

A GUIDE TO
PERIMENOPAUSE
AND MENOPAUSE
FOR WOMEN
LIVING WITH HIV




WE *still*
ARE *^*
HERE

OLDER WOMEN WITH HIV

Sophia Forum is a national UK charity which promotes and advocates for the rights, health, welfare and dignity of women living with HIV through research, raising awareness and influencing policy. Its work reaches women with different ethnic, faith and gender identities, sexual orientations, ages, immigration status and relationships with the criminal justice system. Sophia Forum ensures that women living with HIV are meaningfully involved in all its work.

The content of this booklet was co-created by women living with HIV for women living with HIV. We have partnered with Dr Louise Newson, GP, menopause specialist and the founder of Newson Health, to bring you this resource solely focusing on women, menopause and HIV.

Acknowledgements

To the women who attended our WISEUP+ Ageing with HIV weekend

WISE UP+Ageing with HIV and the 'We Are Still Here' campaign are collaborations between Sophia Forum and Dr Jacqui Stevenson, who carried out doctoral research at the University of Greenwich exploring women's experiences of ageing with HIV in London. Using participatory and creative methods, Dr Stevenson involved women living with HIV in each stage of the research, adopting an advocacy approach to generate new evidence on the experiences of women ageing with HIV in London. This resulted in the campaign 'We Are Still Here': <https://sophiaforum.net/index.php/we-are-still-here/>. Research summary: <https://sophiaforum.net/wp-content/uploads/2020/09/Im-Still-Here-research-summary-Dr-Jacqui-Stevenson.pdf>

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Design by Jane Shepherd



A GUIDE TO PERIMENOPAUSE AND MENOPAUSE FOR WOMEN LIVING WITH HIV

‘We Are Still Here’ is a campaign by and for older women living with HIV. Our aim is to highlight our experiences and priorities. We are calling for:

- Opportunities to pass on our experiences
- Peer networks for older women
- Holistic services and standards of care

All women will experience the menopause. Every woman’s experience of her perimenopause and menopause is different. Women find that they have many questions and can often lack access to comprehensive answers, information and support. This resource has been co-developed by women living with HIV who contributed questions about the perimenopause and menopause that were answered by an HIV clinician and menopause specialist.



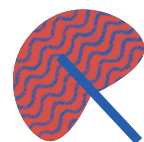
Menopause and HIV

Some symptoms of the perimenopause and menopause can be very similar to some of the symptoms of HIV, and during the perimenopause and menopause, women sometimes worry that their HIV is no longer under control.

We know that women living with HIV experience more mental health problems than women without HIV and that HIV may interfere with sexual function for a number of reasons. Because the perimenopause and menopause can also have an effect on mental health, some women living with HIV may find that these symptoms are made worse during this time.

HIV does not affect the way in which you will experience the perimenopause and menopause although some studies have shown that women living with HIV are more likely to experience more severe perimenopausal and menopausal symptoms. Every woman's experience of her menopause is different. You may be fortunate and not experience many symptoms, or you may have several symptoms for many years.

Having HIV should not make it more difficult for your perimenopause and menopause to be adequately managed. There are many types of hormone replacement therapy (HRT) that can be safely given to women living with HIV. It is important that you see a healthcare professional who is specialised in the menopause, to discuss your symptoms and treatment in an individualised way.



About the menopause

What is the menopause?

The menopause actually occurs one year after your last period. We use the term perimenopause to describe the years leading up to this point when periods start to change, and menopausal symptoms occur.

The menopause usually occurs because the ovaries have run out of eggs, which results in the ovaries no longer producing the hormones estrogen, progesterone and testosterone. The menopause can also occur when the ovaries are removed during an operation or damaged by certain drug or medical treatments. When the menopause will happen depends on many factors such as genetics, underlying conditions, and any surgery or treatments you may have had.

Stages of the menopause

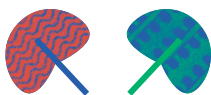
There are different terms to describe the stages of the menopause:

Premenopause – the time in your life before any menopausal symptoms occur

Perimenopause – the time leading up to your menopause when periods start to change, and other symptoms may start to occur. During this time, some women continue to have normal periods even though they are experiencing menopause symptoms. The perimenopause can last for just a few months or several years; for most women this will be in their mid-to-late 40s.

