

Surgical Menopause

Written by Dr Louise Newson

balance
the menopause support app

This booklet has been written by Dr Louise Newson, GP, menopause specialist and director of the balance app. She is also director of the not-for-profit company, Newson Health Research and Education, and is the founder of The Menopause Charity.

Surgical Menopause

Although most women go through their menopause naturally, many women experience an earlier menopause as the result of an operation or other medical treatment. If an operation has removed your ovaries or other medical interventions have stopped them working, the onset of menopause and menopausal symptoms can be very sudden compared to a natural menopause.

Recovering from an operation or illness can often be challenging in itself and experiencing a sudden menopause in addition to this can be very difficult for many women without the correct treatment. Fortunately, a surgical menopause can most often be managed very effectively with the use of HRT.

Types of operation that can result in a surgical menopause

Hysterectomy

A hysterectomy is an operation to remove your womb (uterus). There are several reasons why you might need to have a hysterectomy. The most common ones are: heavy periods, pelvic pain (possibly due to endometriosis or pelvic inflammatory disease), prolapse of the womb, or cancer of the womb, ovaries or cervix.

There are different types of hysterectomy:

Total hysterectomy: your womb and cervix (neck of your womb) are removed; this is the most commonly performed operation undertaken.

Subtotal hysterectomy: the main body of your womb is removed, leaving your cervix in place.

Total hysterectomy with bilateral salpingo-oophorectomy (abbreviated to TAH and BSO): your womb, cervix, fallopian tubes (salpingectomy) and ovaries (oophorectomy) are removed.

Radical hysterectomy: your womb and surrounding tissues are removed, including your fallopian tubes, part of your vagina, ovaries, lymph glands and surrounding fatty tissues.

TAH & BSO and radical hysterectomies usually cause menopausal symptoms to come on suddenly because they involve removal of the ovaries as well as the womb.

If your ovaries remain, they will still make

estrogen and testosterone after your hysterectomy, but it is common that your levels of hormones will fall at an earlier age than average.

As you will not have periods after a

hysterectomy, it may not be clear when you are in the menopause. It is therefore very important that you talk to your doctor if you are experiencing any menopausal symptoms following a hysterectomy.

Oophorectomy

This refers to removal of one or both of your ovaries. If both ovaries have been removed it is likely that you will experience menopausal symptoms afterwards as there will be a very sudden drop in your levels of hormones. If only one ovary has been removed, then the onset of symptoms may be more

gradual, but it is still likely that you will experience an earlier menopause than you would have done naturally.

All women who have both their ovaries removed will be menopausal from the day of this operation.

Other medical interventions that can result in surgical menopause

Certain treatments for cancer can stop the ovaries from working properly and bring about an earlier menopause. As well as the operations already listed, other treatments include:

- radiotherapy to the pelvic area
- certain types of chemotherapy drugs to treat cancer
- drugs that block the action of hormones working (for example,

medication used for women with some types of breast cancer)

Other medication treatments for conditions such as endometriosis or premenstrual syndrome can block or 'switch off' the ovaries and result in lowered hormone levels, which can in turn cause menopausal symptoms. These may be long lasting or only occur over the period of time that the medication is taken.

Experiencing Surgical Menopause

Symptoms of a surgical menopause are the same as those when it is a natural menopause. Estrogen protects a number of different systems in your body including your brain, skin, bones, heart, urinary functions and the genital area – low levels of estrogen can affect all cells in your body.

The most common symptoms are hot flushes and night sweats, however, many

women find the most troubling symptoms are the ones that affect their thinking skills and their mood as these tend to affect day to day aspects the most, such as performance at work and relationships.

If you want to know more about symptoms of the menopause, take a look at our 'Menopause and Me' booklet.

What is HRT?

Put simply, HRT or Hormone Replacement Therapy is a treatment to replace the hormones that you have lost, primarily estrogen but also progesterone and testosterone for women that need it. HRT is the most effective treatment available to relieve symptoms caused by the menopause.

Estrogen is a very important hormone in your body and has important functions on many different systems including your brain, bones, heart, skin, hair and vagina. Taking HRT replaces the estrogen that your ovaries were producing before your operation or other medical intervention.

Progesterone is naturally produced in the body primarily to help regulate the menstrual cycle. It is used as part of HRT for women who still have a womb that take replacement estrogen. Estrogen

thickens the lining of the womb and when it is taken as part of HRT there is a small risk that these 'over-active' cells could turn cancerous. Progesterone (or a progestogen) helps keep the lining thin and reduces the risk of uterine (womb) cancer. So, if you still have your womb and are taking replacement estrogen, you will also need to take progesterone (or a progestogen) too.

