Menopause and HRT

A short guide for women in Tayside

Tayside Sexual & Reproductive Health Service

This information leaflet is written for people assigned female at birth, independent of their gender identity.

This booklet has been written by the specialist staff of the Tayside Complex Menopause Clinic to give basic information about the menopause and HRT (hormone replacement therapy).

We hope that it will put the benefits and risks of HRT in perspective and will help you to decide if HRT might be an option for you.

About the Menopause

Menopause is defined as the time when menstruation stops completely because the ovaries stop working. This is diagnosed 12 months after the last natural period. The average age of patients entering the menopause in the UK is around 51 but this age varies between different ethnic groups.

In the years leading up to the menopause (called the perimenopause) and following their last period, around 80% of patients experience at least some menopausal symptoms. Menopausal symptoms might include hot flushes, night sweats, disturbed sleep, altered mood (mood swings, low mood, and irritability), anxiety, chronic tiredness, vaginal dryness, low sex drive, itchy skin, joint aches, headaches and migraines, palpitations and many others. Some patients get symptoms which are only mildly troublesome. Others can experience more severe symptoms which affect their quality of life and wellbeing, their relationships, family, social, work and sex life. For these patients the menopause can make it difficult to “function normally”.

Menopausal symptoms can last from a few months to several years or even longer. The majority of symptoms will gradually settle with time in most patients. However, vaginal dryness and urinary symptoms might get slowly worse with time rather than better.

People living with autism or ADHD (attention deficit hyperactivity disorder) might find that their autistic characteristics became more apparent during the menopause or perimenopause. Some people even report that menopause played a role in discovering that they are autistic. Please check out the menopause page of the National Autistic Society website for more info: www.autism.org.uk/

What is hormone replacement therapy (HRT)?

HRT is a very reliable way to help patients with moderate or severe menopausal symptoms. HRT is also recommended to protect the health of patients who enter the menopause early (under the age of 51) even if they do not have symptoms or only minor symptoms.

Taking HRT does not prolong or delay the time until menopause symptoms would settle down naturally.

HRT prescribed before the age of 60 is relatively safe for most patients. Only a few patients have medical reasons which prevent them from taking HRT.

The decision about using HRT should be made between the patient and their health care provider, taking their medical history, situation and preferences into account.

There is no limit set on the duration of use. This will depend on the balance between each person's individual risks and benefits.

HRT consists of either the hormone oestrogen on its own or a combination of the hormones oestrogen and progestogen. Oestrogen helps bone health and relieves the symptoms of menopause. It is given at the lowest effective dose.

In patients with a womb (uterus) HRT will also include progestogen which protects the lining of the womb from any potentially harmful effect of oestrogen. After a total hysterectomy, patients can usually use oestrogen alone unless they have been diagnosed with endometriosis.

Systemic ("whole body") HRT comes in different forms including tablets, patches, gels, sprays and implants. The progestogen part of HRT can also be provided by a hormone coil (Mirena®, Levosert® or Benilexa®) which lasts for up to 5 years. Hormone coils which contain a lower amount of hormone like Kyleena® or Jaydess® cannot be used as part of HRT as they are not strong enough, but can still be used together with HRT to provide contraception if needed.

If both oestrogen and progestogen are needed they may be given in combined patches or tablets, or as two separate preparations, for example an oestrogen patch with a hormone 'coil' or a progestogen tablet for 12 or 14 days every month. **It is very important to take both hormones as prescribed**. Patients who take oestrogen and skip their progestogen tablet or don't have their hormone coil replaced every 5 years put themselves at risk of abnormal cells in the lining of their womb which could lead to abnormal cells and even cancer over time.

If it is less than one year since your last period then you will probably be prescribed a combined HRT which is "sequential"; which mimics your normal cycle and leads usually to a monthly bleed.

After a few years this type of HRT is usually changed to a "continuous" preparation and your drug induced withdrawal bleeding will stop.

Early onset of the menopause and premature ovarian insufficiency

HRT under the age of 51 is there to give hormones back that patients would otherwise produce naturally. Therefore there are only very few reasons why patients in this age group could not have HRT. Patients who enter the menopause before the age of 51 should consider taking HRT, **even if they do not experience any or only mild symptoms, especially if they are under the age of 45**. Experts agree that it is usually a good idea for these patients to take HRT for its long-term health benefits on bones and the cardiovascular system (heart, arteries etc.). It is recommended that patients with early menopause take their HRT up to the age of 51 and then reassess the situation to decide if they want to continue to take HRT.