Menopause – a point in time marking a whole year since you had your last period, you may still have symptoms. The average age of the menopause in the UK is 51 years.

Postmenopause – all of your subsequent years after your menopause. Some women experience symptoms for many years after their menopause. The low hormone levels that occur during the menopause will persist for ever.



Menopause symptoms

As well as periods changing and then stopping altogether, symptoms can be numerous and varied because hormones play many important roles throughout the body. The most common symptoms include hot flashes, night sweats, mood changes, tiredness and insomnia, poor mental focus and concentration, headaches, joint pains, low sex drive, vaginal dryness and urinary and bladder problems.

The majority of women will experience symptoms during their menopause; the severity of symptoms varies tremendously between women. Some will only experience them for a few months, others can continue to suffer for years – even decades.

Common symptoms can include:

Period changes – this is often the first sign. You might experience a change in flow (periods may be heavier or lighter) and your periods can become closer together or more irregular, before stopping completely.

Hot flashes – this is the most common symptom of all, affecting three out of four women. Hot flashes can come on suddenly at any time of day, spreading throughout your face, chest and body.

Night sweats – many women find they wake up drenched in sweat and have to change their pyjamas or bed clothes. This can also be a disruptive symptom for partners too.

Mood changes – mood changes can be very disruptive to work and home life. You may find mood changes more common if you have had premenstrual syndrome or postnatal depression in the past.

Fatigue and poor sleep – poor sleep can be related to night sweats, or bouts of insomnia; you may find you are more tired during the day even if your sleep is not affected.





Brain fog – this is a collective term for symptoms such as memory slips, poor concentration, difficulty absorbing information and a feeling like your brain is ‘cotton wool’.

Loss of sexual desire – it is common to lose interest in, and pleasure from, sex around the time of the menopause. Women have testosterone, as well as men, and this hormone can influence our sex-drive. Testosterone levels tend to decline in women during the menopause which may lead to less interest in sex.

Joint pains and muscle aches – estrogen is very important in providing lubrication for your joints and preventing inflammation, so low levels of this hormone can leave your joints sore and aching.

Hair and skin changes – lower levels of estrogen can affect collagen production, resulting in skin changes, including reduced elasticity, fine lines and dryness. Other skin changes can include itching, tingling and numbness, also something called formication which is a prickling or crawling sensation. Changing hormones can also make your hair thinner and less glossy, and you may notice increased facial hair growth.

Worsening migraines – if you suffer from migraines, you may find they become more severe and/or closer together.

Vulval, vaginal and urinary symptoms – low estrogen can cause the tissues around the vulva and vagina to become thinner, dry, itchy and inflamed – known as vulvovaginal atrophy or atrophic vaginitis.

- This can cause symptoms such as irritation, itchiness and pain.
- Your vagina also expands less easily during sex, which can make sexual intercourse uncomfortable or painful.
- You may also find that smear tests are more uncomfortable.
- Some women find it difficult to wear underclothes or even sit down.

The acidity of your vagina changes, which can lead to infections such as thrush occurring. Low estrogen also thins the lining of your bladder and urethra, leading to the urge to urinate more frequently or having some incontinence or leakage of urine. Some women also find they have recurrent urinary tract infections.

Diagnosing the menopause

If you are over 45 years, your periods have changed in some way, and you have experienced some other typical menopausal symptoms, a health professional should be able to diagnose your menopause without the need for specific blood tests. Sometimes health professionals will carry out blood tests to make sure there is no other underlying cause for your symptoms (for example an underactive thyroid).

If you are under 45 years and experience symptoms of the menopause, you may be advised to have blood tests to see if there is a reason for an early menopause. You may have heard of FSH levels (follicle stimulating hormone) and some doctors may use this test as part of their investigation and diagnosis in younger women. Looking at FSH levels on their own however, is unreliable – your account of what’s been happening, and your symptoms are usually the most important factor to diagnosing the menopause or perimenopause.

