Conscious Life presents

Menopause Unmasked

Guest: Fionnuala Barton

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[00:00:09] Dr Anu Arasu

Welcome everybody, I'm Dr Anu co-host of the Hormone Super Conference. Today I'm joined by Fionnuala Barton. Dr Fionnuala is a GP, and she's also a British Menopause Society registered practitioner. She is passionate about educating women about making informed choices when it comes to perimenopause and menopause. Welcome Fionnuala.

Dr Fionnuala Barton

Hello, thank you Anu. Thank you ever so much for having me, it's a real pleasure.

Dr Anu Arasu

Thank you so much. Let's start with the basics and the terms, what is perimenopause versus menopause versus postmenopause?

Dr Fionnuala Barton

That's a great place to start because getting our definitions right can really help us to understand what we're going through, and therefore what options we've got available to us.

As a starting point, menopause is defined as the point at which we haven't had a period naturally for twelve months. It's a finite point in time, one day in your life where it has been twelve months since the last period. Now this isn't always abundantly clear. If you have been using forms of contraception, for example, that stop you from bleeding, or if you've had surgical procedures that mean that you don't bleed on a regular basis, then it can sometimes be tricky to work that out exactly. But ultimately, that's where the point of menopause is.

Anytime after that is often described as menopause, or postmenopause after the point of menopause. This is when we have very persistently low levels of those important ovarian sex hormones, because the ovaries have come to the end of their ovarian potential, and are no longer producing those sex hormones in sufficient quantities.

[00:01:49] Dr Fionnuala Barton

Then we have perimenopause. This is a relatively new term that has been coined recently and is gaining a lot of attention, that's because it's this phase that is often most difficult for many women. This represents the period of time in the run-up to the point of menopause, for that reason it can be pretty ill-defined, it can be pretty nonspecific, it can be difficult to pinpoint, and can represent quite troublesome, diagnostic uncertainty, and it can be turbulent.

Some women, on average, will experience perimenopause for between two to six or eight years before the point of menopause. But we know that some women might experience perimenopausal symptoms for almost up to 15 years before their actual point of menopause. The reason for this is the underlying biological changes.

As I've mentioned at menopause the ovaries have no longer got follicles left to ovulate. Therefore, we're not producing those important sex hormones at all from the ovaries. In perimenopause, women may still be ovulating on a regular basis, or indeed ovulating on an irregular basis. This means that they are still having cyclical changes, but that they might be irregular cyclical changes. In those cycles, they might be producing insufficient amounts of the necessary hormones to support normal cellular function in the body.

When we think about our sex hormones, estrogen, testosterone, and progesterone, the cells of our body have been reliant on these three important hormones for normal function, for most women decades between the point of them starting their periods in puberty, to then the point of their periods ending at menopause.

If the cells of the body, that have been using those hormones to date, no longer have sufficient amounts of them, or indeed have excessive amounts of those hormones swinging around, then sometimes it can wreak havoc. Often there is a crescendo, as you start in perimenopause things can start to become a little bit uneasy, and then as you move through perimenopause to the point of menopause, things can often get considerably worse before they start to settle postmenopausally. Or certainly, that's my experience clinically.

Dr Anu Arasu

Fantastic. What might people experience in terms of symptoms in each of these three different phases?

Dr Fionnuala Barton

These three important sex hormones... Hormones by definition are chemicals produced in the body that have an impact throughout the body, they're produced in one organ that has an impact throughout the body. We've got loads and loads of these hormone systems in the body, and all of those hormone systems interact.

It makes it quite a complicated picture, it's very easy to be overly simplistic about the changes that occur during perimenopause and menopause, but it's important to stand back from that, and appreciate that these changes in the sex hormones have impacts on other hormone systems as well.

[00:04:54] Dr Fionnuala Barton

Not just that, all the cells of our body are using these important hormones to enable normal cellular function throughout our reproductive years. When these levels start to fluctuate, change, or decrease during perimenopause, we experience symptoms from head to toe, that may be heightened or maybe reduced, due to changes in cellular function.

Postmenopausally, when those levels of hormones are persistently low, then that's when we see a persistent low level of activity in the cells that have previously relied on these hormones. To summarize, you can get symptoms in the central nervous system, you can experience headaches, you can experience mood changes, cognitive dysfunction commonly called brain fog, which might manifest as difficulty concentrating, a sense of easy overwhelm, problems with memory recall, and word finding is really common. Difficulties executing complex tasks, or forward planning in many ways.