Please also check out our other patient information leaflet: "Premature Ovarian Insufficiency and Early Menopause" (LN0680).

Benefits of HRT

Relief of menopausal symptoms

HRT is highly effective and will usually improve most menopausal symptoms quickly. **Some patients need to try a few different HRT products, dosages or combinations before finding one which suits them best**. Transdermal oestrogen in the form of a patch, gel or spray which is absorbed through the skin is often better for symptom control and also carries lower health risks compared to oestrogen tablets.
Therefore, patients with risk factors for blood clots in their legs or lungs (VTE) or cardiovascular disease like heart attack or strokes, including smokers or overweight patients with a body mass index (BMI) of 30 or more, should be prescribed transdermal and not oral oestrogen.

Relief of vaginal, vulval and urinary symptoms

The menopause can be associated with vaginal dryness which may cause discomfort with sex. Urinary symptoms such as increased frequency, urgency or pain when passing urine, even after an infection has been ruled out, can also be a problem. Unfortunately, these symptoms do not tend to settle with time.

Systemic HRT will often help these symptoms but local vaginal oestrogen in the form of vaginal tablets, pessaries, creams or rings are also very effective and carry fewer risks. Both treatments need several weeks or months to reverse the vulval, vaginal and bladder changes of the menopause. Some patients need both HRT and local oestrogen at the same time to control their symptoms.

Local treatment is very safe for most patients even in their seventies or eighties and can be used long-term.

Prevention of osteoporosis

HRT will help prevent osteopenia and osteoporosis (thin bones) but is not usually recommended for prevention of osteoporosis alone unless you are under 51. If you are taking HRT to help hot flushes and sweats, then your bones will benefit. However, it is felt that the small risks of long-term HRT outweigh the benefits if it is used for bone protection alone.

Other benefits of HRT

In addition, HRT may have a positive effect on sex drive, concentration, memory, mood (depression, anxiety, mood swings), headaches, sleep and overall wellbeing.

Side effects and risks of HRT

Side effects

The most common side effects of HRT are breast tenderness, bloating, headaches and vaginal bleeding. Some patients may feel that they gain weight because of fluid retention and increased appetite. Many patients find their mood and anxiety symptoms improve with HRT but others feel an increase of their mood issues (mood swings, depression) or anxiety, especially when taking sequential (cyclical) HRT.

Generally, side effects will settle down with time. If they do not settle a different HRT dose, product or route of delivery could be tried out.

If you have not had a hysterectomy and are in the perimenopause sequential HRT may give you a regular bleed each month until continuous (no bleed) HRT may become suitable. Irregular vaginal bleeding can be a problem, especially initially and should be **discussed with a healthcare professional, especially if it lasts longer than 3 to 6 months** after starting or changing your HRT.

Breast cancer risk

Breast cancer is common in the Western World and the major risks are being assigned female at birth and getting older. Most experts agree that taking HRT over the age of the natural menopause slightly increases the risk of developing breast cancer.
Between the age of 51 and 55 the risk of getting breast cancer is the same for patients taking HRT for this time as it would be if they still had periods to 55 years.

Lifestyle factors like alcohol intake (more than 2 units/day) and smoking also increase the risk of breast cancer as does, especially, overweight and obesity (BMI greater than 30 kg/m^2).

There is no or very little increase of breast cancer risk in patients who can use oestrogen only HRT. When using combined HRT the risk of a breast cancer diagnosis is increased but not the risk of dying of the cancer. HRT does not cause breast cancer but can “feed” it when present.

Deep vein thrombosis and Pulmonary Embolism risk

Oral HRT increases the risk of blood clots in veins (deep vein thrombosis or DVT) and lungs (pulmonary embolism or PE) although for most patients the risk is still low. You will have a higher baseline risk of DVT/PE if you are overweight, a smoker, have a family history of DVT/PE or are immobile for any reason. The risk of DVT/PE also increases with age. Transdermal HRT probably has little effect on your overall blood clot risk.
Nonetheless, if you have already had a DVT or PE, HRT is relatively contraindicated.

Heart disease, blood pressure and stroke risk

HRT is generally not recommended for patients who have certain heart conditions like angina or have had a heart attack or a stroke. The risk of stroke increases with age. Research suggests that HRT slightly increases the

risk of stroke and heart disease in patients over the age of 60. If you have high blood pressure which is not well controlled with treatment, HRT may also be riskier.

