In this article, a patient recounts her experiences of being diagnosed with the menopause, and considers the processes she had to go through to receive the diagnosis.

In April 2012, I hadn’t given the menopause a second thought. I was only 45 at the time, yet, just 12 months later, I had become completely consumed by it. I had not felt great since January; nothing I could put my finger on, I just felt tired all the time and had no energy. I reassured myself that lots of people felt the same when the days were long, dark and grey. Spring began to dawn and I felt worse, not better. I had always loved walking my dogs early in the morning, but even that had become a chore. My husband and I had just finished renovating our house and I was running two businesses so my days were always busy, but I began to find them exhausting. It wasn’t just my physical health that was causing me concern; I had started to feel anxious and emotional, and was finding it increasingly difficult to cope with everyday life.

My husband finally persuaded me to visit the doctor in April. When I saw her, I explained how tired and lifeless I felt and she suggested running some blood tests. When I got the results a few days later I was very anaemic. I had suffered with heavy periods and pains for years, and these would often confine me to the house for a couple of days every month – and had even impacted on my social life and holiday planning for as long as I could remember. A previous doctor had told me that the pain I had complained of in my abdomen, bowel and lower back was unexplained after nothing was found on a scan of my kidneys so I just got on with it. My doctor prescribed some iron tablets and told me to return if I did not feel better in a few weeks.

Well, I didn’t feel better. In fact, I felt worse. More blood tests were run and my doctor contacted me a few days later to explain that my CA125 test was causing some concern, as my level had risen from under 30 to over 80 in just a few weeks. I was familiar with CA125 as my mother had been diagnosed with ovarian cancer 22 years earlier. I was booked in for an ultrasound scan and the sonographer explained that I had several cysts on both ovaries and a large fibroid.

The next stop a few days later was an urgent appointment with a gynaecologist. My scan results and family history were discussed, along with my most recent CA125, which had now risen to 118. The consultant explained that it might be ovarian cancer, but there could be other possibilities and she wanted me to have an MRI and a CT scan to see if anything else was going on.
When we met again about 10 days later she explained that the other scans were clear and it had been decided that the safest option would be a total abdominal hysterectomy, including my ovaries and cervix. At that stage I just wanted the operation over and done with as soon as possible so that I could get well and get on with my life. I had my surgery a few days later, and the following day my gynaecologist visited me in hospital to explain that the surgery had been more complex than expected due to the adhesions caused by my severe endometriosis. However, having seen the ovarian cysts, she was as sure as she could be that my surgery had been performed just in time. All I had to do now was to wait for the lab results and concentrate on getting well.

About ten days later my results arrived from the lab and I learned that along with the endometriosis and fibroid I had been suffering from adenomyosis, but the most important point was that no malignancy had been found. I considered myself to be very fortunate and thought I had cracked it. How wrong you can be!

The hot flushes began almost immediately, but were not too bad to start with; I had read a lot about surgical menopause and the physical symptoms to expect. The gynaecologist had advised that I should see my GP two weeks post-surgery to discuss hormone replacement therapy (HRT). When I saw my GP and she suggested it I told her I didn’t want it; I had read that HRT was derived from pregnant mares’ urine and as a horse owner and animal lover that was never going to be an option for me. My GP didn’t ask me why I didn’t want it and I didn’t explain why. I told her that I was hoping to use natural alternatives and although she told me she didn’t agree, she didn’t explain why or offer any alternatives. I visited a natural menopause clinic about six weeks after my surgery and was prescribed several herbal remedies and assured that they would help with my symptoms. Initially, things seemed to go well; I was back at work and looking forward to Christmas and the New Year.

In January 2013 things went very wrong very quickly; I simply fell off a cliff. I seemed to lose my confidence overnight, I became increasingly anxious; my heart would pound, I couldn’t sleep, and my husband had his sleep disturbed every night. I became very emotional and eventually things became so bad that I was scared to go to bed and scared to wake up. Sometimes I felt so heavy that I just could not get out of bed and on my worst days it would take me three hours to get from the bed to the shower, no more than a few feet away. I had never experienced depression before, but each day felt darker than the last, and dragging myself through them felt like wading, waist deep, through treacle.

When my insecurity became overwhelming; my husband had to ask my mother to come and stay with me while he was at work. I would often wake in the early hours of the morning with my heart pounding out of my chest, and to avoid disturbing my husband I would finally managed to sob my way through the details of my husband booked an appointment with my GP for that night. When I finally managed to sob my way through the details of the last few months, she was very kind and said: ‘Ok
“so you have tried it your way, would you let me help now?” I was desperate for her help, but explained through the tears that I couldn’t take HRT because of the way that it was made. My GP explained that I had now run out of any reserves of oestrogen that had been stored in my body and that no amount of herbal supplements could possibly replace it. She told me there was an alternative type of HRT called body identical which was plant derived that I could have in patch form. I cannot put the feeling of relief in to words, knowing there was something that I could try. It was only a few days later that relief turned to disbelief that I had not been given that information sooner. Why had nobody ever thought to explain my options to me before or after my surgery?