You can also experience low mood, sometimes without obvious reason. Anxiety swings in mood, you might feel absolutely fine one day, and then feel absolutely awful the next. This is what can be so discombobulating, to say the least.

Panic attacks are quite common, as parts of the brain responsible for our emotional response have different levels of hormones regulating them. Then we can see changes to things like our eyes, our eyes can get dry, and our vision can start to change. Estrogen is a very potent hydrator and anti-inflammatory. If you lose hydration in the eye, it can give rise to a number of symptoms, equally in the mouth, and in the entire gastrointestinal tract.

These hormones have an important regulatory function in terms of, making sure our gut microbiome stays in decent balance, also our gut mucosa is working well. If our microbiome goes out of whack, or our mucosa isn't working very well, we're much more likely to experience symptoms like gut sensitivities to new foods, leaky gut symptoms, bloating, changes in bowel habits, these kinds of things. Which again, are a really common complaint both in perimenopause, when things are chaotic, but also postmenopausally.

We can experience symptoms in our cardiovascular system. Estrogen, as I've mentioned, is a potent anti-inflammatory, it's also very useful for maintaining normal levels of cholesterol in the bloodstream, and it's a useful relaxant. It helps to maintain good blood pressure, and it helps to reduce cardiovascular risk. It's also important in terms of regulating rhythm in the heart, et cetera.

When levels are fluctuating, women might see palpitations experiencing, or they might start to experience chest discomfort symptoms. They may see an increase in their risk of cardiovascular disease, or their blood pressure might start to go up.

We've got symptoms in our joints, joint pain is an incredibly common symptom and often it's persistent joint pain postmenopausally, and it might be intermittent joint pain during the perimenopausal years. It's often associated with swelling or stiffness, and can often impact a person's ability to enjoy their life, enjoy the activities that they've usually been doing, fulfill their work obligations, or complete tasks at home. Which in turn can have a massive impact on how we feel, our self-esteem, and our worth, et cetera. There's all these complex links moving together.

[00:08:36] Dr Fionnuala Barton

Skin is one of our biggest immune organs, and having healthy skin is a really important part of our immune system. It's also a really important part of our identity, who we are, and how we present ourselves to the world. When we've got fluctuating levels of hormones in perimenopause, and deficient levels of hormones postmenopause, we see a profound number of skin changes, as well as hair changes.

We're more prone to acne or rosacea, which is this inflammation of the skin. The skin gets dry, it gets dehydrated, we get more water loss from the surface of the skin, we get more inflammation, we're more prone to dermatitis and eczema, and those skin conditions, which can be tricky to keep tabs on. And like I said a moment ago, then the impact of that, not only is it disruptive to your skin and your immune system, but can have a profound knock-on effect on your confidence and your self-esteem.

I could go on, there are symptoms that you might get anywhere in the body. You put an arrow anywhere on the body, and you can pretty much think of a symptom that might start there.

One of the other ones that I feel quite passionately about is this, as well as brain function, and central nervous system function. We rely on our central nervous system to keep us integrated in the world, doing things normally, perceiving things, interacting, responding, et cetera. Sometimes in perimenopause if hormones are fluctuant, they're having a knock-on effect on our neurotransmitter levels, these are the chemicals that are firing messages around our nervous system, then that can have a profound effect. We can start to see problems manifesting as a result of that. I think we're going to dig into that in a little bit more detail later on.

Dr Anu Arasu

There's so much going on underneath the surface, and you touched on so many points. I'm going to ask you about two more, which I think are such big ones for women, osteoporosis and weight. What would you say about those two?

Dr Fionnuala Barton

I think these are both really important points. The one thing I didn't even mention there was it's a multisystem situation, because of the nature of the underlying issue. Of course, many women will experience menstrual changes because of the impact of those hormones changing on the endometrium, and the fact that they may be ovulating, or they may be not ovulating. After menopause, they're not ovulating at all, that is something that's important to bear in mind.

One of the myths around perimenopause is that if you're still having regular periods you can't be in perimenopause. I would just say that that's not true, you can be perimenopausal with having regular periods still because you might just not be mounting the same hormone response with each cycle.

