they've got a very strong family history and they don't want to go near it.

And their anxiety is such that you're never going to get them to have hormone therapy even though you can see they'd really benefit from it. So you can't push it. But these are other agents which we've luckily found can be useful for flushes and sweats. And you'll see these are the SSRIs and SNRIs. So they have about a 50 to 60% reduction in flushes and can be very useful. You do need to consider some of the SSRIs when they're on tamoxifen because they can inactivate that. So just be very aware of that. And there's some lovely information on this on the Jean Hailes and the Australasian Menopause Society website, under 'non-hormonal options for menopause symptoms'. Clonidine is an old agent, it's good for migraine prevention, it's good for blood pressure, and you start gradually and build it up. I don't use a lot of this, but some of my ladies do quite well.

It's quite drying, but it's the only one on the PBS and it is a useful option. And often when we're trying not to use hormones, I will use all of these options and when we bomb on them all, I look at the lady and I say, 'Well, it looks like we might need a trial of hormone therapy.' And she'll at that point be so exasperated that she'll say, 'Let's just give this stuff a go.' Only if appropriate, not if there's a contraindication. Gabapentin's really interesting. As you know, it's good for pain, it's an epilepsy agent, but it's really good for sleep, it's really good for flushes. And I start very gradually and build that dose up. The difficulty is it does need to be twice or three times a day, but some women will get to 200 milligrams twice daily and be fine. Some women will get to 400 milligrams at night and be fine, they'll be able to sleep, their flushes will be fine.

Some can be groggy on this medication. And one lady told me off heartly because she gained weight, and when we looked at the product information it was a 3% risk versus placebo. So everyone's very different. We're all very different. Women will come and say, 'I'm on this, that or the other', and these are natural treatments. Unfortunately, placebo controlled studies have not shown any benefit from things like phyto-oestrogens, soy, red clover, et cetera. We do want these things to be part of a healthy diet, but whether buying them over the counter at the chemist is going to help, probably not when symptoms are very advanced. It might help to take the edge off some symptoms, and in some women, I'm not discounting them. If women want to take a natural strategy, black cohosh is probably the most effective from the studies to date and it can relieve mild flushes, it may not do much for sleep and those other things.

There is a very, very contentious and rare risk of liver toxicity. It is contentious and we usually say that, well, six months is safe, but they do use a lot of this in Germany and Europe. So we are very different here. But that would be a good option and I do recommend this for some women if they've got mild symptoms. Other options are out there. Acupuncture, it just depends on the proceduralist and the woman, but that can be useful. Paced respiration, relaxation training, and cognitive behavioural therapy can be done online. There's a lovely book by Myra Hunter, and I just thought this is just rubbish, how can you train someone to deal with their flushes? It's actually just dealing with, it's not going to get rid of flushes, but it's dealing with the whole concept. 'I'm having a flush, I can breathe through it, I can get through it.'

And that's very useful also for anxiety and sleep as well. So that can be very useful. Hypnosis in studies is quite compelling, but again, it will depend on who's doing it. And stellate ganglion block is theoretically a benefit if they've got terrible sweats, but it's difficult to find someone who can do that and can do it reliably. So I'm just going to go through bioidentical compounds. This is hormones that are compounded to a prescription or whatever, and women will come, the marketing is very persuasive and they'll say to you, 'There's no cancer risk. It's natural. I want bioidentical hormones for my menopause.' But we don't have study data, we don't know about the quality of these, we don't know about the safety and we don't know about if they really work. And they're not cheap. And we do know that some of these hormones have put women at risk.

There was a study, there's a paper in the MJA some years ago, which said that the women on these hormones, or some of them, did get womb cancer or endometrial cancer because the progestogen was not adequate for protection when they were on the oestrogen. So none of the expert societies condone their use, and it's really about endometrial protection and also other things that we don't know about. If a woman comes to you wanting bioidentical hormone therapy, send her to the Australasian Menopause Society website and the Jean Hailes website for some good, considered information and also tell them, 'We can use pharmaceutical, fully tested, pretty safe body-identical hormone therapy that's been tested.' You can't always say it's absolutely safe, there are risks involved, but I would much rather a lady be on body identical than bioidentical. And never agree, if you're not comfortable with this, and I would never agree to it, to supervise someone who says, 'I'm on those bioidentical hormones that are compounded, you are my trusted doctor, please supervise me while I'm on it.'