It can be very useful to track your periods and symptoms, especially before meeting with your healthcare professional. Use a menopause app such as *balance* www.balance-app.com or complete the menopause symptom questionnaire at: <https://balance-menopause.com/uploads/2021/10/Menopause-Symptoms-Questionnaire-1.pdf> This will help your doctor or nurse have a clear picture of how you are doing and help monitor progress if you start on any treatments.



Long term health risks related to the menopause

Women who go through the menopause have an increased risk of heart disease, osteoporosis, type 2 diabetes, osteoarthritis, obesity, depression and dementia. There are of course other risk factors for these diseases, which also need to be taken into consideration.

Osteoporosis – this is a loss of bone strength (bone density) and it makes the bones weak and more likely to break. Estrogen helps keep our bones strong and healthy but falling levels during the menopause put women at greater risk of developing osteoporosis than men. A bone density scan (also called a DEXA scan) can be undertaken to measure whether this bone loss is happening and how severe it is.

Cardiovascular disease – this term means damage to your heart and blood vessels, and includes coronary heart disease, stroke and vascular dementia. Estrogen helps keep your blood vessels healthy and helps control cholesterol. Lower levels of estrogen can leave you at greater risk of cardiovascular disease. Annual checks on your blood pressure and cholesterol level will help monitor your cardiovascular health over time.

Diabetes – there is a small increased risk of developing type 2 diabetes after the menopause – this is because of the metabolic changes that occur when your hormone levels are low.

Dementia – the hormones estrogen and testosterone are very important for brain function. Dementia is far more common in women than men and this is thought to be related to low female hormones.

Vaginal and urinary symptoms – this collection of symptoms can get worse as you get older. These symptoms may have started during the perimenopause but for other women they occur some years after their menopause.

Treatments for the menopause

Eating a healthy balanced diet and taking regular exercise – that is weight bearing and strength training – is beneficial and can also help to lower your risk of having any of these conditions mentioned above.



There are lots of things you can do to help manage your menopause symptoms, and in many cases, vastly improve your quality of life. Your first step should be talking to a health professional about your options, so you can make an informed decision about the potential benefits and risks. Don't wait until symptoms become unmanageable before you seek advice.

The most effective way to treat menopausal symptoms is to replace the hormones that your body has stopped producing. Hormone replacement therapy (HRT) usually involves **replacement estrogen and progestogen** (if you still have your womb) and some women may benefit from replacing testosterone as well. HRT is most effective when it is started before the 'menopause' point of time (i.e. before periods have actually stopped), or at least within 10 years of the menopause. There are still usually benefits from starting HRT after this time for most women.

Types of HRT

There are different types of HRT; these days the safest type and one that is recommended and provided by the NHS, is 'body identical' HRT. This is derived from yam plants, (the root vegetable) and has the same molecular structure as the hormones we produce in our bodies.



- Taking HRT doesn't necessarily mean you need to take tablets every day. The preferred way of taking **estrogen** is actually through the skin, in a gel, spray or patch form. You can still shower and swim regularly while wearing an estrogen skin patch, and the gels and sprays are quickly absorbed and do not have a lingering smell.
- If you still have your womb, you will also need to take a form of the hormone **progesterone** (called a progestogen), because taking estrogen on its own will thicken the lining of your womb. Progestogen helps keep the lining thin and reduces the risk of cells overgrowing and possibly becoming cancerous.
- The progestogen can be in the form of a Mirena coil – which is also a contraceptive and has the advantage of stopping periods altogether, in most cases.
- Another option is to take the progestogen in capsule form, for example Utrogestan – which is 'micronised progesterone' and is the safest type of progestogen. This capsule can be taken orally or is sometimes inserted into the vagina like a pessary (off license use). Utrogestan can also have a sedative effect so many women take it before going to bed, to aid their sleep.
- An alternative to taking estrogen and progesterone separately, is to use a skin patch that is a combination of both hormones.
- If you have had a hysterectomy then you do not usually need to take any progestogen replacement.
- Some women also benefit from adding in testosterone as well, if they are experiencing ongoing fatigue, poor concentration and lack of sex drive; this is available in a cream or gel (usually from a menopause specialist).