In answer to the question, or your point about weight and osteoporosis, I'll take them one by one, if that's okay. If you're at a stage where you're experiencing symptoms that you think might be due to underlying sex hormone changes, then you're perceiving something that's happening in your body. It's obviously at a level that it is perceptible.

[00:11:40] Dr Fionnuala Barton

There are a number of changes that are happening with these hormone fluctuations that are imperceptible, and these are changes happening to your bone mineral density, and in many ways to your cardiovascular system. You're not going to feel your blood pressure increasing. You're not going to feel cholesterol being laid down in your blood vessels. You're not going to feel a change in your bone mineral density.

But if you're experiencing symptoms, it's likely that you are also experiencing changes on a cellular level in these two important systems. This may increase your risk of having lower bone mineral density, which increases your risk of osteopenia and osteoporosis, which are two conditions that will increase your risk of fracturing if you fall.

That doesn't necessarily sound like a big deal to a lot of people, but if you're living a dynamic, busy, chaotic life, you fall over and you break your hip, you're out of action for several weeks, and you might never fully recover normal function again. It can be devastating. Not just hips, fingers, toes, wrists, the number of people I speak to who've stubbed a toe and it's broken, because we're at this stage in our lives, and it does take you out of action for a considerable amount of time.

We know that having normal hormone levels is important for good bone mineral density. What's also really important for good bone mineral density is a diet that's rich in calcium, has adequate vitamin D levels, which we don't very much get from dietary sources, we more often get our vitamin D through sunlight exposure to the skin.

The research indicates that we need about 10 minutes, 10 to 15 minutes per day with head, neck, and arms in the sun, to the extent that they feel warm, to get adequate vitamin D levels naturally. But in many places in the world that's not feasible on a daily basis, particularly in the UK in winter, and in many other places across the world.

Also, we have to be mindful of our skin cancer risks, a lot of people have got SPF all over their skin, whenever they go out in sunlight, to avoid the risks of aging from the sun, or skin cancer from the sun. And culturally there are a lot of people who don't wish to show their skin. Or if you're somebody who is ultimately relatively housebound for whatever reason, and you don't get the chance to leave the house very often, those people are also at increased risk.

Vitamin D is really, really important, and if you're in an at-risk group, as well as being in perimenopause or menopause, vitamin D supplementation is something that I would really highly recommend for people.

Weight-bearing activity is the other really important key element of good bone mineral density, and reducing osteoporosis risk. This can be completely free, it just involves doing something and moving on a regular basis, that is, putting weight through your joints in different ways in order to trigger bone regeneration ultimately.

This is something that in our modern-day lives, people often lack, you might get up in the dark, drive to work in the dark, sit at your desk in the dark all day, get stressed, go home, eat dinner, and then sit on the sofa, watch tv, and then maybe go to bed. That kind of day isn't unusual, and in that kind of a day, you're not doing enough weight-bearing activity in order to maintain normal bone

mineral density. It's accessible, it's important alongside whatever other strategies you use at this stage of life.

[00:15:05] Dr Fionnuala Barton

Weight, we could talk for a whole hour just about weight. Gaining weight in midlife is normal, it is a normal part of aging. It's not necessarily favorable for us in terms of our health and well-being. And in many cultures, it's not deemed to be something to aim towards gaining weight. Our culture now very much celebrates not being overweight, which is fine because we know that having a normal body weight is conducive to lower rates of metabolic diseases, like type 2 diabetes, lower rates of immune and inflammatory diseases, lower rates of cancers, and also lower rates of things like cardiovascular and cerebrovascular disease.

We know that it's better for us not to gain weight, but aging means that we tend to. We have an opportunity at this phase of life, in perimenopause, if we start to notice that it's different managing our weight to how it used to be, we might need to make some changes. The reason that we do start to gain weight as women during this phase is quite clever, in many ways, it's your body's adaptation to changing hormone levels.

Your hormone levels are changing, and your body is saying, we don't have as much of these ovarian hormones hanging around anymore, because the ovaries aren't working so well, I know what I'll do, I will upregulate fat cell production, because fat cells can produce things like oestrogens and testosterone. It's a very clever adaptation, but it's not necessarily advantageous for us in the long term.

