

Paula Briggs

Supplements, things that are being promised to women, everything with menopause as part of the title, if you're desperate and you're symptomatic, I think you would pay for any form of treatment that promises to improve your symptom control. It's very easy to be drawn in and to purchase stuff that promises all kinds of things and I think we all need to take a step back and be a little bit skeptical about what we see.

LuAnn Heinen

That's Dr. Paula Briggs, United Kingdom National Health Service consultant in sexual and reproductive medicine and immediate past chair of the British Menopause Society. We're discussing menopause, perimenopause, and the booming marketplace serving women's midlife healthcare. Experts say the growth and awareness has created new challenges including misinformation, overdiagnosis or misdiagnosis, and the sidelining of primary care.

In this episode, we talk about clinical best practices, evidence-based care, and examine science-based treatments.

I'm LuAnn Heinen and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers.

Good morning, Dr. Paula Briggs, so glad to have you on the podcast today.

Paula Briggs

It's a real pleasure to have been invited onto the podcast, thank you.

LuAnn Heinen

Well, in this country, we used to very much not talk about menopause, kind of a symbol of aging and the end of fertility, but that is old news. Menopause has come into focus in a big way and is recognized as a key transition affecting half the population in the prime of our working lives. You're an expert on the topic, tell us a little bit about your background and then we'll get into it.

Paula Briggs

Yeah, I started as a general practitioner and moved specialty into a relatively new specialty called sexual and reproductive health and that includes menopause and all medical gynecology. I moved to Liverpool Women's Hospital to do an MD, you know, a further degree which involved a research project into something called genitourinary syndrome of menopause. I now lead the menopause service there and I'm immediate past chair of the British Menopause Society. I have about 40 years experience of menopause, covering both primary care, general practice and secondary care. So a really diverse background in menopause management and I have to say I've seen ups and downs with menopause, but as you say, it's become much talked about, which is a good thing for women and families.

LuAnn Heinen

Well, this is going to be easy, easy, but can you explain the difference between perimenopause and menopause? Because we're seeing a big uptick, especially of late, in perimenopause awareness as well.

Paula Briggs

Yeah, I kind of think about this as reproductive life. We are potentially fertile as women when we're in premenopause and postmenopause is 12 months after a woman has her last menstrual period, so those two things are easily identifiable. Perimenopause is a transition, the transition period between reproductive and post-reproductive life and it's much more difficult to identify. The average age of perimenopause in the UK is 46, but it varies from country to country and what we've seen in the UK is women presenting younger and younger because they're very anxious

about perimenopause. But generally speaking, there'll be a change in menstrual patterns, so a change in periods. They might become heavier or lighter or the gap can become shorter between periods or longer between periods. It would be unusual that there'd be no change in menstrual history and also women then start to experience symptoms of menopause. The classic symptoms are hot flushes and night sweats. Genitourinary syndrome of menopause results in vaginal dryness, itching, burning, pain with sex, recurrent urinary tract infections. Those are clearly linked with menopause. But the difficulty for perimenopause is other symptoms such as anxiety, mood-related symptoms, musculoskeletal pain. They may be associated with perimenopause, but they are multifactorial in origin. The worry, I think, is if everyone is thinking perimenopause, are we going to miss other diagnoses in this particular group of women? And the women in whom perimenopause is most difficult to diagnose are younger women between 40 and 45 because doing blood tests in that group is not particularly helpful.

But it's not always perimenopause that results in symptoms. I feel strongly my specialty involves contraception as well, that women who think they might be perimenopause or become very anxious about symptom control, but the focus moves away from the need for contraception, yet these women are still potentially fertile.

LuAnn Heinen

Okay, so 46 is the average age of onset of perimenopause or by 46, most women are you're saying having symptoms of change?

Paula Briggs

Yeah, the average age of onset, but it can be earlier and it might be later. It's a difficult thing to define accurately.

LuAnn Heinen

Then the average age of menopause is what?

Paula Briggs

51 in the UK, but again, that varies from country to country.

LuAnn Heinen

Does that mean on average in perimenopause for five years?

Paula Briggs

Yeah, five years roughly.

LuAnn Heinen

Okay, so do we need to diagnose and treat menopause? I mean, this is something that all women go through, perimenopause and menopause. Why do we talk about diagnosis and treatment?