Cardiovascular disease is not an absolute reason to avoid HRT but each patient must be considered carefully, assessing their individual risks. Transdermal HRT is regarded as safer with regards to these risks too.

Table showing number of cases per 1,000 patients aged 50 – 59 over 7½ years, with and without HRT

	No HRT use	Combined oral HRT
Breast cancer	22.5	5 more
Deep vein thrombosis	3	7 more

Are you thinking about taking HRT?

All patients are individuals: patients will be guided by their healthcare professionals to make their own choice on what is right for them.

HRT has been around for a long time and over the years there has been both positive and negative press about it. Large studies have shown that there are small risks associated with HRT. The best way to consider HRT is that it is a form of medication and, like any other, is associated with benefits but also possible risks and side effects.

Only a few patients have medical reasons which prevent them from taking HRT to help them with severe menopausal symptoms. Systemic HRT may be taken for as long as necessary at the lowest effective dose and the decision to take HRT or not can be reviewed at any stage. Local vaginal oestrogen to treat vaginal dryness and other genitourinary symptoms can be used safely for many years, as long as it is needed.
If patients made a decision to start or continue with HRT they should usually take it for a reasonable period of time. There is no maximal length HRT can be prescribed. We suggest that you are reviewed by your GP 3 months after starting or changing HRT and then every year, once stable, to discuss any issues and the decision to continue with HRT or not. If you decide to stop, it is suggested you do so gradually.

Menopausal symptoms might come back once a patient stops HRT although often not that severely. Life might have changed for the better and it might be easier to cope with symptoms.

Life in general is full of choices to make and people take risks of varying degrees every day. Overall, **the risks of HRT are much smaller than the risks of cigarette smoking, alcohol excess and obesity**. Sometimes, just the fact of feeling better and sweating less while taking HRT gives patients finally the strength to reduce these other risks by eating better, joining an exercise class, stopping smoking etc.

Using the hormone coil as part of HRT

The Mirena® ‘hormone coil’ (or similar devices called Benilexa® or Levosert®) can be used for contraception, to treat heavy periods and as the progestogen part of HRT.

This is particularly helpful for patients who still need contraception, have bleeding problems before starting HRT, or on HRT, and those who have significant side effects with other progestogen preparations. **In patients using these coils as part of their HRT, the device needs to be changed every 5 years. They need to make sure to arrange a replacement when due as their HRT prescription becomes otherwise unsafe**. Tayside Sexual & Reproductive Health Service will not remind patients regarding this and many GP practices do not have a recall system either.

Alternatively, patients can change their HRT type to a combined product once the coil has expired or add the progestogen in the form of a separate tablet. A hormone coil alone without additional oestrogen is unlikely to help with menopausal symptoms.

"Bio-identical HRT"

"Bio-identical" HRT products are widely marketed on the internet and often prescribed by private health care professionals who might not be recognised menopause specialists. These products are not recommended by the British Menopause Society because they are not regulated and there is no evidence of their effectiveness and safety. There is also insufficient evidence to justify serum and saliva hormone tests to "individualise" this type of HRT. The potential benefits of bioidentical hormone therapy can be achieved using conventionally "body-identical" licensed products, without having to resort to unregulated and very expensive compounded varieties from specialist pharmacies.

Recommended check-ups while on HRT

While taking HRT, patients should have their blood pressure and weight monitored once a year but more frequently if there are concerns about high blood pressure.

Patient with a neck of the womb (cervix) should attend for their usual cervical smear screening tests when they are called.

Patients with breasts should check their breasts regularly. The UK Breast Screening programme invites patients for a mammogram every 3 years between the ages of 50 – 70 years. **Patients should opt to continue mammograms after this age by calling the Breast Screening Service if they are still on HRT or stopped taking it within the past 5 years**.

Transgender health and the menopause

We do not have currently much information how the menopause is experienced in transgender people. Lots of the information is still valid for people who were assigned female at birth but identify as male or non-binary.

There is a current lack of published information about how the menopause is experienced by people who are transgender, including people who are non-binary. Although the language of most websites giving information around the menopause is gendered, lots of the information regarding relevant symptoms is still applicable for people who were assigned female at birth but whose gender identity is different to this.

Talking about menopause can be challenging and may be a significant source of dysphoria for transgender and non-binary people. If this is something you find difficult, it is important to find a health care provider you are comfortable with, and to let them know what language you prefer to use when referring to yourself, your body, your genitalia etc.