I would refuse that. But you've all got to make your own decision about it. So some women do get terrible genitourinary symptoms. It used to be called 'vulvovaginal atrophy', you'll see it called GSM now. I don't think the change in name makes a real big difference. I just want the symptoms treated. So vaginal dryness, dyspareunia, urinary symptoms. As soon as oestrogen leaves the building, everything down below, there's less nerve supply, there's less blood supply, everything gets sort of thin and it's just a little bit of a sad situation. But there's lots of options there. There's Ovestin cream and the pessaries, which are ovules. There's Vagifem pessaries. We use a loading dose daily for two weeks, and then twice weekly thereafter. And I ask the ladies to just put an alarm on it and they just pop it in before they go to sleep, and then they sleep.

It should be absorbed overnight. Some find the cream messy, but some find it soothing. You do not need a progestogen with that regimen. But if they've got a hormone-dependent cancer, we try to avoid it. And I would always use, firstly, a vaginal moisturiser such as the product Replens. It is a polyphilicc gel. You just use it like you would use the Vagifem Ovestin, twice a week. It's like you moisturise your face, you're just moisturising down below, and Replens has no risks associated with it. Women will ask about vaginal laser, again, it's very persuasively marketed. There's a lot of interest about it. We just don't have the long-term safety data and there are studies being undertaken right now which will give us that data. So I think, well, might be useful, but let's wait for some good evidence and some good studies.

So I'm just going to almost finish with this, but this is about testosterone. So this is conveniently timed for this. There was a meta-analysis last year that went through over 8,000 women from 20 to 77 who'd had testosterone compared to placebo or oestrogen and progestogen. So you'll see there all of the red arrows showed that sexual function measures all improved. And the green one at the bottom is the level of distress associated with that decreased. And that's a universal thing with all of the types of testosterone used in these studies, which was transdermal, there were injections, there were implants, there's all sorts of things historically used for testosterone use. But at the moment in this country, we've really just limited to a transdermal 1% cream, which is not custom compounded. It's a pharmaceutical grade product. And I can talk about that to you another time and another webinar if you wish to.

But this is from the meta-analysis too, in terms of women asking about it, in terms of adverse events, acne, hirsutism, and weight gain. And that might be because it's a lean weight. So muscle mass is something associated with testosterone use. But you'll look there serious adverse events were not any increase compared to placebo or hormone therapy. And the other things down the bottom that you would worry about, breast cancer, CVD and VTE events, et cetera were not increased. I'm interested in the wellbeing thing because women on testosterone are, my ladies tend to say, 'I just feel better. I feel normal and I feel better.' But interestingly in the meta-analysis, that wasn't the case. And also conveniently timed, there's a global consensus position statement on testosterone in women, which states that really the only evidence-based indication in women is hypoactive sexual desire disorder, which is low desire causing distress.

And that really is the bottom line. I didn't agree in this statement. Some countries just don't have a testosterone product for women. They did say that male testosterone products could be used. I don't agree. In this country there is a product that can be used for women, which is pharmaceutical grade, and I would always go for that and I would really much avoid compounding testosterone. I've had one lady who was compounded the wrong amount of testosterone and she ended up with male levels of testosterone and was very distressed by that. And that was not my practice, she came to me after the fact and I had to sort of mop it up. So Eva, she's back again. She's looking happy and chirpy after her webinar. She wanted to pursue natural treatment and that's absolutely understandable. She did have a three month trial of black cohosh, but at the three month review, her bothersome symptoms persisted.

So we talked about a trial of body-identical hormone therapy. She had an oestradiol patch twice weekly and micronised progesterone at night. And then at the three month review, happily enough, she did have the scant bleeding and breast tenderness, but it settled in the first month. She had a little patch site irritation. And when I looked at it there was some welts and it was getting a bit red and I thought, well, she probably wasn't absorbing it very well or on the cusp of not absorbing it well, was going to get a nasty reaction. But she did have pretty good symptom control, hence we changed that to a daily oestradiol gel and a micronised, she kept going on the micronised progesterone. And she was happy without her symptoms that bothered her. So I'm very happy to have spoken to you all. I'm sorry about the start, and I think we've rallied there and I think there are lots of questions.