Paula Briggs

I think the most important thing in relation to perimenopause and menopause is providing women with the correct information a long time ahead of what is basically a life stage. Then I think it's important for women to have the right information on which they base their decision about their care. I think many women will want to use hormone replacement therapy, but others are still anxious about it. The problem in the UK is now women almost feel under pressure to have hormone replacement therapy, which the more international term is menopausal hormone therapy, MHT, because it's not an absolute deficiency state. It's a natural life stage. It's not the same as an underactive thyroid, for example.

LuAnn Heinen

I do know that in the U.S., since the black box was removed by the FDA, the black box warning, the prescriptions nearly doubled from like, I don't know, 20 million to 36 million, something like that in just a few years. Is that going on in the UK as well?

Paula Briggs

Yeah, we've definitely seen an increase in prescribing, but it's not got to the point, I don't think, where it was at before the Women's Health Initiative study. That was in 2002; so a long time ago. It shows you the impact that information around cancer particularly can have on a woman's desire to manage perimenopause and menopause with hormones.

LuAnn Heinen

Where does the menopause research stand right now? What do we know now about the safety of menopause hormone therapy?

Paula Briggs

Women should be assessed on an individual basis. I think it's important that it's part of a midlife MOT, having MHT. Ideally, a woman would have their blood pressure checked, their weight measured, information about lifestyle choices, their personal history will impact on their ongoing risk. For the vast majority of women under the age of 60, the benefits associated with MHT outweigh the risks. In the UK, we use NICE guidance and the NICE guideline supports the use of MHT for women who don't have ongoing risk factors, for management of menopausal symptoms. So the things that I talked about before, hot flushes, night sweats, and the genitourinary symptoms. What NICE doesn't suggest is that MHT is used for maintenance of bone mineral density, although we know that it will help maintain bone mineral density in association with exercise, adequate vitamin D and calcium intake. I think the worry for me is that things have been almost made black and white and super simplified so that women think anyone can have MHT. Now, that doesn't apply to anyone about any medication and that personalized consultation is really important. We also need to move away from the thought that MHT is dangerous and that women shouldn't use it because that's also wrong. I think we've come from one end of the spectrum almost to the other end of the spectrum and probably the comfortable place for women is somewhere in between. I think most healthy women potentially could benefit from MHT, but some women would prefer to use exercise to manage menopausal symptoms. Some women would prefer to use other non-hormonal treatment options, some of which are outside of license and others which are licensed now to manage hot flushes and night sweats.

Pretty unusual to go through menopause without any symptoms at all. It does happen and if you're a woman who has no symptoms whatsoever, do you want to take a prescribed medication? If it was me, yes, I probably would, but it's not for everyone. I think that's the really important message here and with bone density, like I said already, it's the whole picture, the diet, the exercise, menopausal hormone therapy. These are all really important pieces of the jigsaw.

LuAnn Heinen

No, it is really interesting because I think that you can see also how it bleeds into perimenopause because if this is something that's good for me once I'm menopausal, younger women who want to be proactive and want to start something sooner and...

Paula Briggs

I think it's really important that you've raised this because in perimenopause, women are still producing estrogen and using HRT in that group of women, particularly the younger women who may actually not be perimenopausal, you can cause very high estrogen levels and that can be associated with heavy, abnormal bleeding that needs further investigation and could, in some particularly high risk women, result in excess thickening of the lining of the womb, which is a risk

factor for cancer of the womb. So I don't think we should be treating younger and younger women because we're worried that they may be perimenopausal. If they have no risk factors, I think are better managed with natural estradiol contraceptive pills or the Mirena IUD or the equivalent. But I think we can proactively improve women's quality of life by providing the right treatment at the right life stage. There's a lot of misinformation in the public domain now, and it's very easy for women to be kind of swept along with using MHT and discarding anything that might actually be more effective for providing good health overall.

LuAnn Heinen

So those are for women who are perimenstrual, need contraception, but they're getting some estrogen benefit, you're saying?

Paula Briggs

Yeah, they're getting their own fluctuating estrogen levels and you might want to top that up a little bit as they kind of move through perimenopause. But you can start with that premenopause benefits include management of bleeding in the perimenopause and it's a foundation to build on with estrogen as part of HRT, MHT.

LuAnn Heinen

What is going on with the synthetic versus natural hormones?