Testosterone is not just a male hormone, it is mostly produced in your ovaries so after your operation (or medical intervention) you will experience a reduction in the amount of testosterone in your body. As a result, you may find that your mood, energy, concentration and also sex drive are negatively affected. Taking testosterone can often improve these particular symptoms.

How do you take HRT?

Replacement **estrogen** can be given to your body in various ways - either as a skin patch (like a plaster), as a gel or a spray from a pump action bottle, or as a tablet that you swallow. The type of estrogen mostly used is 17 beta-estradiol, which has the same molecular structure as the estrogen you produce in your body. It is derived from the yam root vegetable. The safest ways to take estrogen are via the patch, gel or spray, as they are absorbed through the skin; taking the estrogen in tablet form has a very small risk of developing a blood clot.

The safest type of replacement **progestogen** is called 'micronised progesterone' - branded as Utrogestan in the UK, and it comes in a capsule that

you swallow (some women prefer to use this progesterone vaginally rather than orally). An alternative way to receive progestogen is to have the Mirena coil inserted into your uterus. This is also a very effective contraceptive and it needs replacing after five years.

Testosterone is available in a gel or a cream that is rubbed into the skin and while it is not currently licensed as a treatment for women in the UK, it is widely and safely used by menopause specialist doctors and some GPs. It can sometimes take a few months for the full effects to work in your body. More information can be found in our 'Testosterone' booklet.

HRT protects your future health

Without treatment in the form of hormones, there is a greater risk of conditions such as osteoporosis, heart disease, type 2 diabetes, bowel cancer and dementia. It is very important that if you have your ovaries removed or blocked by medication when you are

under 51 years of age, that you replace those lost hormones with HRT up to the natural age of menopause (51 years) at least, as you would still be producing those hormones naturally, if it were not for the medical intervention.

Starting HRT at the right time

The ideal scenario is that your doctor explains the likelihood of a surgical menopause to you – and what this means – before any operation or treatment. A discussion around taking HRT and the risks and benefits for you personally should also happen beforehand, and - if you are willing - HRT should be started immediately after the intervention. Unfortunately, this is not the case for some women and they are given little, if any, information about the menopause and HRT. It can be very frightening when they experience symptoms they were not expecting and do not understand what is 'wrong' with them.

If you are due to have surgery involving removal of your ovaries (or treatment that will stop them from working), it is really important that you talk to your doctor - ideally the surgeon who will be performing your operation - to talk about your options for taking HRT.

For most women under the age of 60, the benefits of HRT outweigh the risks. The best type of HRT for you depends

on your medical history, existing conditions, and whether you still have your womb. After hysterectomy, most women only need to take estrogen, and 'estrogen-only' HRT does not have an increased risk of breast cancer. Some studies have shown that women taking estrogen-only HRT (without progesterone) actually have a lower future risk of breast cancer, which is very reassuring.

Taking combined (estrogen and progestogen) HRT may be associated with a very 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 2 glasses of wine a night.

If you have a history of blood clots, liver disease or migraine, you can still take HRT, but it will be recommended you take the estrogen as a patch, gel, or spray, as this is associated with no risk of clots. You can also greatly reduce your risk of developing heart disease, stroke and many cancers by not smoking, taking regular exercise and eating a healthy diet.

Taking the right dose of HRT

Most women are under the age of 51 years when they have surgery to remove their ovaries; their body's requirements for hormones is greater compared to that of older women going through the menopause naturally. This means that younger women typically require much higher doses of these hormones – especially estrogen – than if they were older.

If you are still experiencing menopausal symptoms after your operation – despite taking HRT – then the most likely reason

for this is that your dose or type of HRT needs changing. Many young women actually need two, or even three, times more HRT than the average dose given to older women. Many young women really benefit from taking testosterone too.

In addition to taking HRT, it is important to consider ways of improving your bone and heart health by eating a healthy, balanced diet, exercising regularly and reducing your alcohol intake.

