424 – Women's Health

With Steven Bruce, Dr Nikki Ramskill and Brooke Robinson

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Steven (00:00:00):

My main guest is Dr. Nikki Ranskill. Nikki is a GP. She's a member of the Royal College of Obstetricians and Gynaecologists. She's also a British menopause practitioner. Her own practice specialises in women's health issues, which is of course something we've covered on a number of previous occasions. But Nikki's not only an expert in this topic, she's also got a particular interest in incorporating the physical therapy aspects of treatment as well. So very relevant indeed to what you do in your own clinic. Now I've also asked Brooke Robinson to join us. Brooke is a very experienced osteopath. She's has special interest in women's health issues herself. So my theory is that she's likely to be able to ask much more pertinent questions than I can. So ladies, good evening.

Steven (00:00:54):

I've not done you justice in my little introduction there. So Nikki, if I can start with you, could you tell us a little bit more about your own practice? And I've said that you involve physical therapy and so on, so in what way do you do that?

Nikki (00:01:08):

So women's health traditionally doesn't get looked after very well. The NHS seems to be the first area that gets cut research as we'd like it to be in women's health.

And I was coming across a lot of women that were saying they didn't have a person to listen to their story to help them. We've got statistics saying things like nine years to get a diagnosis of endometriosis, for example. So I thought, I'm going to use my background and I'm going to start my own clinic. And that's essentially what I'm trying to help support the women in the local area and even online now to bring down the time it takes for their diagnosis. Somebody to get themselves heard, basically to be listened to. So the clinic that I run is not just about menopause, it's about all women's health, right from when someone's had a baby, before they've even had a baby, after they've had their baby and everything in between.

Steven (00:02:10):

And your clinic's in Milton Keynes, I think, isn't it?

Nikki (00:02:12):

The physical in-person place,

Steven (00:02:14):

Right. So how do patients find you? Are there other clinics around in the country where they've got alternatives to you or are you it?

Nikki (00:02:21):

Well, there's a lot of menopause specialists out there. There are a lot of private menopause clinics. There's very, very big well-known ones. You don't often come across a clinic that's specifically aimed at women's health, though. It's either a general GPs practice and they've got a women's health specialist on the side of that, or it's a menopause specialist clinic, or you've got a gynaecologist who's a surgeon and that's kind of what they're interested in. They don't really want to do the kind of office-based gynaecology, which is what being a general practitioner is all about. So I wouldn't say I'm unique, but there aren't many of me doing what I do

Steven (00:03:00):

Dare I say It sounds to me very like you are not really a general practitioner, you are a women's health practitioner.

Nikki (00:03:07):

So my background is in obstetrics and gynaecology. I've got the same qualifications as a consultant. I just don't do the surgery and I can help women before they even need surgery. Even if they do need surgery, they might not need it at all if I can give them the support they need.

Steven (00:03:23):

Yeah, that's probably a route we need to chat about later in the show about when we can point people in the right direction. Brooke, I've introduced you as an osteopath specialist in women's health. You've done Renzo Molinari's course, haven't you?

Brooke (00:03:36):

Yes.

Steven (00:03:36):

There's probably a lot of people out there, especially the chiropractors, who aren't allowed to do his course as far as I'm aware, but myself included, I would like to know what you cover on that course.

Brooke (00:03:48):

So we pretty much cover everything from periods in general and women's health in general, but also from fertility and infertility through to being pregnant to post-pregnancy from a postpartum as the mother. We also look at the baby and then we go all the way through to peri-Menopause and then the ageing female. It covers pretty much Everything

Steven (00:04:15):

So on that course, I'm absolutely certain that Renzo won't be saying that osteopaths can treat everything, that you never need the conventional medical approach. Is there any interaction between you, the students on the course and say someone like Nikki?

Brooke (00:04:32):

Yeah, so we had a doctor come in who was a women's health specialist and talk to us a lot about HRT. We have imaging specialists who come in and talk to us about the role that they have, especially in endometriosis from a scanning point of view and the technology that is out there. And then we have obstetricians who come in and who again particularly specialise in endometriosis or fibroid removal, and he talked us through what his work does and how he approaches patients. It's not just, obviously there are lots of osteos, but they also bring in lots of other specialists to make sure that we are aware of who's out there and what's needed.