Paula Briggs

I think that's a whole other area where it's been blown out of proportion. So natural progesterone is produced by the ovaries following release of an egg, ovulation. It's a difficult hormone for women to cope with. The big push for body-identical progesterone is kind of a little bit odd. There is nothing wrong with synthetic progestogens and in fact, they are often better for bleeding. I think we're really lucky that we have choices and at the end of the day, natural or body-identical progesterone is produced synthetically. Nothing is organic, if you like.

One of the problems is this massive increase in use of micronized progesterone, which is body-identical but not so good for bleeding. That's impacted on the number of women presenting with abnormal bleeding. There are other body-similar progestogens, which they are synthetic, but if you look at the chemical structure, they look more like naturally occurring progesterone and that might be a good compromise. I think it's very difficult to sort of blanket say all synthetic progestogens are bad and body-identical, which are produced synthetically, are good. Again, that's a very polarized black and white argument.

LuAnn Heinen

So MHT is well accepted now in both the U.S. and the UK. We haven't talked about contraindications.

Paula Briggs

Contraindications really are a few, particularly if we're using things delivered through the skin. If women have had a blood clot previously, a DVT or a pulmonary embolus, that's a blood clot in the leg or the lung, that would mean that oral estrogen should be avoided. Because of that, in the UK, most women are now prescribed transdermal, so estrogen through the skin as a patch, a gel, a spray. So lots of choices. If it's a very fit, healthy, lean woman who doesn't smoke, has no risk factors for blood clots, then that woman might choose to use oral HRT because it's simple. The oral route is very well recognized for medication. But I think it's great that we've now got more choices and we can be more inclusive for women who do have risk factors. Having had a hormone-dependent cancer, and most of these women have breast cancer, may mean that HRT, MHT is contraindicated. It's really fortunate that we now have licensed non-hormonal treatment options, neuroendocrine therapies, which mean that women who've gone through breast cancer, for example, they may be having treatment with hormone blockers, which are to prevent cancer

recurrence, but they are eligible for treatment. The problem previously was that we couldn't give these women HRT, and therefore they stopped taking the hormone blockers because they make menopausal symptoms so much worse. We now have treatment options for women who have hormone-dependent cancers and I think with everything that's happened in menopause and the boom, that particular group of women were left out to the extent that some of those women with breast cancer would take the risk, even if they had a hormone-dependent cancer, would take the risk of MHT because they're so desperate for a better quality of life. We do occasionally use HRT for women who've had a history of breast cancer, but it has to be a very considered decision.

LuAnn Heinen

What is your point of view now on the status of menopause research? Are we still behind? What's missing? What do we need to know?

Paula Briggs

There has been a lot of research, and I think we've got in the States, ongoing studies looking at safety of MHT. Even the WHI, there was some good stuff came out of that about, as we talked about before, about maintaining bone mineral density. We still need some research into newer modalities. We have several trials that have been undertaken on neuroendocrine therapies. But I'm thinking about genitourinary symptoms, what my research project was on. We don't have good assessment tools, so it depends who women present to, whether they get the right diagnosis. And things like laser therapy is a non-hormonal treatment, but that has been reserved, if following NICE guidance, for research purposes only. It takes a long time, and it's very difficult to get grant money to undertake large, multi-centered, randomized controlled trials, but they are viewed as gold standard. I think in comparison to other areas of medicine, women's health is still generally underfunded in terms of research.

LuAnn Heinen

What's going on now is what's kind of been described as a gold rush for menopause care, women who are looking for solutions outside of their traditional doctor's office, including things like higher doses of MHT, or starting sooner, or layering in testosterone, I mean, all kinds of things.

Paula Briggs

I think it is very worrying. I work within the National Health Service. I don't do any private work any longer, partly because I became aware that lots of doctors, nurses, paramedics, pharmacists were setting up in private practice, and I just kind of wanted to move away from that. I think it's very difficult for women to know whether they're seeing somebody who genuinely has many years of experience. It could be somebody who has done an online course and decides to call themselves a menopause expert. It's an area which is relatively unregulated, private menopause clinics. That's one thing I would be concerned about. Supplements, things that are being promised to women, everything with a menopause as part of the title, if you're desperate and you're symptomatic, I think you would pay for any form of treatment that promises to improve your symptom control.