Those fat cells tend to be deposited around our intra-abdominal organs, sometimes called visceral fat, but also in our intra-abdominal, and under our intra-abdominal skin. We tend to see this central weight gain, this belly developing. It can be very difficult to lose that if it piles on, and piles on, and piles on without adequate action. There aren't any hard and fast solutions to it, but I think it's something that's really important that people are alert to.

It can be subtle, as I've mentioned perimenopause can happen insidiously, it can happen subtly. It relies on people being alert to all the different things that might point towards this change happening under the surface, in order that you can pause and say, what can I do proactively to help maintain good health at this stage of my life? Part of that is going to be strategies in order to maintain weight.

There's a lot of different strategies that you can use. What I would say is everybody is individual, and some things will work brilliantly for some women, and some things will not work brilliantly for others. It's about finding what works well for you within the confines of your lifestyle. Very easy for me to wax lyrical about a healthy diet, exercising five times a week, and thinking about intermittent fasting, and cutting out alcohol. But a lot of the pressures that we live under currently mean that women aren't able to access even those basic changes.

That hasn't necessarily answered the question specifically, but I hope it's been a good pause for thought about the weight issue.

[00:18:14] Dr Anu Arasu

I loved that description of the body trying to help by conserving fat because the fat cells can make estrogen. Certainly, some women find when they're replacing their hormones, if they get that balance right, that can help their weight shift.

You mentioned a bit earlier about myths, one of the myths being that if someone's having regular periods, it doesn't necessarily mean that they can't be in perimenopause. What other myths do you commonly come across?

Dr Fionnuala Barton

One of the ones that I come across very frequently as a relatively young woman in perimenopause, working in the menopause and perimenopause space, is you're too young. This infuriates me for so many reasons. As I've mentioned, perimenopause can start up to 15 years before the point of menopause. The average age of menopause is around 52, or 50 to 52. But that might be coming down as population studies suggest that for whatever reason, that average age is starting to come a little bit lower.

Part of the underlying biology of perimenopause is this change in ovarian reserve. We are born with a finite ovarian reserve, and from the point that we start, from the point that we're born, we start losing follicles from the ovaries. Then from the point that we start having periods, we're losing quite a few follicles on a monthly basis throughout our reproductive years. At some point, we start to lose those at a slightly accelerated rate, and that tends to be around our 30s. This is why we are told that our ovarian reserve, and our fertility, start to decline quite dramatically from our 30s onwards.

It stands to reason that if it is the same biological issue underlying the change in fertility in our 30s, as it is the change in hormone levels in perimenopause, I think this is something that women in their 30s need to be aware of, and need to be thinking about, how can I proactively identify and then manage this situation?

I've got plenty of patients who come through the clinic, who have gone to their doctors with a myriad of symptoms, and quite rightly, they have explored what other issues might have given rise to those symptoms. As I said it's a multisystem issue, so it's really important to rule out other causes of all of these symptoms. But if all of those tests are negative, they've then been told, "Well, you're too young to be perimenopause, or you're too young to have HRT."

This is one of the myths that really, really gets to me, because there is no such thing as too young to be concerned, and to be proactively managing your hormone health. Particularly, as we know, when hormone levels are declining, we see an increase in our cardiovascular disease risk and an increase in our osteoporosis risk.

There is more and more evidence building to suggest that declining sex hormone levels also increases inflammation, and has an impact on our metabolic health, two big areas of disease that can cause untold problems as we age. It is something that I feel really passionately about proactively looking at. The solutions, as I said earlier, are all going to be different for different people.

[00:21:24] Dr Fionnuala Barton

This is a useful point to talk about slightly different forms of menopause. There is something called premature ovarian insufficiency, historically called premature menopause. This can happen very frequently to women of any age. I have teenage patients who have premature ovarian insufficiency, their periods either started and then stopped within a few years, or their periods never started.

This is something that affects women of any age. 1 in 100 women under the age of 40 will experience premature ovarian insufficiency or premature menopause. 1 in 1000 women under the age of 30. These are big numbers. It's important that we're all open to this as a possibility as clinicians, and that patients and women are aware that this might be something going on in their lives, too.

The other specific types of menopause are medical and surgical menopause. These can happen at any time also. If you've had lymphoma and you've had to have chemotherapy and radiotherapy for that, or any other type of cancer treatment, that can have a significant effect on your ovarian reserve, and your ovarian function moving forward.