None of the body identical types of hormone replacement medications will usually interfere with any treatments for HIV.

Benefits of HRT

The benefits of taking HRT are essentially two-fold; HRT relieves symptoms and protects your future health. The hot flushes and night sweats usually stop within a few weeks of starting HRT. Many of the vaginal and urinary symptoms usually resolve within three months (but it can take around a year in some cases). You should also find that symptoms such as mood changes, difficulty concentrating, aches and pains in your joints and the appearance of your skin should also improve. Basically, after a few months on HRT most women start to feel more like their old self again.

Even if you have hardly had any symptoms, it is worth considering replacing the hormones your body no longer produces, to protect your future health. Your risk of cardiovascular disease and osteoporosis will reduce. Other studies have shown your risk of other diseases such as type 2 diabetes, osteoarthritis, bowel cancer, dementia, and depression may also be reduced.

Risks of HRT

One of the main reasons that women don't want to take HRT is they feel it has too many risks but what does the evidence really show? There has been a huge amount of media attention regarding the perceived risks of taking HRT following the results of some large studies. These studies raised a possible increased risk of breast cancer with some types of HRT and also a possible increased risk of heart disease. Since then, some of these studies have actually been shown to be inaccurate and flawed.

- Your actual risk of developing breast cancer, blood clot or a stroke depends on many factors (such as your age, family history and general health) and not just whether or not you take HRT. This is why it is very important for your doctor to discuss your own individual risks, based upon your medical and family history, and weigh this up with the benefits of taking HRT for symptom relief and your future health. For most women who start taking HRT under 60, the benefits outweigh the risks.
- You can also greatly reduce your risk of developing heart disease, stroke and many cancers by not smoking, by taking regular exercise and eating a healthy diet.

- The best type of HRT for you depends on your medical history, existing conditions, whether you still have a womb (uterus) and if you are still having periods. Women who take estrogen-only HRT have a lower risk of developing breast cancer. Taking combined (estrogen and progestogen) HRT may be associated with a small risk of developing breast cancer. This risk is very low – for example, you have a greater risk of breast cancer if you are overweight, or drink two glasses of wine a night than the risk with taking HRT. Taking estrogen with micronised progesterone has never been shown to be associated with a risk of breast cancer
- If you have a history of blood clots, liver disease or migraine, you can still take some types of HRT, but it is recommended you take the estrogen as a patch, gel or spray, as this is associated with no risk of clots (oral estrogen tablets have a very small increased risk of blood clot). If you still have your womb and need to take a progestogen then you should either take micronised progesterone or have a Mirena coil (older types of progestogens are associated with a small increased risk of clot).

Side effects of HRT

The most common side effects of HRT include nausea, some breast discomfort or leg cramps. Side effects are most likely to occur when you first start taking HRT, and then usually settle with time. If side effects persist, the dose or type of HRT can normally be adjusted to suit.

Some women find that certain brands of HRT skin patches cause irritation of their skin. A change to a different brand or type of HRT may help if side-effects occur. Various estrogens and progestogens are used in the different brands. If you have a side-effect with one brand, it may not occur with a different one. Changing the delivery method of HRT (for example, from a tablet to a patch) may also help if you develop any side-effects.

Other treatments for the menopause

If you cannot or do not wish to take HRT, non-hormonal treatments for menopausal symptoms can be tried, such as antidepressants, clonidine, gabapentin, or cognitive behavioural therapy (CBT).