I can see that myself. I look at social media, and it's very easy to be drawn in to purchase stuff that promises all kinds of things. I think we all need to take a step back and be a little bit skeptical about what we see. I think information on social media, again, it's unregulated. If women want to get the right information, they have to go to reputable sources. The British Menopause Society have their patient-facing arm, Women's Health Concern. We talked about the National Institute for Clinical Excellence, NICE guidance. They have a specific patient section. That's where I would recommend that women go for their information in relation to menopause so that they are not being sold anything. I think women are beginning to realize in the UK, certainly where I work, we have really good networking with general practice, with patients. As part of my consultation I say, be careful, you don't have to spend money on this. The patient feedback now is, yes, I understand

that. We did have a massive number of women referred in for testosterone and I have to say that there is a massive placebo effect with testosterone. It probably genuinely only improves symptom control in about 1 in 10 women. It is definitely not a deficient hormone. Female ovaries continue to produce testosterone lifelong and in women who don't have ovaries, the adrenal glands also produce testosterone. So the information out there saying it's an essential female hormone, that is flawed information. I haven't got a problem with people trying testosterone, but I'll say, we'll reassess your symptom control at 6 months and ask yourself, has it made any difference? And if it hasn't, it's just another thing to apply and to monitor. But you know, you get patients who come through who clearly have benefited from the addition of testosterone and therefore it's important that we don't stop offering that option to women.

LuAnn Heinen

In the UK, do you have a regulated dose of testosterone for women?

Paula Briggs

It's going through the regulatory process with the MHRA, which is our regulator. But currently, where I work, we use a male product outside of license and that is problematic because the leaflet within the packaging is not suitable for women. We see some very high testosterone levels, which I suspect are associated with, probably by accident, women using too much.

LuAnn Heinen

So all of this is creating more sort of load or, you know, burden on the UK health system, it sounds like.

Paula Briggs

I think the requests for testosterone, because our protocol is that it's initiated in secondary care, the patient is stabilized. We monitor bloods at baseline 6 weeks and symptom control at 6 months, and then post prescribing and monitoring annual monitoring of a testosterone level to the GP. So that is one thing that has impacted on clinical throughput. But the main thing that is difficult to manage is bleeding on HRT. That has potentially impacted on women's journey through the urgent suspicion of cancer pathway. Most women bleeding on HRT don't have cancer, but they do need to have investigations. It's not something that can be ignored. Generally speaking, in the first 3 to 6 months, we would say bleeding on HRT is normal. But I think as a woman, if you have to go through, it used to be called rapid access, but an urgent suspicion of cancer pathway until you come out the other end, you think you have got cancer. And we can't underestimate the impact that has on well-being. It's not just the patient, it's the family well-being, because everybody then is anxious about what's going on in the background. And obviously menopause and perimenopause is also linked with mood related disorders. We touched on that, particularly, anxiety. But like I said before, I think being in early with the right information is important. We are also now having a real pushback against antidepressant medication and I think it's really important that women have an open mind. You might be on some MHT that manages flushes and sweats, but still have anxiety or difficulty sleeping. These things definitely impact on well-being. Therefore adding something else to me is a much more logical and sensible solution rather than increasing the dose of estrogen, particularly if that's not going to make a difference, but it is going to tip things over into a more problematic bleeding profile.

LuAnn Heinen

It also makes the case for women who are on hormone contraceptions.

Paula Briggs

As women enter into their 40s, the assumption now is that they're not going to get pregnant and that is not true. You can still conceive even into your 50s. We've got such great contraceptive choices. Many of them are not hugely different to HRT, so MHT. So we've got natural estradiol

pills, Estetrol is fetal estrogen, very safe, seen in high doses in utero. These are things that we need to be promoting between the ages of 40 and 50, particularly, and then maybe transferring to MHT around the age of 55, because we think that contraception should be used up to the age of 55.

LuAnn Heinen

People are confused about this. There's a lot of news out there, social media, there's celebrity influencers. The group at Mayo, the menopause group there, published a study on evaluation of the accuracy of large language model responses on menopause and hormone therapy and the responses were found to be inaccurate and/or incomplete, pretty surprisingly high levels.