If you've had a disease, a gynecological problem, that has necessitated a hysterectomy and oophorectomy, where the ovaries have been surgically removed from the body, you are instantly plunged into the depths of profound menopause. That happens at any age for a whole range of reasons, so again there's no such thing as too young.

On the point of surgical menopause, patients who are facing an oophorectomy need to talk to their clinicians and their surgeons, "What hormone therapy am I going to be on? Am I going to be on it immediately post-op? And do I need to be on high doses?" Because these are really important elements of how they're going to recover from that surgical procedure.

Women who have an early menopause, or a surgical menopause, who are using hormone replacement therapy, or menopause, or hormone therapy, are advised to stay on that therapy until at least the average age of menopause, so that they are not losing out, at a disadvantage, to those people who haven't gone through that early. Does that make sense?

Dr Anu Arasu

This is such a helpful point to be flagging up, because a lot of the debate, the talk, about menopause is when the periods naturally end, and sometimes there's this sense of, oh, but isn't it a natural ending? What you're putting attention on is quite how common it is, or how common it can be, for menopause to happen so much younger. At that time menopause is a real issue, and it has to be treated and addressed properly. So I thank you for that myth buster, that's incredibly helpful.

Dr Fionnuala Barton

Another one I just wanted to add, that I won't go into quite so much detail on, is that you are too old. Another problem I see in the clinic very frequently is, "I'm 60, I had HRT for a couple of years, but was told I needed to stop it because it was risky. Am I too old? Is it too late?" The answer to that question is no.

[00:24:25] Dr Fionnuala Barton

Women of any age can be considered for hormone replacement therapy, or menopausal hormone therapy, for the management of symptoms on an individualized basis. We need to take into account the benefits of medical treatment versus the risks. That is something that is very, very individualized.

This is something that has changed recently. What we know is that postmenopause, when our cardiovascular disease risk increases as our hormone levels are low, we have about a 10-year window of opportunity to optimize cardiovascular disease risk by initiating HRT. If you've got somebody who had their menopause at 55 and comes to you age 60, saying, "I'd quite like to consider HRT." It's in their interest, even if they haven't got a huge number of symptoms, because it's going to help with their cardiovascular risk, which is a huge risk for women in general.

Even outside of that 10-year window of opportunity, there are still advantages for some women to be using hormone replacement therapy, or at the very least be considering proactive management of these issues. Even if it's not systemic hormones, sometimes things like vaginal estrogen, or vaginal DHEA, for example, can be really helpful in improving pelvic health symptoms as we age, which reduces our risk of cystitis and UTI.

As you probably know, UTI is really common as we get older, sepsis from urinary tract infections is really common as we get older, and it can be profoundly difficult, and it can be very dangerous for women as we get older. So there is no such thing as too old either.

Dr Anu Arasu

If women are doing well on their hormones there's no arbitrary time that they need to stop. Earlier on you mentioned the nervous system, and that related to hormone changes, can you tell us a bit more about that?

Dr Fionnuala Barton

Our sex hormone system, as all of our hormone systems, is interconnected. One of the other hormone systems that our sex hormone system is connected intricately with is our stress hormone system. We often call our reproductive hormonal system the HPG, or hypothalamic-pituitary-gonadal axis. There's also the hypothalamic-pituitary-adrenal axis or HPA, it's that system that governs our stress response.

The two communicate really closely and interact and affect each other closely. An example of this is we haven't quite evolved out of this stress response. Having a stress response is very normal, it's protective, and it helps us to avoid danger, and get out of harm's way. When we see something that is stressful we mount a biological stress response, we have adrenaline, cortisol, and other hormones flying through our system in order to fight, flight, freeze, flee, or get to safety. That's what prevented us from being eaten by tigers when we were cave people.

Via this same process, when our stress hormones are high, that messages to our sex hormone axis that it now might not be a great time to fall pregnant, or to carry a young child. So high stress hormone levels directly impact the part of the brain that then controls ovulation. Sometimes we see a downregulation in ovulation in times of stress. For example, in times of famine often women

will stop having periods because it's not going to be evolutionarily advantageous for them to be pregnant, or have a small child at that time.

[00:28:04] Dr Fionnuala Barton

We haven't evolved out of this important evolutionary primitive reflex. Our modern-day lives, constantly switched on, constantly being exposed to things with super high expectations of ourselves. Women have been told that we can do everything, and not only do everything, we can do everything brilliantly. And actually, it's really hard.