So I will just show you before that, there are some excellent resources. I know Tracie has alluded to those, but the menopause tool is really, it's been really well considered and it's a lovely foldout tool. You can get it online of course, and it's got lots of different situations there for if you're struggling for, 'What do I do in this situation?' The Practitioner's Toolkit for the Management of the Menopause is excellent. Sue Davis and team constructed an algorithm whereby you can go through, 'Oh, she's got this and oh, she's got that, and oh yeah, we'll use that.' So that's very good as well. And this is the Australasian Menopause Society Guide to Equivalent Hormone Therapy Doses. So it mentions them by dose, it mentions them by PBS, it mentions combined products and it mentions oestrogen-only and progestogen-only. Therefore, it's a very, very useful tool. You can get it online, you can have it in the desk. And I think that if you're struggling, especially at the moment with all these hormone therapy shortages, you can easily go to the tool and say, 'Ooh, I can actually use this. This is moderate dose and that product is available.' So I think that's very useful. There's lots of information out there, Jean Hailes has made it our mandate to have that information. I'm thanking you for listening to me and I'm very happy to try and tackle your questions. Thanks so much for having me.

**Host:** A couple of the questions that came in before this evening were around managing mood changes around menopause. Have you got—

**Dr Sonia Davison:** So just be aware, if someone comes and there's nothing new in their life and their mood is different, they're anxious or they're cranky as, or they've got a low mood, just consider that this might be due to hormonal changes. Some women are very offended. People are easy to take offense when you hand out an antidepressant. And some of them will explore then, is they're a hormonal reason? And some of them will do really well on some form of hormone therapy or the Pill if they're perimenopausal or another form of hormone. But also anxiety and depression are common at this age. And again, even though they might be offended by it, the SSRI group or similar antidepressants might be useful and needed. And the right strategy.

**Host:** Is there a bone-preserving dose of MHT?

**Dr Sonia Davison:** So it's really tricky because Henry Berger was a good one to talk about this. He said even very, very, very low doses of hormone therapy can protect bones, and what we're doing with bones, we're stopping bone loss. Bone always grows and it falls away. So we're just really trying to stop this bit of bone will slowly grow. So really low doses theoretically can do that. But I think the reality of it is, if you are looking at hormone therapy treatments and you're looking at bone specifically, I will always do a bone density scan a year after starting hormone therapy and then I'll assess if, clinically, there is a relevant change. If bone density is steady, that's still a win because they would usually have reduced bone density over that time. But if they're not really doing well, if they're losing bone density, they're just obviously not on enough. But even low doses of hormone therapy can turn this off. Yes.

**Host:** Okay, thank you. And there's another one on focal migraines. So they're asking is oral HRT or MHT contraindicated, can we use an oestrogen patch? There's a few people that have asked that, that one.

**Dr Sonia Davison:** So there's a big difference here with doses. So the Pill is a really big dose of oestrogen and progesterone to just replicate a pregnancy and turn off our natural hormone production when we're sort of premenopausal. But hormone therapy is actually a much lower dose and we can use hormone therapy when there's been a history of migraine or when there's current migraine. There's an excellent information sheet on the Australasian Menopause Society website targeting this, menopause, migraine and hormone therapy. And it nicely goes through what happens at perimenopause as well. So you can definitely use hormone therapy. I would probably go, if it was really atypical migraine and aura, et cetera, I'd probably use transdermal hormone therapy as my first line.

**Host:** And I'll just remind everyone, we do have a great webinar in our webinar library around MHT migraines as well. So I'm not sure about this one, but how do you deal with bleeding SEs or MRT? Does that make sense? I'm not sure what SEs are.

**Dr Sonia Davison:** Side effects, bleeding side effects, or—

**Host:** Is that what it is, yeah, okay. Could be. Bleeding side effects with MH, MRT.

**Dr Sonia Davison:** So it really depends on the woman. Some do want to have a withdrawal bleed and don't mind about it. Some will have flooding, some will have excessively heavy bleeding. And you think when they keep coming back, how do you manage that? I love to have a Mirena in for those ladies or to get them an endometrial ablation. Some women will actually just need a hysterectomy and it's sort of hard at the moment to do that. And some progestogens are better at controlling bleeding than others. So those older progestogen are a little bit better at controlling bleeding. And so I would try and increase the progesterone dose, I would change the progestogen, I would get a gynaecological ultrasound and I would probably enlist my gynaecological colleagues to help me with that.