Paula Briggs

I think the problem with AI is it's populated by previous information, so if it keeps having the same information, which is what we are seeing with an increase in celebrity input, then it begins to believe that, that is problematic. You can use AI to your advantage, but you have to look at what's coming out the other end. I'd also like to just pick up on the celebrity thing, because it's massive. What happens to one high profile person cannot be transferred to an individual woman who has a completely different background. The explosion in books about individual women and their experience through menopause, I think, is really hard to accept as a source of information. Again, I go back to getting information from peer-reviewed resources. They've been reviewed by experts in the field, and we have ways of identifying experts. Most experts will have high-profile positions within international organizations like IMS, British Menopause Society, European Menopause Society, will have been actively involved in research and presenting. They will be working together, and I think that's really important. So if it's an independent team, you're not going to have the same level of scrutiny as you have when you pull together a group of experts.

LuAnn Heinen

Is there anything else you think that the healthcare system and traditional healthcare providers can do more of or do better to ensure patients are receiving evidence-based care? The other thing is they are promoting, we know, diet, sleep, exercise, stress management, which is same old, same old to a lot of patients compared to a new solution.

Paula Briggs

Well, I think we have to acknowledge the impact of the WHI. There was no education, there was no research for many years. So you had a whole generation of clinicians who had absolutely no education on menopause. But now we have good educational resources. Obviously, I'm in the UK, so my go-to would be the British Menopause Society. We have an online education program which gives information, assessment and accreditation. It's not cheap, but I think having that investment to know that your clinician has done the best possible qualification and has got the right information. If we had one GP in each practice who was able to have maybe extended time to deal with women, that would be an investment. But without additional funding, government funding, I can't see how that will happen.

LuAnn Heinen

With that, are you leaving the door open to private clinics and telemedicine, or the specialists and consultants like yourself who have to spread yourself thinner?

Paula Briggs

I'm not keen on the concept of private clinics. I'm really, really, really keen on the concept of specialists supporting primary care clinicians to do the best job they can. That's the way I think will make things better. We have to look at different ways of making that work. We do an online Teams meeting for GPs that they can pop on, ask a question, and that saves them having to refer the patient in. Our waits for appointments are horrific, like 12 months. Obviously, during that

time, desperate women will go to private providers and some of the private providers are very good. I'm not saying all private providers are bad, but it's a mixed bag. You could say the same of the NHS, couldn't you? It depends who you see and who you get, but I think why pay for something if it's not absolutely the best thing?

LuAnn Heinen

Got it, got it. So what should I have asked you but didn't? You've got such a wealth of knowledge, what have I not tapped?

Paula Briggs

I think we've talked about getting information to women way ahead of menopause, promoting contraception for potentially fertile women, it's better for preventing pregnancy, for bleeding profiles, it's more appropriate than MHT for that group. We talked about the fact that most women are eligible for standard MHT, particularly delivered through the skin, the estrogen part. As women get older, then obviously the risk of medical problems increases. So you might get high blood pressure, therefore an annual checkup. It's all part of the life course. Whilst you might have somebody under the age of 60 who has no medical problems, no issues giving them MHT, when they get into their 60s, then that can change and as you move through life, your risk of breast cancer, relatively speaking, will go up.

LuAnn Heinen

You know, I realize we haven't talked about the off-ramp. When do women stop?

Paula Briggs

Women don't have to stop, but equally they don't have to continue. Above the age of 60, I think, like I've just kind of touched on, the risk of complication increases. But I would normally say if somebody's fit and well in their 60s and still working, then actually being on MHT can be an absolute game changer. Once you stop work, your life might change. If you don't sleep well at night, you don't have to necessarily get up the next day to go to work. I think it depends on what's going on in the woman's life. What she wants to do is really important, but I don't think anybody should be told they have to stop HRT, MHT. That still happens, that's not right. But equally, women should not feel under pressure to continue taking it. It is, after all, medication that can cause complications. It's an ongoing journey, ideally done with a good clinician to support the patient.

LuAnn Heinen

Thank you so much, Paula, for this nuanced and complete discussion of menopause and menopause hormone therapy. Thank you so much.

Paula Briggs

Oh, my pleasure. Thank you for having me.

LuAnn Heinen

I've been speaking with Dr. Paula Briggs, senior physician at the UK National Health Service, who trains other clinicians on reproductive health, including menopause and hormone therapy, an effective but not universal treatment.

I'm LuAnn Heinen and this podcast is produced by Business Group on Health, with Connected Social Media. If you liked the episode, please rate us and leave a review.