- **Antidepressants**, such as citalopram or venlafaxine, in low doses, can reduce hot flushes and night sweats for some women. While they can be helpful for these symptoms, they are often given inappropriately to menopausal women for mood-related symptoms. Antidepressants are usually not effective for mood changes experienced during the menopause.
- **Clonidine** is usually a medication for blood pressure but can be given to treat hot flushes. In the UK, current guidelines do not recommend that antidepressants or clonidine be given before considering HRT.
- **Gabapentin** (an epilepsy medication) is used in some countries to treat hot flushes, but it may cause side effects such as drowsiness and dizziness.
- **CBT** has been shown to help with menopausal low mood and anxiety and even physical symptoms such as hot flushes, joint pain and vaginal dryness.
- **Local estrogen** – applied vaginally – can often still be taken if you have been told you can't take conventional HRT and it can be very effective in improving urinary and vaginal symptoms.
- **Complementary and alternative medicines** can be very beneficial in improving a sense of wellbeing at a challenging time. These include acupuncture, aromatherapy, yoga and mindfulness.
- You may have heard of **herbal remedies** to help with the menopause, like St John's wort, black cohosh or isoflavones. There is some evidence to suggest these ones specifically can improve hot flushes and night sweats.
- Because there are multiple ways of producing herbal medicines, quality and potency can vary. Look out for the Traditional Herbal Registration mark (THR). It is worth remembering that 'natural' does not always mean harmless, and you need to make sure these remedies won't interfere with any other medications you take or have unwanted side effects.



Always check with your healthcare professional before using any herbal medicines. Some HIV medications have an adverse interaction with St John's Wort, for example.

Sex and relationships

Menopausal symptoms can affect all aspects of a woman's life; relationships in particular can be put under immense strain during this time and made more difficult by the fact that many couples don't openly discuss the menopause. While it can be a challenging time for any couple – it doesn't have to be.

Learn about the menopause together to help you both understand what is going on in your body. It might be helpful for your partner to attend your health appointments with you, to offer support to you, but also understand the issues better for themselves.

Be open with your partner about how you are feeling, and what you need in that moment; don't expect them to know already. You may not feel like making big decisions at this time, so explain this and ask them not to put pressure on you. Your partner will need to be patient, flexible, and show understanding if you need time alone now and again.

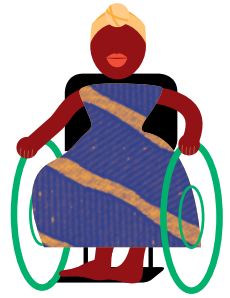
You may feel sad about your own lack of interest in sex or how uncomfortable you now find it. Often both partners long for physical intimacy to return but neither want to start the conversation, which often leads to an ever-widening gap. The best way through this is to talk about it.

FOR WOMEN WITH MALE PARTNERS

It is still possible for some women to get pregnant during the perimenopause and menopause, so if this is not something you are planning, contraception remains important – even if your periods are very infrequent. Current guidelines in the UK are that you should still use contraception for two years after your last period, if you are under 50 years old, and for one year after your last period, if you are over 50 years. All women can stop using contraception at 55 years, even if they are still having the occasional period.

The best type of contraception for you depends on your age, lifestyle, and any medical conditions. Discuss options for contraception with your doctor or nurse to decide what will suit you best.

Commonly asked questions



Why is my hair getting thinner and falling out more, what can help?

Many women will experience concerns with their hair during or after the menopause. Falling levels of estrogen can make our hair thinner, it can also become drier, finer and break more easily.

Use a gentle shampoo and a good quality conditioner to help tackle this problem and avoid tight hair styles to reduce the strain on hair follicles. Wearing a hat when it is sunny will protect the scalp and hair from UV damage too. Colouring your hair does not usually cause a problem. A balanced diet is ideal and those who can have red meat once a week should. If you're trying to lose weight, do it gradually – as a sudden drop in calories can be bad for your hair.

Taking HRT can help slow down or even stop hair loss in some cases. Managing stress can also be very important in dealing with hair loss in the long term.

There are other reasons for hair loss and changes in hair which include low levels of iron and some scalp conditions. Some causes of hair loss can run in families. If it is really concerning you, it may be worthwhile having a blood test to check your iron levels and your thyroid function tests.

Should I take antidepressants to help with anxiety and sleeplessness?

Antidepressants should not to be used as a first line treatment in menopausal women. This means if you go to see your health professional with symptoms of the menopause (and do not have a history of depression) you should not be given antidepressants/SSRIs as the first treatment option.