Some people using testosterone as part of gender-affirming hormone replacement therapy will experience menopausal symptoms as a side effect of this therapy. As periods will usually stop as a direct result of taking testosterone, it will be less clear when an individual enters the menopause.

Additionally, transgender people who were assigned female at birth may experience menopausal symptoms following gender-affirming surgery (if their ovaries are removed surgically), or as their ovaries go through the typical aging process.

Transgender people who have breasts need to go for their routine breast screening (mammogram) from the age of 50 and transgender people who have a cervix (neck of the womb) need to continue their routine smear checks every 5 years.

Many transmasculine people try to avoid systemic HRT containing oestrogen but topical (vaginal) oestrogen is only absorbed minimally and could be used if they develop troublesome genitourinary symptoms like a dryness, urinary symptoms or pain during sex.

Transfeminine people who are taking oestrogen as part of gender-affirming hormone replacement therapy, usually for life, will not experience menopausal symptoms.

For more info about menopause and transgender health: please check out this website: https://www.queermenopause.com/resources

Non-hormonal medical alternatives to HRT

If you cannot or do not wish to take HRT, you might consider non-hormonal treatment of your symptoms. Sometimes they are also used to help with symptoms not quite controlled with HRT.

General symptoms

Antidepressant drugs are generally used for treatment of depression in the general population but they can also reduce hot flushes and night sweats by around 40%. They might also improve mood and sleep pattern. The specific antidepressants used are usually from drug groups known as selective serotonin reuptake inhibitors (SSRIs) or serotonin and norepinephrine reuptake inhibitors (SNRIs).

Side effects include nausea, headaches, constipation, disturbed sleep and sexual problems like lack of sex drive. Nevertheless, new onset depression in the menopause should be treated with HRT as the first line option.

Gabapentin is often used for the treatment of chronic pain but can also be beneficial for patients having hot flushes. Another non hormonal option is Oxybutynin which can also help with urinary symptoms and other bladder problems.
None of the non-hormonal alternatives to HRT are officially licensed to be used for menopausal symptoms, but we know they can be effective and help a patient to cope with them. They must be prescribed by a doctor who will usually suggest a trial for 3 months initially. If the drug has had no effect in that time then it should be reviewed. If the drug is helping menopausal symptoms, we suggest continuing the treatment for 6 to 12 months then wean it down gradually, depending on the symptoms. If the menopausal symptoms return thereafter, the drugs could be restarted again.

Local symptoms

If you wish to avoid local symptoms, there are other ways to improve the vaginal, vulval and urinary symptoms which occur after the menopause. These include general measures such as avoiding soap, wipes, perfumes, talc and man-made fibres in the vulval area. Vaginal moisturisers and lubricants such as Sylk® or Yes® can be very helpful to ease discomfort and you can request free samples on their websites. Emollient lotions may be helpful for washing and moisturising vaginal skin. Ask your GP or the Sexual & Reproductive Health Clinic to suggest the best products for you.

Please check out our other patient information leaflet: "Vaginal, vulval and bladder problems in the Menopause" (LN0660).

Lifestyle tips, self-help measures and natural alternatives to HRT

Hot flushes/night sweats:

- Avoid heat, very hot baths or showers and very spicy food.
- Cut down or avoid alcohol, caffeine, and smoking.
- Wear layers of clothing that can be removed easily as soon as a flush starts.
- Hand-held fans, a cooling spray or cooling pillow can help.
- Moist wipes may be useful but avoid use on the genital area.
- Avoid synthetic and/or thick night and bedclothes.
- Sleep on a big towel to absorb sweats.

Anxiety/palpitations:

- Try deep, slow breathing and other relaxation techniques.
- Try mindfulness by attending a local course, reading a book about it, listening to a podcast or audiobook or downloading an app like Calm or Headspace.
- Yoga and Pilates can be helpful to reduce anxiety.
- Regular exercise can also help with anxiety.
- Reduce caffeine intake.
- Speak to your GP about a referral to counseling or an online CBT (cognitive behavioral therapy) course.

Exercise:

- Regular vigorous exercise will help reduce the frequency and intensity of hot flushes and sweats (for example
  4 x 30 minute sessions per week).
- Choose a form of exercise that you enjoy and will continue with in the long term.
- Exercise also helps control weight gain, lifts mood and helps prevent heart disease.
- Weight bearing exercise can help prevent osteoporosis and exercise outdoors helps with calcium absorption.