It took just 48 hours for me to start to feel better, the improvement was dramatic, the clouds lifted and I quickly began to feel like me again and an increase in my oestrogen dose after three months had me feeling back to my old self. All went well for several months, but I began to experience broken sleep, heart palpitations and anxiety. During my research I came across some information that indicated that as a woman who had been diagnosed with severe endometriosis, I should not be taking unopposed oestrogen as there was a risk of stimulating any remaining endometrial tissue. GPs that I saw over the next few months refused progesterone on several occasions and sent me to see a cardiologist twice for the palpitations. My heart got a clean bill of health on both occasions. Eventually, I insisted on a referral to a specialist menopause clinic, even though I had to wait four months for the appointment. The menopause doctor listened patiently to my story and then pronounced that progesterone was ‘a horrible hormone’ and she would not prescribe it. I was offered a blood test to check my oestrogen absorption and the doctor suggested that my own GP consider prescribing a very small dose of testosterone. I left the appointment feeling confused and upset; I had read so much that clearly indicated that oestrogen-only HRT was not appropriate for those who had suffered with severe endometriosis and it was possible progesterone could also help with my remaining symptoms.

Eventually, I decided to take matters in to my own hands and booked an appointment to see Mr Panay at his clinic in London. In September 2015, three years after my surgery, Mr Panay confirmed that I should indeed have been prescribed a combination of oestrogen, progesterone and testosterone as a woman who had experienced surgical menopause with a history of grade four endometriosis.

I am delighted to say that this combination resolved the remaining symptoms and I no longer suffer from sleep deprivation, anxiety or palpitations. My own GP practice prescribes for me and I see Mr Panay or a member of his team twice per year at his NHS clinic at the Chelsea and Westminster hospital. I also kept my promise to myself and now run menopausesupport.co.uk, a counselling and advice service for women and couples.

COMMENTARY

BY DR LOUISE NEWSON

There is still a misunderstanding about menopause and HRT among some healthcare professionals and women. Many women think that the menopause is just a time in their lives when their periods simply stop. They often know about vasomotor symptoms, yet the psychological effects of the menopause are still often not talked about and many women do not associate their symptoms of low mood, anxiety and memory problems with their perimenopause or menopause.

A recent survey undertaken by West Midlands Police revealed that 77.3% of women did not realise that the symptoms they were experiencing were related to their menopause until they were given information about symptoms of the menopause.

The menopause transition and early postmenopausal period are associated with a 2-4-fold increased risk for clinically significant depressive symptoms.1 Around 40% of women have psychological symptoms, and many women are inappropriately offered or given antidepressants for these symptoms.

It is known that women experiencing menopause induced by surgery have symptoms of oestrogen deficiency that are often more severe and longer lasting than those seen in women experiencing a natural menopause2. This is likely to be related to the rapid decline in hormone levels.

The NICE guidance on the management of the menopause is clear that women who are likely to go through menopause as a result of medical or surgical treatment should be given appropriate support and

- Information about menopause and fertility before they have their treatment
- Referral to a healthcare professional with expertise in menopause.

However, this is still not routinely being offered to women in all parts of the country.
HRT should be considered for the majority of women following a surgical menopause, especially younger women under 45 years. Bilateral oophorectomy involves the loss of androgens as well as oestrogens and progesterone. Results from small, short duration clinical trials in surgically menopausal women suggest that oestrogen therapy could be of short-term cognitive benefit when initiated at the time of oophorectomy. Many women are not aware of the advantages of transdermal oestrogen and micronised progesterone compared to alternative types of HRT containing oral oestrogen and synthetic progestogens. These advantages are well documented and should be considered for more women.

Testosterone is the most abundant active sex steroid in both pre and post-menopausal women and is present at levels three-four times that of oestrogen.

Surgical menopause is more likely to be associated with sexual dysfunction, especially hypoactive sexual desire disorder (HSDD), due to the more profound endocrine deprivation that occurs in these women. Large, placebo-controlled randomised controlled trials have demonstrated benefits of continuous testosterone therapy for women diagnosed with HSDD. Testosterone has also been shown to have favourable effects on bone health, cardiovascular health and cognition.

Current UK guidelines recommend consideration of testosterone replacement in either naturally or surgically menopausal women who have low sexual desire despite HRT. However, a lack of a licensed product for women in the UK prohibits a widespread prescribing of testosterone, which means that many women are denied a treatment that could potentially make a positive difference to their quality of life. A testosterone cream, AndroFeme, is now licensed for women in Western Australia and it is hoped that this will be licensed in the UK in the near future.

A recent survey by the British Journal of Family Medicine showed that only 66% of healthcare professionals felt confident in treating the menopause, despite 86% of them agreeing that menopause should be managed in primary care. The vast majority of these healthcare professionals, 68%, had never prescribed testosterone for menopausal women with low sexual desire.

Managing the menopause correctly and in line with the current guidelines can potentially offer women many years of preventative healthcare. Women should not be denied HRT if they could potentially have more benefits than risks from taking it, and many more women should be offered body identical HRT and also testosterone, when appropriate.