Despite this clear recommendation, many women are facing this situation and are repeatedly offered antidepressants in the first instance, for their menopausal symptoms.

If the underlying cause of low mood and anxiety is a disruption to hormones, antidepressants are rarely an effective treatment and often make women feel even worse due to side effects of the medication. Research has shown that if women are given HRT when they are perimenopausal (before or within a year of their periods stopping), this can reduce the incidence of clinical depression developing.

I feel exhausted every morning, what will help me?

It's no wonder we can feel so tired when we look at the range of possible symptoms that can interrupt a good night's sleep and learn more about the role hormones play in helping us get those all-important eight hours. Fluctuating estrogen can lead to hot flushes, night sweats and needing to go the loo lots. Lower levels of progesterone can lead to anxiety, restlessness and frequent waking in the night.



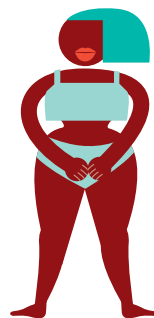
Most women find once they begin HRT, they have a lot more energy and can then consider other activities that will help them feel less tired, such as regular exercise. Some women find that adding testosterone to their HRT can improve energy.

- If there are times of the day that are worse for you, try and plan social activities at other times. There's nothing wrong with saying no and having nights in, or a quiet weekend when you need it, to recharge your batteries.
- Try to stick to a strict bedtime routine and go to bed at the same time every night. Most women need 7-8 hours of sleep per night.
- Avoid caffeine in the afternoons.
- Switch off screens with blue light (phones, tablets) at least an hour before bed.
- Try blackout blinds to keep your room as dark as possible, and in the day try to get as much natural sunlight as possible.
- Reduce your alcohol intake as it acts as a stimulant and can keep you awake at night.
- Stress is one of the biggest things stopping people from sleeping at night. Try to meditate before bed to clear your mind or use some lavender scents.

- Our body needs magnesium to make energy and help muscles relax. Try taking a magnesium supplement with vitamin B to help improve sleep and lower stress levels.

I have problems with a sore vagina and vulva, I also need to urinate a lot and I'm having some accidents if I can't get to the toilet in time. What can be done?

The most effective treatment for these kind of problems – which are known under the umbrella term of genitourinary syndrome of menopause (GSM) and are all linked to low levels of estrogen – is to use **'local' or vaginal estrogen**. This is different to the type of estrogen you take in HRT, but it still needs to be prescribed by a health professional. It contains a low dose of estrogen but it is not absorbed into your bloodstream. You do not need to take a progestogen replacement if you are only using vaginal estrogen and it is also safe to take HRT with vaginal estrogen.



You put local estrogen into your vagina, including the vaginal hormonal treatment that contains DHEA (e.g. Intrarosa®) – a hormone that our body naturally produces and converts to both estrogen and testosterone in the vagina. There are three main ways to do this.

Estrogen cream or gel – (e.g. Ovestin® Blissel®) these creams or gels are inserted inside the vagina (using an applicator) and/or spread around the vulva as needed, on a daily basis for the first two or three weeks, and then twice weekly after that. You may need to use it more than twice a week for effective relief of symptoms, which is safe to do so.

Estrogen pessary – (e.g. Vagifem® Imvaggis®) a small tablet containing a low dose of estrogen that you insert into your vagina, using an applicator or your finger, usually daily for the first two or three weeks, and then once or twice weekly after that. Women usually insert the pessary at night-time so it stays in place in the vagina for several hours.

Estrogen ring – (Estring®) a soft, flexible, silicone ring you insert inside your vagina. The ring's centre releases a slow and steady dose of estrogen over 90 days and it needs to be replaced every 3 months. A health professional can insert the ring, if this is preferred.

Many women find that using the **right type and dose of HRT** can really improve their symptoms. Local estrogen can be used alongside HRT, and it can be used for as long as it is needed.