Steven (00:05:28):

It's always a bit of a race on this show to see how quickly the first question comes in and to see how quickly Simon can get in a question. Simon always asks a question, and this one's just come in, he says, do either of you think that if menopause or endometriosis was a “man's problem”, that there would be more research and more drive to solve the challenges?

Brooke (00:05:48):

Absolutely, Simon, the answer to that,

Steven (00:05:50):

He only asks, he says, because of the problems his wife and several cousins have faced with very little support. So it goes back to what you were saying there, doesn't it about your support for women?

Nikki (00:05:58):

Absolutely. I mean, if you look at, I forget the number of studies, but so many more things have been done about erectile dysfunction than there have been about things like endometriosis. So is completely right on that, unfortunately

Steven (00:06:11):

Is we're getting a bit off piste here, but is the gender balance in the medical fraternity, is that evening up? Are there more female doctors now, which I would imagine would drive more research into female issues?

Nikki (00:06:24):

There are many more female doctors now. That used to be the other way around, but unfortunately what's happening is you're not getting a lot of women into the kind of higher tiers, if you like, for lots of reasons. So yes, there is the option to do the research. There are lots more women going into it, but I just don't think there's the driver there or the money or there's something that's not quite working.

Steven (00:06:49):

Yeah, I was thinking as you were saying that one of the drivers would be money, wouldn't it? I mean, I imagine that there's lots of money in orthopaedic surgery because

Nikki (00:06:59):

It makes a lot of money

Steven (00:07:01):

And it'll involve sports people as well, won't it, which where there's lots of money swishing around in those pools. Going back to the physical therapy side of things, you have a physiotherapist at your disposal who is a women's health specialist. I don't know how that might differ from say what Brooke's done, what does she get up to?

Nikki (00:07:21):

So I try and have a good referral network. So this lady that I came across in one of my other professions, she looks at postnatal health in particular. So she'll do the examination looking at prolapse. She'll be telling women how to do her pelvic floor exercises properly, she'll check their abdomen. That's her main thing that she likes to do. But she'll also help older women as well that have perhaps gone through menopause or in perimenopause that've got issues with vaginal problems as well. So that's kind of her area I can imagine. I mean I'm not sure, but I can imagine there'll be other things that you would also be able to help with beyond that.

Steven (00:08:02):

Yeah, it's all about pelvic floor, isn't it, Brooke?

Brooke (00:08:06):

It's important, yeah.

Steven (00:08:07):

But…

Brooke (00:08:08):

Renzo's course is very much about it, but also osteopathy is very much about you look at the body as a whole. So the pelvis is one part of it, but actually when you're treating someone with prolapse, incontinence, all that sort of stuff, you look at the pelvis, but actually you need to look at what else is happening in the rest of the body because actually a lot of the time what is happening in the pelvis can be caused by issues in other parts of the body, especially through the thoracics and spine. And even

Steven (00:08:39):

You smiled when I said that Renzo's course isn't open to chiropractors. Was I wrong? Is it open to chiropractors as well?

Brooke (00:08:46):

I don't a hundred percent know actually, but we were all osteopaths and it's very much about driving the very traditional sort of thoughts

Steven (00:08:54):

When I looked at his website. It does say that the entry qualification is DO or equivalent,

Brooke (00:08:59):

So I think it is, but

Steven (00:09:01):

It'd be interesting to know what the chiropractic equivalent courses are. There must be some out there, aren't there, and probably all done in Bournemouth at the Bournemouth College, which is now in charge of the UCO of course.

Steven (00:09:13):

So let's get back to your practice. “It's not all about hot flushes” is one of the taglines I've used for this show. Is that what people think of women's health out there?

Nikki (00:09:21):

Oh, absolutely. I mean, a number of patients I've spoken to that said, well, don't get hot flushes, so I've been told it's not perimenopause. That's one of the last things that happens. And actually not many women get that. You tend to have other things. Brain fog for instance is really common. So not being able to concentrate on work, forgetting things,

Steven (00:09:41):

You said you've had that recently, but I think that was to do with children, wasn't it?

Nikki (00:09:45):

Well, there was that, but I also have something called premature ovarian insufficiency, which I wanted to Talk about.

Steven (00:09:50):

Excellent.