- The Dundee Green Health Partnership can help you with ideas on how to become more active: https://www.greenhealth.scot/

Alcohol:

- Alcohol can make hot flushes, sweats and low mood worse and may also add to weight gain due to the calories it contains.
- More than 2 units daily (1 unit = a single measure of whisky, a ⅓ of a pint of beer or ½ a standard glass of red wine) may double the risk of breast cancer.
- Too much alcohol can also reduce bone strength and increase the risk of osteoporosis.
- Try to reduce your alcohol intake and have at least three alcohol-free days a week. If this is difficult for you, speak to your GP about this.

Weight:

- Obesity (body mass index (BMI) greater than 30 kg/m^2) may treble the risk of breast cancer, increases your risk of heart disease, stroke and blood clots and makes sweating much worse.
- Please speak to your GP to talk about your weight and a possible referral to a nutritionist or dietitian.

Smoking:

- Smoking greatly increases the risk of heart disease and stroke, both of which are more common after the menopause. It is also associated with an increased breast cancer and blood clot risk.
- Smoking also interferes with the absorption of calcium from food.
- Please speak to your local pharmacy or your GP about the different ways to help you to quit.

Please check out the Women's Health Concern (WHC) (patient branch of the British Menopause Society BMS) Wellness Hub for more information about nutrition, exercise, weight and emotional wellness around the menopause for all people assigned female at birth: https://www.womens-health-concern. org/help-and-advice/menopause-wellness-hub/

Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT) can be very beneficial for controlling symptoms in patients on HRT whose symptoms are not completely controlled, or patients who do not take HRT (anymore). It also helps with anxiety and depression. Excellent self-help books by authors like Sheryl Green and Myra Hunter on the subject have been published.

Please check out the useful CBT factsheet by WHC:
https://www.womens-health-concern.org/help-and-advice/ factsheets/menopause/

Patients can also download the excellent Sleepio app from the National Wellbeing Hub for free.

There is lots of evidence that CBT can help patients suffering from insomnia.

https://wellbeinghub.scot/resource/quick-guide-for-accessing-sleepio/

Aromatherapy

Some patients feel they get benefit from alternative therapies, although there is no scientific evidence to support their use. Methods include essential oils of lavender, camomile and rose which some people feel promote calm and improve mood and sleep.

Other alternative therapies
Homeopathy, acupuncture, reflexology and massage can help relax muscles and relieve stress. Yoga and Pilates can be beneficial for some patients by producing a calming effect. Hypnotherapy can also help you to tolerate menopausal symptoms better.

Diet

- Phytoestrogens ("plant oestrogens") for example soya products, beans, lentils, cereals and linseeds can supplement falling levels of oestrogen. Linseeds also provide the essential fatty acids omega-3 and omega-6. Plant oestrogens can also be bought in tablet form.
- Oily fish (salmon, herring, and tuna for example) should be eaten twice weekly to increase levels of omega-3.
- Calcium should be consumed daily, preferably from food, for example milk, yogurt and cheese, to help prevent osteoporosis.
- A variety of fruits and vegetables and whole grains should also be eaten.
- Cut down on caffeine as caffeine may worsen flushes, sweats and palpitations.

Calcium and diet

Bone is a living structure which is constantly being renewed. To ensure healthy bones, a reliable supply of essential vitamins and minerals, particularly calcium and vitamin D, is important. Calcium provides strength and rigidity to the skeleton and is particularly important for patients after the menopause where falling oestrogen levels cause a drop in bone density leading to osteoporosis.

Recommended daily calcium intake:

Patients over 45 years	1200mg
Patients over 45 years on HRT	1000mg

Eating a calcium rich diet is the most natural way to help your bone health. Calcium rich foods include milk (of any fat content), (calcium boosted) soya milk, tofu, yoghurt, cheese, oily tinned fish, spinach, nuts and dried figs.

Please check the following link for 'Healthy Living for Strong Bones', a patient information leaflet about calcium rich diet and other support material: https://theros.org.uk/

You might also want to check your calcium intake by using this calcium calculator: https://theros.org.uk/information-and-support/bone-health/ nutrition-for-bones/calcium/

In order for your body to make the best use of dietary calcium, it needs vitamin D as well. We manufacture vitamin D naturally in our skin when exposed to sunlight, so plenty of fresh air is an easy and cheap way to make the most of your dietary efforts.

In addition, there are a number of foods that are rich in vitamin D, such as oily fish (sardines, mackerel), eggs, cheese and vitamin D enriched foods (for example margarine and breakfast cereals).