If our stress hormone levels are constantly switched on, and we're firing off all these stress hormones, which in turn are having an impact on our neurotransmitters, the chemicals controlling our nervous system, then it can have a direct impact on our sex hormone levels and vice versa. We see this interplay between the two systems.

We know that our sex hormones are really important for producing sufficient amounts of important neurotransmitters, things like serotonin, noradrenaline, and dopamine, to name a couple.

If our sex hormone levels are out of whack, we don't necessarily produce these neurotransmitters as effectively, or we don't help these neurotransmitters work as effectively. That can manifest in central nervous system dysfunction. In the same way that when we're stressed, we might feel pins and needles, we might feel jittery, we might experience headaches, mood changes, or cognitive dysfunction, the sex hormone changes can contribute to that.

If you're somebody who has a predisposition to having a slightly jangled nervous system. If, for example, you're what might be termed sensory sensitive, or if you're somewhere on the neurodiversity spectrum, whereby you are more sensitive to certain things, those fluctuations in sex hormones during perimenopause, and then the frank deficiency of those hormones, either after natural menopause, or medical, or surgical menopause, can have a profound effect on the way that your nervous system works.

I see this quite commonly in the clinical setting. Currently, there is a big discussion around ADHD, and in particular, undiagnosed adult female ADHD. Because women generally are very good at masking things like ADHD symptoms, and a lot of women are coming to the clinic in perimenopause with a lot of these central nervous system symptoms, overwhelm, anxiety, insomnia, difficulty regulating emotions, et cetera, a whole myriad of them, and there's a real overlap.

The HRT that we often prescribe helps, and the lifestyle changes that I often recommend help, but often there's something else that isn't quite going to plan. In these women, often they've gone on to then go and seek an ADHD or a neurodiversity diagnosis, which helps them to explain why things might have been a little bit harder for them.

I'm interested in this interplay between our hormone system and our central nervous system. Even if you don't seek therapeutic or pharmacological interventions for these issues, what's important is that you start listening to your body, and you start listening to the messages that your body is giving you.

[00:31:24] Dr Fionnuala Barton

If you're feeling overwhelmed, if you're physically jangled, if you're not sleeping, and if you're experiencing distress as a result of all of this, it's your body trying to tell you that it's not coping, and something needs to give. A lot of that is going to be resting, it's going to be working with your nervous system, not against it. As I said, in a world where we are constantly switched on, exposed, and expected to do and be, all of these things, it can be really hard to stop, to pause, and to say, "This isn't working for me, I need to do things slightly differently."

I really encourage as many of my patients to do that as possible. One of the easiest ways is to get out in nature, is to start connecting with the breath and learning to breathe again properly, because a lot of us don't do that very well. And really prioritizing calm, ease, and rest, which have a positive effect on our nervous system, which in turn will reduce the stress response, and potentially have a positive impact on hormones and vice versa.

Dr Anu Arasu

That's a fantastic link about the association between hormones, hormone imbalances, and neurodiversity because that's another tool in there for people to address what's becoming an increasingly common diagnosis.

Dr Fionnuala Barton

The women I see are often, they're supporting a child who's had a diagnosis and it's been really hard because their child has been challenging and that's okay, but it's okay to find things hard. They've noticed that there are traits that they're seeing in their child, who's then subsequently had a diagnosis, and they think, goodness me, this is something that reminds me of me when I was a child. Often it's through that lens that it's useful to start thinking about how we can support our own central nervous systems, and seek a diagnosis, if that's what's useful.

Dr Anu Arasu

You've touched on so many of the lifestyle things, or the struggles that people are having in their real lives when dealing with hormone imbalances, in your experience what situations do you see women come in with?

Dr Fionnuala Barton

Everything, this is why I love my job, I see women from all different walks of life, who've got very different backgrounds, who've got different ethnicities, who've had different challenges, who've had different reproductive journeys, and who are in different circumstances now, who also have a whole variety of different beliefs, and feelings, and thoughts about their experience, and where they want to be going.

There is just a huge breadth of experiences, and no two women are going to have the same experience, which is a big reason why there's no way we can ever say, "This is the toolkit that everyone needs, there is a one-size fits all magic potion to this." This is why I feel it's important that absolutes are left out of the perimenopause menopause conversation, because it can alienate

women if they hear people saying, "Well, this is the best way to lose belly fat," and it's not helped, it's made the situation worse for that human.