Nikki (00:09:51):

So there we go. So it leads into it. So basically I've gone through, it's kind of like menopause before the age of 40 with fluctuating ovarian function. So some months it will be fine, some months it won't be fine, but overall it's not great for bone health, brain health, heart health in the same way that a menopausal woman would have except far earlier than it should have happened. So it's a really strange place to be in when you think you're really on it and all of a sudden you can't find a word, you can't remember what's happened. I used to do strange things like leaving my keys in the front door. I'd walk in, I'd do everything as normal, and my husband would come home an hour or so later saying, do you do realise your keys are in the front door still, don't you? And I wouldn't have had a clue that that's what had happened. I never did that before.

Steven (00:10:35):

Ladies and gentlemen, this is a lady to whom you are entrusting your healthcare in, a primary care setting!

Nikki (00:10:38):

But since HRT, that completely shifts and it does really, really help. That I would say for women is one of the biggest issues and a lot of them are dropping out of the workforce because they think they can't do the job anymore. This is another part of

the problem. So you've got women that are leaving the profession when they actually should be at their highest income level, their pensions are suffering as a result, they're not getting into the C-suite because of all these things. So actually menopause is far more than just hot flushes. It's an economic disaster if you don't treat it properly.

Steven (00:11:15):

Yeah, I wasn't familiar with the term premature ovarian insufficiency until I started looking into what you do in your practice. Are women generally aware of that?

Nikki (00:11:29):

No,

Steven (00:11:30):

They're not. Would gps generally be aware of that? Do you get talk about that on Renzo's course?

Brooke (00:11:37):

Yeah, but it's something I have as well.

I was lucky enough to have my daughter. They're not really sure how, but yeah, so it's more through a personal experience or friends or whatever, but it's becoming a bit more well known I think as we're getting older and people are having more trouble having babies and things like that. So

Steven (00:11:58):

I guess my question is to the patient, to the woman in the street, it doesn't really matter what it is behind it, does it feel like menopause? Is that why everything is menopause? Because the symptoms, the signs are all the same

Nikki (00:12:12):

And it is colloquially that's what people would understand,

Steven (00:12:16):

In which case it doesn't matter as long as they seek treatment.

Nikki (00:12:19):

Yes.

Steven (00:12:20):

Okay. And how would that differ then?

Nikki (00:12:22):

It doesn't. This is the thing. I mean, the only slight difference I suppose, would be you do a bone scan, you do a DEXA scan before you start treatment or around the time you start treatment just because you want to know what that woman's baseline is. Because if they've not recognised or not been treated for so long, they may well have early signs of osteopenia or osteoporosis happening. That's probably the main difference. The other difference is to just look into a cause - the younger somebody is, the more likely it is that there's a genetic problem or something else has happened. The older you get, the more likely it is,perhaps, it's just a very early onset of perimenopause, but there may still be other problems that haven't been addressed like diabetes or celiac disease or rheumatoid arthritis. So it's important to know

Steven (00:13:10):

How long is perimenopause before it becomes menopause?

Nikki (00:13:14):

On average, about eight to 10 years

A long time.

But a lot of women will still have symptoms even after they've gone through menopause completely. It's not uncommon as well for people to suddenly start getting perimenopausal type symptoms in their sixties, and that's usually because they've got an issue with their cardiovascular system. So their blood pressure, for instance, has gone up. So that's the first thing I'll check if someone's been absolutely fine and then suddenly not, and usually that's the issue. So yeah, it does affect women for a long time.

Steven (00:13:47):

Kim's come in with a question about pelvic floor, an observation about pelvic floor exercises, which reminds me that I was going to say that we've had a show before, and I'm racking my brain to think of who the guest was, but she was saying that you can overtrain the pelvic Floor

Brooke (00:14:02):

Absolutely.

Steven (00:14:03):

And actually that can be counterproductive and you're nodding vigorously Brooke. So how does that work then?

Brooke (00:14:10):

Just like any tight muscle, a tight muscle of any sort can be inefficient. So I always tell my patients their muscles need to be long and strong, not short and weak. So actually for anyone who needs pelvic floor work or potentially pelvic floor work, they should be assessed first before they're prescribed anything in order to determine what's working, whether it is weak.

Steven (00:14:36):

Is there a general assumption across much of our professions collectively that you always need to train the pelvic floor then?

Brooke (00:14:44):

Well, yes, I think so.

Steven (00:14:46):

It's like anything else you've got to work out whether it needs that kind of training.

Brooke (00:14:49):

Yeah, actually you need to allow things to relax before you reactivate.