**Host:** Okay. I'll just answer a few more if you're okay, Sonia?

**Dr Sonia Davison:** Yep. All good.

**Host:** Is there a maximum time of using MHT? So I guess that's—

**Dr Sonia Davison:** Well, I've always got these stories of ladies who are in their eighties and they say, 'Sonia, I want to be on my hormone therapy.' And I say, 'Well, do you know what? You're 80, you're on low dose transdermal hormone therapy. I don't think there's a problem in continuing.' It's like, one lady came along, she was 87 and she had, sort of, liver failure and renal failure. And I said, 'Do you know what? I don't think you need the added extra risk of the hormone therapy anymore.' I felt a bit cruel, but it's about the situation and it's about health. I've got lots of 80-year-olds who are bouncy and healthy and insulted when I ask if they've retired. So I would be using the lowest dose transdermal hormone therapy for the right reasons, for absolutely the right, and make sure they're up to date with screening and all that other stuff.

**Host:** Okay. And please, have you got any comments around MHT and the prevention of dementia, if there's any research?

**Dr Sonia Davison:** So it's really a mixed bag. To know really about dementia, you need to do the studies from the forties, probably, up until the seventies, and we're never going to get those studies done. You just can't do them and it would be too expensive, too risky and whatever. It's a mixed bag. There are cognitive changes which are quite marked around perimenopause. They are amenable to hormone therapy and they tend to usually settle with menopause. Some women will benefit cognitively, they'll have less brain fog, et cetera. They'll feel better on hormone therapy and they'll sleep better, so therefore they'll get a cognitive benefit. But if we're doing this for prevention of dementia, apart from the ladies with premature menopause, I think that's a little bit out there. But I can't go against the concept because in premature menopause it does give cognitive benefit and prevents against cognitive decline.

**Host:** Okay. When do you change from cyclic MHT, oh, hang on, someone's got the question. When do you change from cyclic MHT to continuous MHT if starting a perimenopausal patient?

**Dr Sonia Davison:** So it will depend on bleeding and I'll always ask about bleeding and has it lightened up? And if the bleeding lightens up on sequential hormone therapy, that's usually a sign that they might be closer to menopause. They might be closer to their own body saying, 'I don't need to bleed anymore.' And that's a good opportunity to try and use a continuous combined product. And some people on a sequential product will just stop bleeding anyway, and that's an indication that they can go onto the other. So it will really just depend on the lady, but you just give it a trial at some point and it might be a success. And it might be a failure, and then you just go back to the other strategy.

**Host:** Thank you. In women that cannot have the Pill but have started MHT and also need contraception, how do we manage the oral progesterone if Mirena is not used? Can POP be the progesterone component?

**Dr Sonia Davison:** So is this in perimenopause, I suspect? Is that right?

**Host:** They haven't listed. Ruth, I don't if you want to pop that in the chat box, if you're talking perimenopause. I'm assuming you would be, or the contraception. I'm not sure.

**Dr Sonia Davison:** So we can't rely on the progesterone-only Pill. Someone asked me about Kyleena the other day, the new, sort of, mini Mirena. We just don't have the study data to suggest that that's adequate progestogen cover for hormone therapy. So the Mirena, definitely, you're covered there, but I would be using a hormone therapy progestogen rather than the progesterone-only Pill if you're adding oestrogen. And the same with the Implanon, I've been asked that as well. I would not be relying on an Implanon on as the progestogen for hormone therapy purposes.

**Host:** So when you say 'high dose in premature menopause', can you please give us an example of dose? Can you answer that one or?

**Dr Sonia Davison:** Sure. So if you think of that typical average level that reproductive women have, they have an average level of oestradiol of about 400. And I'm not saying that you have to measure oestradiol levels. The patches typically are associated with about 150 to 200 at the most. Sometimes you'll inadvertently do an oestrogen level on the patch and find it's not even detectable. You'd probably want a 50 plus Estradot patch and around 100 would be ideal. But some women will just not tolerate it. I just wouldn't want to be lower than 50 and I'd want to be higher than that if I could be. But remember that for premature menopause, the Pill may be a good option and they're getting lots of oestrogen from that. It just will depend on tolerance really.