If you do not have enough calcium in your diet, do not do much weight bearing exercise and do not get out much you may wish to take a calcium/vitamin D supplement. Please discuss this with your doctor as taking calcium in the long term has been associated with some risks. Let your GP know if you are vegan as some brands of vitamin D supplements are derived from animals.

Supplements may also be prescribed by your doctor if you have already developed thin bones, are at increased risk of developing thin bones or are already taking other drugs for your bones.

Herbal remedies

Some patients may wish to avoid conventional HRT preparations and want to explore other options like herbal remedies. Unfortunately, there is little evidence that any of these are of significant benefit and they can be expensive. Herbal remedies which are not regulated by a medicine authority should not be considered safer, as there is much variety in their effectiveness and potency and that there may be significant side effects.

Plant oestrogens contained in soya and red clover are often referred to as isoflavones or phyto-oestrogens. St John's Wort and Black Cohosh may help but may cause interactions with other medication.

Be aware that many herbal or plant extracts have weak oestrogen-like activity and should be avoided by patients who had breast cancer.

You might want to read the factsheet about Complementary/ Alternative Therapies by WHC: www.womens-health-concern.org/help-and-advice/factsheets/

Contraception around the menopause

HRT is not a contraceptive. Contraception is needed for patients at risk of pregnancy until the age of 55 or for one year past their last final period for patients aged 50 or over, and for 2 years past their final period for patients between the ages of 40 and 49. Patients using hormonal contraception (including the hormone 'coil'), HRT or following some gynaecological operations might not get periods at all. For this reason, it can be difficult to know at which point they can stop using contraception. They should therefore speak to their nurse or doctor for advice.

Low sex drive

Loss of interest in sex is a common complaint around the time of the menopause and has a complex relationship with many other changes happening at the same time. There are a few treatment options which may help.

Psychosexual counselling

We have a psychosexual service within our Sexual & Reproductive Health Service to look at these problems. Referral is through your GP.

Use of testosterone

Testosterone occurs naturally in patients and has a role in sex drive, mood and energy levels. Patients who have had their ovaries removed before the menopause can experience a significant loss of sex drive. Ovaries play a key role in producing testosterone and the role of testosterone replacement is now established in these patients. Testosterone treatment is less well studied in patients who still have their ovaries or who are perimenopausal.

You may wish to discuss testosterone therapy with your GP, practice nurse or menopause specialist to improve your sexual desire. Your healthcare providers will exclude other causes of your low sexual desire like remaining menopause symptoms, relationship problems, mental health issues, pain during sex, sexual boredom, sexual trauma, side effects of medication, lack of sex education, body image concerns, lack of sexual confidence, excessive alcohol intake etc., before considering testosterone. Testosterone treatment is usually only started in patients already on HRT and their other menopausal symptoms are under control and stable. Unfortunately, its therapeutic effect is usually only minimal.

There is currently no testosterone product licensed for use in menopausal patients on the UK market. Potential side effects from testosterone include greasy skin, acne and increased facial hair growth although these are rarely a major problem.

Tayside Menopause Clinic

Most hormonal and non-hormonal treatments of menopausal symptoms are prescribed by GPs and Practice Nurses. The Tayside Complex Menopause Clinic team is based within Tayside Sexual & Reproductive Health Service and gives advice to GPs and other health care professionals about the menopause care of individual patients, but speaks directly to some more complex patients following their referral. Most patients assessed in the Menopause Clinic are then referred back to their GP with advice.

Useful contacts:

Women's Health Concern

Website: http://www.womens-health-concern.org

Patient arm of the British Menopause Society (BMS) – excellent fact sheets, videos etc.

Rock My Menopause

Website: www.rockmymenopause.com/

Funded by the Primary Care Women's Health Forum – lots of information, podcasts, webinars etc.

NHS Inform (Scotland)

Website: www.nhsinform.scot/

Type menopause or early menopause in search function: info and videos

Royal College of Obstetricians and Gynaecologists (RCOG)

Website: www.rcog.org.uk/en/patients/menopause/

"Menopause Hub" with lots of information for patients

Royal Osteoporosis Society

Website: https://theros.org.uk/

Includes downloadable factsheets about calcium-rich diet, healthy living etc.

Developed and reviewed by specialist staff of the Complex Menopause Clinic at Tayside Sexual & Reproductive Health Service and has been reviewed by patients.

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This leaflet can be made available in other languages and formats on request
Speak to the nurse looking after you to arrange this