Steven (00:14:55):

Kim here has said that it's important to train the whole body. She's an osteopath, but she also says it's very difficult to train the pelvic floor if the pelvis is out of alignment. So I guess most osteopaths and chiropractors would think along those lines anyway. Although I dunno. I dunno whether pelvic alignment is going out of fashion in our circles to some extent.

Brooke (00:15:15):

Someone said that recently

Yeah. It's not about apparently weak glutes and it's not about pelvic alignment as a topic. Apparently it's going out of fashion.

Steven (00:15:27):

How would you describe yourself as an osteopath? Are you a sort of fairly traditional, old fashioned osteopath who does that whole sort of pelvic alignment, whole body stuff? Hvts?

Brooke (00:15:38):

Yeah, I was very much like a sporting background. I was very much a rub and crack, and that's almost how we're trained in Australia to be a little bit rub and crack, a little less traditional. But actually as I've got a little bit older, as my patients have changed and certainly as I've done the course now, I suppose I've listened to the tissues a lot more and take a much more of a varied approach. And especially, it doesn't necessarily have to be women's health related, but I've tried to become through Renzo and a lot of the old school osteopaths we had on the course, they really taught you about listening to the tissues and using much more of your fascial and your more indirect stuff in order to really sort of understand the body a lot more. So yes, I still rub and crack, but I also go, okay, that's not responding the way I want. Where else is it coming from? But also actually, does it need a gentler approach?

Steven (00:16:34):

It's a bit of a challenge actually, isn't it? Because for you in the sense that I suspect that a woman with sort of problems that we've described, they're not going to look first for an osteopath, are they? They're going to probably look first for a doctor, not necessarily a woman's health specialist doctor.

Nikki (00:16:51):

See, not even that. Not even that. Usually their neighbours first or their friends or Holland & Barrett for instance, they'll go somewhere else, they'll take a supplement though. They'll look at things like that rather than go to a professional.

Steven (00:17:05):

So what is the nonsense that we ought to be looking out for in stuff our patients say so that we can say, Hey, hang on, don't trust the internet with everything.

Nikki (00:17:14):

I'm finding a lot of Americanisms coming through. So for instance, people think that when you are diagnosed, you must have a blood test, you have to have a blood test, otherwise you don't know.

Steven (00:17:27):

Is that before or after the MRI?

You've got to have that as well, haven't You?

(00:17:31):

Yeah. Things like the FSH level, for instance, that might be abnormal. It might not be abnormal. Somebody who's very much in their menopause, it will be abnormal, it's fine. That's how you diagnose it, but you wouldn't actually use that because it's so obvious because the person stopped having periods. So it makes sense for a

younger woman who's maybe 45, there's no point because some months it'll be fine, some months it might not be fine. If it's normal, are we going to say go away. No, we're going to help her. So in my view, there's no need to do it. Another one that goes around a lot is progesterone. There's a lot of women asking for progesterone level to be done. It's only one hormone. And we tend to use that for people that are struggling with their fertility. There is no research or anything that says if you have this level of progesterone, your uterus is protected. Or if you have this level of progesterone, you are balancing your oestrogen. And there's a lot of people saying oestrogen dominance is a problem. Okay, yeah. If you're taking too much oestrogen externally or you haven't perhaps got enough progesterone, you might end up having bleeding issues or you might having other symptoms, nausea for example.

Steven (00:18:40):

So where are they getting the oestrogen from that they're taking externally?

Nikki (00:18:43):

Well, it depends on who they've gone to. So if they might go to someone like me, for instance, and they'll be given HRT, and there's some clinics that actually are giving very high doses of oestrogen,

Which in itself is not necessarily a problem as long as it's being balanced properly with progesterone and you are protecting the uterus. For other people, they're going to what's called bioidentical clinics where they're having these thick concoctions made for them based on some tests they've had done that says they're low in whatever. But no, the problem is the safety around it. It's questionable. We're not sure if it is safe or not and the British Menopause Society, just don't subscribe to that at all. So you will have some women that are on very high doses of oestrogen that will say, oh, you are oestrogen dominant. What does that actually mean? It is so different. Everyone's so individual, it doesn't really have any basis in how we would look after someone. It's what are your symptoms? Let's deal with those.