**Host:** Okay, thank you. There's two questions that have just come in from this person. How is cardiovascular disease risk a contraindication for MHT? That's the first question, and

**Dr Sonia Davison:** I'll tackle them one at a time.

Cardiovascular risk, it's a mixed bag. If a lady comes to me and she's 50 and she has a family history of cardiovascular disease, well, I think she'll actually get some cardiovascular protection if we use hormone therapy around the time of menopause. Because there was a neat study called ELITE, which looked at women who were about 13 years out from menopause and they had no harm in taking hormone therapy, in terms of the cardiovascular risk markers, but they also looked at women very close to menopause and found that there was actually a benefit. There was a reduction in their cardiovascular risk markers if they took hormone therapy close to menopause. So I'm always thinking on the other side of it. And if you look at the studies, actually there is a cardiovascular disease risk benefit, but it just possibly depends on the hormone therapy and when they start it, if you're starting up when the arteries are stiff, probably from 65 plus, then you might be in trouble. But if you've been on it from 50 years up until 60, you've probably had a cardiac benefit. And the second part of that question is, I'll wait for that.

**Host:** It's a very different question, but it goes back to the beginning of the evening. Is premature menopause the same as premature ovarian failure?

**Dr Sonia Davison:** No, because you might have premature menopause because your ovaries were removed because of endometriosis treatment or cancer treatment or whatever. Premature ovarian insufficiency or failure, there's lots of words there. And 'premature ovarian insufficiency' usually means menopause that's premature from autoimmune or other causes. So it's not really easy to understand. But I think the main thing is, if you know that whatever reason that oestrogen is not being produced, and usually you don't find a cause unless you know it's from cancer treatment or radiotherapy or whatever, that menopause less than 40 years is premature menopause. And some of those women will have premature ovarian insufficiency. It's not, it's a tricky, I know it's very tricky, fraught with hazard. But, guess what? There's some really lovely information on the Jean Hailes website and also on the Australasian Menopause Society website, and I refer you right to there.

**Host:** How long would you leave the Mirena in for the purposes of treating menopause symptoms? Someone said five plus or minus two years.

**Dr Sonia Davison:** Right. So if a Mirena is in and there's hormone therapy being used, you can keep the Mirena in for five years and the hormone therapy can continue for five years. If they stop the oestrogen, the Mirena can still stay in and can still stay in up to seven years without causing any problem or harm. But we are not relying on it for endometrial protection if we're still on oestrogen after five years. So I will always, if the Mirena's in, and that's been a really good strategy for the woman, I will just get another Mirena. But what I've been doing recently, if they're really postmenopausal and the Mirena was put in at the perimenopausal phase, I will then introduce another progestogen to see if they tolerate it, just when the Mirena is coming up for renewal or removal. If they tolerate the other progestogen, then I'll have the Mirena removed and they'll just continue on the other progestogen and the oestrogen if they need it. And then if there's bleeding that's bothersome and they prefer the Mirena, then I'll just refer them off to have another Mirena.

**Host:** Okay. So last question for tonight. Would you use MHT if the woman only has significant mood disturbances with no vasomotor symptoms, hot flushes, sweats?

**Dr Sonia Davison:** Yes.

**Host:** Oh, that's easy answer.

**Dr Sonia Davison:** It depends. Well, do you know what? Some ladies you refer, as a group, you refer ladies to me who are terrible, who are suicidal, who can't function, can't have relationships, can't go to work, and they're desperate. And those women, hormone therapy can sort of save them. And some ladies walk in and say, well, when they used to walk in say, 'My life has changed, I can function.' And the three words that are really important in menopause generally are, 'I feel normal.' So if a woman has come to you with symptoms and she says those three words, it always just puts a 'yes' moment for me, because feeling normal is really, really important. And as I said, this is about quality of life, wellbeing, sleep, doing the things that you always did and not letting menopause bugger those up.

End of transcript

Information about the podcast

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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