Genital and urinary symptoms and vaginal estrogen

When there is a lack of estrogen in your body you might notice changes to your vulva and vagina because these areas are lined with cells that respond to estrogen. There is often less lubrication, less blood supply to these cells, less of the 'good bacteria' that helps fight infection, and the lining of the vagina often becomes thinner and less stretchy. These changes can lead to soreness, discomfort, itchiness and pain during sexual intercourse, when using tampons, or when having vaginal examinations (such as cervical screening). The soreness or itchiness can occur around the vulva area as well, and there may be more frequent episodes of thrush. In addition, the lining of the bladder and urethra becomes thinner and more prone to infections like cystitis; you may need to pass urine more frequently or have occasional leaks or accidents.

Fortunately, there is very effective treatment for this particular set of symptoms in the form of 'local' (or topical) estrogen. This is estrogen that you apply directly into the vagina and it is not the same as the HRT we have described so far.

Vaginal estrogen comes in the form of a pessary, cream, or gel that you insert (with the aid of an applicator if needed) on a daily basis initially, and then usually 2-3 times a week thereafter. Alternatively, there is a flexible, silicon ring called an 'Estring' that is inserted into the vagina and has a slow release of estrogen over a 90-day period; it needs replacing every three months.

Local estrogen is very effective at bringing relief from these uncomfortable – and often embarrassing – problems but if you wait until symptoms are severe, it will take longer for the estrogen to have a noticeable effect, so it is important to treat genital and urinary symptoms as soon as possible. Women who cannot have HRT for clinical reasons can usually still use local estrogen treatments in the vagina. It is perfectly safe to use vaginal estrogen alongside HRT.

Vaginal moisturisers can also be particularly helpful at relieving discomfort throughout the day and non-hormonal lubricants can be useful for relieving pain during intercourse.

Looking after your pelvic floor

Pelvic floor exercises are very useful for strengthening the muscles around your vagina and your anus and can really help reduce urinary leaks or incontinence (and improve your sex life), when done properly and consistently. There are videos or a factsheet describing what to do on the menopause doctor website.

Pelvic floor exercises are easy to do, wherever you happen to be, and no one will notice that you're even doing them. Try to do the exercises two to three times a day if you can, maybe while brushing your teeth or some other daily activity, to help you remember.

Looking after your sex life after hysterectomy

The usual recommendation from healthcare professionals is to wait 4-6 weeks after hysterectomy before resuming sexual intercourse. This allows time for scar tissue to heal, and any bleeding or discharge to resolve. If you don't feel like resuming your sex life after this length of time, do not worry; it varies tremendously from woman to woman. A lack of sex drive is also a symptom of the menopause and this is commonly made worse by low mood, poor sleep or stress. If any of these symptoms persist and continue to negatively affect your sex life, speak to your doctor or nurse about it.

When returning to sex after having a hysterectomy people are often concerned about painful sex, decreased sensation, struggling to orgasm or their partner is worried about hurting them. Talk to your partner about your feelings and ask them how they feel. If sex feels painful or uncomfortable, take the focus off any penetration, and enjoy kissing, cuddling, oral sex, mutual masturbation with fingers, or use a sex toy with lubricant.

Use a sexual lubricant that is free from irritating ingredients including glycerin,

glycols and parabens. Lubricants come in different formulations; water-based lubricants are compatible for any sex play, and with all sex toys and condoms. Oil-based lubricants are thicker, longer lasting, and are compatible with any sex toy but not with latex condoms. Silicone lubricant is slippery, long-lasting but not compatible with silicone sex toys. You may have to try several lubricants before finding one that works for you, and always do a skin test first.

Having a hysterectomy may shorten your vagina and it can feel tighter as scar tissue heals, making penetrative sex feel painful or uncomfortable. Try different positions that prevent deep penetration and use a slim, skin-safe sex toy, or silicone dilator which helps to stretch the vagina and massage scar tissue. Using a vibrator promotes blood flow, which in turn speeds up the healing process, as well as increasing sexual sensation in and around the vagina and clitoris. If you have less sensation or take longer to orgasm, try a small bullet vibrator; these are great for solo play or with a partner.

Above all, take your time to resume your sex life at your own pace and have fun.



Dr Louise Newson is a GP and menopause specialist in Stratford-upon-Avon, UK and the founder and writer of the balance app and website.

The website and app contain evidence-based, non-biased information about the perimenopause and the menopause. She created both platforms to empower women with information about their perimenopause and menopause and to inform them about the treatments available.

Her aim is for people to acquire more knowledge and confidence to approach their own GP to ask for help and advice about their hormones. She is passionate about improving awareness of safe prescribing of HRT in all stages of the perimenopause and menopause.

Louise is also the director of the not-for-profit company Newson Health Research and Education.



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