Steven (00:19:37):

We had a show on Men's health sometime ago. In fact, we're doing a similar show in a few weeks time. And one of the points made in that show was that the PSA test is notoriously unreliable for prostate cancer. But what was really useful is to know what your baseline was, so that you could see when it changed. Is that something which is useful in blood tests? If you said to a woman, right, well, we'll take your FSH and we'll do all these bloods now and then in the future we'll be able to see if they've changed one way or the other. Would that be helpful or are they still too Variable?

Nikki (00:20:07):

It's too variable. This is the problem. One of the things that I do use is testosterone as a baseline. So if a woman wants to start testosterone or she's thinking she might want to in the future, it's always handy to know what's going on first.

(00:20:20):

So at least if I know the baseline, I know she's not starting from a really high level or something, then I can start testosterone generally pretty quickly without a problem, and then we would just monitor it for a few months after that. So that's the only one that I would do a baseline with. Oestrogen can fluctuate before you start HRT. I might use it to guide my strategy and how somebody might take the HRT, but it wouldn't necessarily stop me from starting or anything with that. And FSH, I mean notoriously in the condition that we have, FSH can go up and down from one month to the next, from one day to the next. So actually to say to somebody, right, your baseline is menopause and then three months later you start HRT and your FSH is now normal, that person might think that they're being treated unnecessarily, whereas actually it's the HRT that's causing the FSH to go down, not their body suddenly healing and recovering.

Brooke (00:21:17):

So how do you decide what you put someone on?

Nikki (00:21:19):

As in what type? It comes down to the risk profile. So you can have oral oestrogen. If somebody hasn't got problems with migraines, with aura, if they haven't got other reasons for higher blood clot risk. So if they're overweight, if they smoke, if they've got cardiovascular disease, you wouldn't want to put someone on oral oestrogen because it increases their risk of blood clot.

Brooke (00:21:41):

No, no, no. And I get that, but it's more, you talked about symptoms, so rather than doing blood tests, if someone comes to you and say, I'm struggling with all these symptoms, and you say, okay, HRT might be the answer,

If You're not doing the blood test, how do you then decide how much of what to put them on?

Nikki (00:22:03):

Again, I suppose medicine's like an art as well as a science, isn't it? So I would start somebody on a level based on their age where I think they would be. So younger women, I tend to start higher doses. Older women, I tend to start lower doses. You don't need as much as you get older. And then we'd sort of base it off of that. And then if they've responded really well, great, that's the level they stay at and then review it three months later. If it's not right, we can go up or down depending on

what's changed and what hasn't changed. And there's a really good symptom questionnaire that you can use that helps guide that process. Okay.

Steven (00:22:36):

Is that a freely available questionnaire? Yeah,

Nikki (00:22:39):

There's one I'm going to share with the audience afterwards.

Steven (00:22:40):

Thank you. I've got a couple of questions about testosterone, but the first one is mine, which is do you find you are having to do a bit of education with women coming to you because there would I imagine, be an instinctive resistance to testosterone because that's a man's hormone.

Nikki (00:23:00):

There's more resistance from the medical profession actually. Really women are asking for it, they want it. The problem is there's a lot of fear around it because there's a lack of understanding. You're right. People do worry that it's a man's hormone and if we give you testosterone, we're going to turn you into a man. You do have to educate a little bit about that.

Steven (00:23:21):

It's actually quite prominent in women, isn't it? It's not just a trace element of testosterone.

Nikki (00:23:26):

No, I forget the number now. I think it's something like there's four times more testosterone in a woman's body than there is oestrogen most of the time in a fertile woman. So actually we are producing a lot more testosterone, just not as much as a man has. So when our ovaries start to decline in function, the testosterone will start to decline, not in the same way that oestrogen does, but it does over time. For some women, that does not bother them at all. It doesn't make any difference. But for others it really does make a difference. And they notice it and they have the HRT and they just feel like something's not right. Still. They've got no energy or motivational libido or just life just feels joyless. And as soon as you start them on testosterone, it completely changes.

Steven (00:24:08):

Right. Well the two questions that came in here first from Sarah, which you've kind of addressed here. What do you think about prescribing testosterone for menopausal

women? She's been told that it's overrated and there's no need for it. So she's not sure what to believe. And the other one is, can you get testosterone on the NHS? This is a question from Jane. She says she thought you could only get it if you had no libido.