[00:34:42] Dr Fionnuala Barton

I think it's really important that we accept that because of our divine, wonderful complexity as women, perimenopause, and menopause can be really complicated. There is no simple solution that is going to work for everybody, and those solutions need to be individualized.

I've got some women who come in and they have gone through their early 50s, but their periods have stopped and they've got a couple of hot flushes that are disrupting them during the daytime, and maybe disrupting their sleep a little bit at night, but otherwise are well. There are strategies that will work for those women that might include HRT, that might include looking at their diet, reducing alcohol consumption, exercising more, thinking about stress management, and that's probably going to be relatively straightforward.

On the other end of the spectrum, we have more complex cases of women who might have a number of underlying, pre-existing medical issues, like endometriosis, rheumatoid arthritis, thyroid dysfunction, or a previous malignancy that's required treatment and that has been traumatizing, and there's PTSD. We do tend to be quite complex.

We know, there's some pretty good research to suggest that the perimenopause menopause experience tends to be more severe in those women who have experienced severe trauma. That's not necessarily big t trauma, it can sometimes be cumulative small t trauma, these microaggressions that people have experienced throughout their lives. Obviously, there are huge cultural differences between the microaggressions that different cultures have experienced throughout their lifetimes.

It ends up being this massive, huge scale range of experiences, and it's about having time to listen to a woman who tells you their story, to pick out the important elements that we can address, either through lifestyle change, or through medication, or pharmacological intervention, holding space for them, being supportive and allowing things to be okay.

A lot of the time we are under all these pressures that we must be perfect, and one must be okay all the time. I think this is the time of life where we can say it is going to be hard for some people, it's going to be harder for some people than others, and that's okay. But it's important that you seek help and advice because it doesn't need to feel horrible, it doesn't need to feel awful.

I know that's not a specific example, but I suppose I really just want to demonstrate how there is such a breadth of experiences. The take-home is what works for your friend may not be the right solution for you. What's important is thinking about the whole range of tools that you've got available, and finding what works best for you, in your own personal toolkit.

That's going to look at stress management, sleep management, diet, gut health, movement, as well as HRT, or MHT for some people. Or if that's not an option and medical intervention is still required, then things like antidepressant medications, or oxybutynin, or gabapentin. There are a number of other medicines that aren't HRT that can be helpful at this phase.

[00:37:56] Dr Anu Arasu

It's so rich, isn't it? There's so much power in us sharing our stories, and yet each of our experiences is so individual that we can't make assumptions, or assume that what's right for us is going to work for someone else.

The other thing I heard when you were saying that was, that essentially this journey that we're on, there's no blame because even if we're living well, we're eating well, we think we're doing the right things. What you're seeing is a huge diversity of women with different lifestyles coming in, who may all have terrible symptoms. There's a lot we can do, but there's nothing that we're doing wrong necessarily, that's causing the symptoms to happen.

Dr Fionnuala Barton

Absolutely. I think there needs to be no shame, there needs to be no blame. I don't like the term menopause, there's something... It's not a very positive word. I think one positive that you can take from it is pause. Take this as an opportunity to stop, and let life simmer around you for a little while, and for you to start internally thinking, what works best for me? What are my priorities? What do I need to do here in order to live the life I want to lead positively, with purpose into my future? That is going to be different for everyone.

Dr Anu Arasu

Yes. Fionnuala where can people find out more about your work?

Dr Fionnuala Barton

I have a small information platform on Instagram, so you can follow me @themenopausemedic. I'm also dabbling in TikTok, so please come and join me there if you like TikTok. It's the same handle @themenopausemedic.

I have a website, themenopausemedic.com. I can consult one-to-one patients who have a registered address in the UK, and we see patients across the UK via video consultations. I have a clinic in Hertfordshire, which is just north of London, where I see people face-to-face.

I'm hoping that by speaking in events like this, the small work that I do on the ground amplifies and we can reach a much broader audience, allow as many women as possible to benefit, feel back in control, and feel empowered through this stage of life, rather than feeling disempowered, and out of control, and unable to find a path forward.

Dr Anu Arasu

You certainly have empowered us with so much information today. Thank you.

Dr Fionnuala Barton

You're welcome, it's been a pleasure. Thank you, Anu.