As well as vaginal estrogen there are other products that will help ease discomfort and provide lubrication when needed:

Vaginal moisturisers (YES VM, Sylk Intimate, Regelle, Epaderm, Hydromol) – Moisturisers don't contain estrogen but keep the tissues well-hydrated and feeling less sore. Moisturisers are for help throughout the day and are longer lasting than lubricants, so you might only need to use a moisturiser every two or three days. It can often be a case of trial and error to find a product that suits you best.

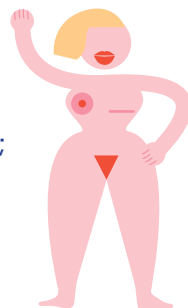
Lubricants (Sylk, YES OB and YES WB, YESBUT) – Lubricants are for using just before sexual activities to make vaginal penetration more comfortable. If you are using condoms for contraception, and use a lubricant when having sex, make sure it is a water-based lubricant as this type will not dissolve the latex in the condom.

Can I take HRT if I've had cancer?

Some treatments for cancer – surgery, radiotherapy and chemotherapy – can bring on an early menopause. Information about the impact of an early menopause should be provided before your cancer treatment begins; you should not have to wait until your menopause symptoms become unbearable before seeking help.

If your cancer is not hormone-related, you will usually be able to take HRT to improve your symptoms and safeguard against developing osteoporosis and cardiovascular disease in the future. You should speak to a health professional about your individual circumstances so you can make an informed decision. Some doctors will give a 'no HRT' response to all women who have had breast cancer or have a family history of breast cancer. This is not necessarily the case for all women and it is worth seeking a second opinion and/or seeing a menopause specialist to discuss it further. Women who have had some types of endometrial (womb) cancer may be advised not to take HRT.

If you are already taking HRT and feel like your symptoms aren't improving within a few months, speak to a health professional. If you are going through the menopause at a younger age (for



example because of cancer treatments), your body's requirement for hormones is often greater compared to older women. It may be that your HRT dose is too low as many young women actually need two or even three times more HRT than the average dose given to older women, so your dosage or delivery method may need adjusting. Some women may need the type of their HRT changing, for example from a patch to a gel and some women benefit from taking testosterone in addition to estrogen.

If you cannot take HRT or choose not to take HRT, other non-hormonal treatments can be offered such as antidepressants, clonidine, gabapentin, or CBT. Local (vaginal) estrogen can usually still be taken and be very effective in improving urinary and vaginal symptoms as the dose is very low and the estrogen is not absorbed into the body.

Some women who have had breast cancer still choose to take HRT, if other non-hormonal treatments have not been effective at improving their symptoms. They often feel that living with their menopausal symptoms has become so unbearable they would rather take the possible small risk of a return of their cancer and enjoy a better quality of life.

How long should a woman take HRT for and what happens when you stop taking it?

There is no set length of time you should take HRT for. Guidelines in most countries state HRT can be taken for as long as necessary, and for as long as the benefits carry on outweighing the risks. The dose of estrogen may decrease with age as the body usually requires less over time. If you are taking HRT, you should see a health professional once a year to review that it is still appropriate for you to take it.



Am I too old to start HRT?

There is very little evidence regarding starting HRT for older women because this research has not been undertaken. However, most women who are otherwise fit and well do still gain benefits from taking HRT – even if it has been more than 10 years since their menopause.

It is important that you seek individualised advice from your doctor, or another healthcare professional, and discuss all the treatment options available to you. If your regular doctor will not consider HRT for you, you may wish to find a doctor or nurse who has a special interest in the menopause.

Older women often only need smaller doses of estrogen than younger women and there are preparations of lower doses specifically for older women. The safest way to take replacement estrogen is through the skin in a patch, gel or spray form. Even a small amount of estrogen replacement can often alleviate your symptoms effectively and provide you with the bone and heart protection you need.

Does taking HRT just delay the menopause?

Many women think that taking HRT just delays the natural duration of the menopause in your body. This is not the case. If your symptoms return when you stop taking HRT it is not because you have been taking hormones, this is because you would still be having symptoms of the menopause at that time even if you had never taken HRT. The low hormone levels that are associated with the menopause last for ever so the menopause is not just about symptoms.



Are there any lifestyle changes that will help my menopause?