Nikki (00:24:29):

So it can be overrated. So if someone has no response by six months, you will usually say to them, look, your levels have come up. How do you feel? No difference. Okay, what's the point in carrying on with it? Then we've demonstrated by blood tests that we have gone up to a better level and you feel no different. Therefore, is it the testosterone or not? And often women will make that decision at that point and they'll say, no, I want to carry on with it for a bit more time just to see or No, I'm going to stop. So yes, it can be overrated. It doesn't always work for everybody.

Steven (00:25:06):

What are the potential adverse side effects?

Nikki (00:25:08):

Well, if you're taking too much, you can have hair growing in places you'd rather not have hair, a deeper voice that permanently changes. Cardiomegaly, aggression, oily skin. That doesn't happen very often though. You're giving an eighth of a dose, you're giving a really tiny amount of testosterone,

Steven (00:25:28):

An eighth of …

Nikki (00:25:28):

So I actually don't have any sachets to show you, but the little sachets and are tiny and a man would have one or two of them. A woman, you're literally eking out an eighth of a dose. You're making one sachet last eight days. For some women, I give them even one over 16 days depending on what their levels are initially. So it's really tiny doses and we always monitor. So for the first six months, you're monitoring every three months and then you're monitoring it annually as long as nothing has changed. So it's closely monitored. And that's part of the problem why it's not always available in the NHS because of all the extra tests that have to come with it, it's off licence. And yes, the British Menopause Society say that it's for post-menopausal women with no libido. We know that's not the only thing that it helps with, but there's no robust evidence yet to say that it helps for other things as well.

Steven (00:26:20):

So any GP could prescribe this off licence to their patients, but of course this is a real nightmare of hormonal balances, isn't it? And if they haven't got the evidence at their fingertips, then they're not likely to prescribe It.

Nikki (00:26:34):

No. And you've got to chase women as well to do it. So in my clinic, I have to make sure that I send a reminder out to women to make sure they get it done because I don't want to be prescribing them something that they haven't actually then checked. And I have come across a few women that have been on it for years and then no one has ever done a blood test. Let's just make sure, I mean you're probably fine, but let's just see, because you don't want someone to be permanently damaged by taking a hormone that actually perhaps they had too much of in the first place, but at the doses we give, it's more unlikely.

Steven (00:27:03):

Yeah. Interestingly, that does reflect what another doctor said on this show a couple of years ago. I think now in that people are often put on drugs, but no one ever checks after a year or whatever's gone by that they still need those drugs or that they're doing the job that they were intended For.

Nikki (00:27:16):

Exactly.

Steven (00:27:17):

Because, and again, it sounds though I'm criticising the medical profession, but we all know why that happens - just because there's just too much bloody work,

Nikki (00:27:23):

Too many patients,

Steven (00:27:23):

Too busy pelvic floor. Victoria says, have you got any thoughts on the Emsella chair for pelvic floor? Ever heard of that?

Speaker 2 (00:27:32):

No. No.

Steven (00:27:33):

Well, right then Victoria, you have to tell us about the Emsella chair because I dunno anything about it. And while you're doing that, I'm absolutely certain that Justin will

be beavering away in the gallery, to find a picture of it that we can put up on the screen so that we can have a chat about the Emsella chair. That would be interesting. Ross says, what are the options for premenopausal women on oestrogen blocking therapy like Tamoxifen for breast cancer, which causes menopausal like symptoms?

Nikki (00:27:57):

Oh yeah. This is another big area that I think will change eventually. You have to look at the risk for that woman. So you can technically put somebody on HRT, but you have to be cautious as well, obviously. So if she doesn't mind. So I've got friends that have decided to stay on their HRT even being treated for breast cancer because they feel that their ever-so-slight percentage chance of it coming back is not worth the menopausal symptoms that they're suffering

Nikki (00:28:28):

But then you'll have somebody else that perhaps has got two, three children and they want to be around for as long as they possibly can and that tiny risk is too much for them. So then you have to look at what are the non-hormonal routes that we can take. So the British Menopause Society have got a really good patient facing website called the Women's Health Concern, and it's actually really helpful for professionals as well. And there's a load of fact sheets on there and one of them is about complementary therapies and it even goes into complementary therapies for women that have had breast cancer. So you might be looking if it's hot flushes that are the issue, looking at things like gabapentin for example, venlafaxine, these are common painkillers and antidepressants that we might use that have got some evidence to suggest that it would help. Clonidine is a licenced medication that we can give for hot flushes and there's even a new one that's come out called Veoza (fezolinetant), I believe is the brand name. It's not available on the NHS. It's only available privately. It is coming on the NHS though, and it targets the area of the brain that actually is affecting your temperature control. It hasn't been tested on women that have had breast cancer, but it's got no hormones in it. So I don't see why you couldn't perhaps have that one.