Absolutely, follow these five principles and you'll be on the right track:

- 1. Exercise** – love it or loathe it our bodies need it. Being active is so important during the perimenopause and menopause – for our bone strength, muscle mass, heart health, our mood, and keeping weight-gain in check. A good mix of aerobic (cardio), weight bearing and resistance exercises can help, preferably those you enjoy doing – be that walking/jogging, dance classes or Pilates.
- 2. Diet and supplements** – the main principles are to eat a balanced diet with lots of fruit, vegetables, wholegrains, fish and poultry – and easy on the red meat. Eat less processed foods, less sugar and less refined carbohydrates. A diet rich in calcium, vitamin D,



magnesium, omega 3 oils, and fermented foods that act as probiotics will help your nutritional and gut health through your menopause. If you think your diet does not contain enough of these vitamins and minerals, you can take them as a supplement, taking into account any potential interactions with your HIV medications. Vitamins and minerals in food do not interact with your meds but when in supplements they might reduce the effectiveness of the medication, so always check first.

- 3. Cut back on alcohol, tobacco or other recreational drugs** – they can make your symptoms worse.
- 4. Take time to do things you enjoy.** As well as exercise, find leisure activities that make you feel good and help you relax and unwind.
- 5. Look after your mental as well as physical health.** This might mean planning in time to socialise – or much-needed time on your own – sharing with others about how you feel, or finding a menopause buddy who is going through similar experiences – whatever helps you feel closer to having a sense of balance.

Does my ethnicity affect my experience of the menopause?

Some women who are Afro-Caribbean find that they struggle more with hot flushes and night sweats (known as vasomotor symptoms).

As the menopause is a long-term hormone deficiency, even women with minimal symptoms still have low hormone levels. This means they often still benefit from taking HRT.

Information and support

Useful resources

Menopause

Dr Louise Newson: www.balance-menopause.com

Free *balance* app: www.balance-app.com

Menopause Support: menopausesupport.co.uk

British Menopause Society: thebms.org.uk

Queer Menopause Collective: www.queermenopause.com

NICE Guideline (2019) Menopause: diagnosis and management. www.nice.org.uk/guidance/ng23/chapter/Recommendations#individualised-care

Dr Louise Newson (2019) *Menopause Manual*. Haynes, and (2021) *Preparing for the Perimenopause and Menopause*. Penguin Life Experts

Jane Lewis (2018) *Me and My Menopausal Vagina*

Jane Simpson (2019) *Pelvic Floor Bible*

Dr Avrum Bluming, *Oestrogen Matters*

Menopause and women living with HIV

University of Liverpool: www.hiv-druginteractions.org/checker

We Are Still Here: <https://sophiaforum.net/index.php/we-are-still-here/>

Sophia Forum (2020) *WISE UP+ Ageing with HIV Workshop report*.

<https://sophiaforum.net/wp-content/uploads/2020/02/WISE-UP-Ageing-with-HIV-Evaluation-Report-final.pdf>

PRIME Study (2018) *Menopause in women living with HIV in England: Findings from the PRIME Study*. www.ucl.ac.uk/global-health/research/a-z/PRIME

British Menopause Society (2018) *HIV and the menopause*.

<https://thebms.org.uk/wp-content/uploads/2020/04/05-BMS-TfC-HIV-and-the-menopause-APR2020.pdf>

NAM *Fact sheet: HIV and the menopause*. www.aidsmap.com/about-hiv/menopause-and-hiv

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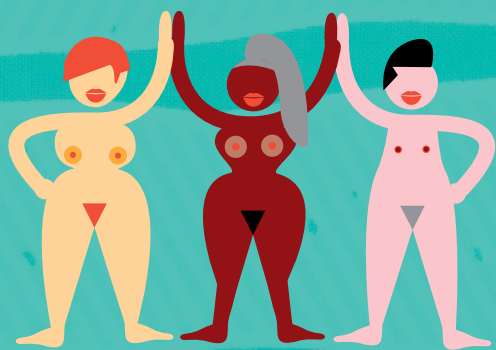
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Dr Shema Tariq T @savoy_truffle



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