(00:29:38):

And then you have to look at what other symptoms are going on. So if it's hot flushes, which is the one that I've already said is not the only symptom, if it's vaginal dryness, there's moisturisers, lubricants. And actually we do now know that women can have vaginal oestrogen safely on things like tamoxifen because it's not systemically absorbed, or at least if it is the tamoxifen is rendering it useless anyway. So you can actually use vaginal oestrogens very successfully. For women that have been going through that. I have seen consultants as well that have prescribed things like testosterone for women that have got libido issues. Again, there's not really the evidence around it, so you can't really say one way or the other. And usually we give

it with oestrogen. So it's a bit of an unusual way to give it. It's possible, it's just that the person in front of you has to be aware that the evidence is not there yet. We haven't got that, but it's doable.

Steven (00:30:32):

And of course communicating the evidence behind treatment is very important for all of us. And our regulating body comes down heavily on anyone who doesn't express all that sort of stuff clearly to their patients. But I suspect that patients often come to you with preformed ideas about what they need. And so sometimes you might be talking them down from something rather than trying to convince them of the evidence or lack of evidence for it.

Nikki (00:30:56):

One of the big ones is I want to go on HRT, but I'm scared that it's going to give me breast cancer. That is one of the biggest questions that people ask me. So I always direct them to a really interesting book. It's called Oestrogen Matters, and it's, I think the name's Dr. Avrum Bluming Off the top of my head.

Steven (00:31:13):

We will look it up and share that.

Nikki (00:31:15):

And what he's done is he's looked at the evidence that was put forward by things like the Women's Health Initiative in the nineties to basically say you should not be on HRT because it will cause breast cancer. And he's actually completely demolished it. And it's really interesting when you read it and actually what the research is now saying is that if you give someone oestrogen-only HRT, because she hasn't got a uterus (you can only do that in those women) actually it can reduce someone's risk of getting breast cancer.

If you give it with what's called body identical progesterone, you actually are not massively increasing someone's breast cancer risk within the first five years of taking it. So there's a lot of myths that can be busted because of this old research that happened many, many years ago that we're still relying on or still using.

Steven (00:32:08):

Thank you for that. I dunno how this is going to progress our conversation, but we do have a picture of an Emsella chair, which might give us some idea as to, I have no idea how that affects your pelvic floor.

Brooke (00:32:19):

Is it like a power plate?

Steven (00:32:20):

Maybe it's a vibration plate, which it might be entertaining if nothing else. So there's your pelvic floor, before and after, apparently. I've seen chairs like that in hospital, but for a completely different purpose it seems to me. I mean maybe Victoria will come back to us and tell us what she thinks.

Nikki (00:32:38):

I mean if it works, great, it'd be interesting to know the lasting effects of it and what the procedure is exactly what it is that it's doing.

Steven (00:32:56):

Well in that sense, at what point do you refer people for physical therapy of whatever nature? It's primarily physiotherapy at the moment, isn't it? From your practice? What makes you decide they need to go and see a physio?

Nikki (00:33:10):

Well, if somebody's not sure how to do pelvic floor exercises, but they have a prolapse and that's one of the things that we know can help, then I think it's really important to see a professional because then you can actually be guided properly in doing it and you're not just kind of guessing because a lot of women don't know what pelvic floor exercises feel like. If they're postnatal, they don't often get that care and attention after they've had their baby because it's all about the baby, it's not about them. So seeing a professional I think is really important. And the more I'm learning about osteopathy and chiropractors and what they do actually is even more important to make sure that they see somebody because they're looking at the whole body. They're not just looking at the pelvic floor.

Steven (00:33:50):

So Brooke, you are now talking to a GP specialising in women's health problems. What would you be saying? What sort of patient would you want Nikki to send to you? How could you complement what she's doing? That's put you on the spot, hasn't it?

Brooke (00:34:08):

I suppose it's that whether it be one of your HRT patients or just someone who has some incontinence or anything like that, it's sort of understanding why. I mean obviously I'm not helping their body produce hormones, but the hormones start in the brain ultimately. So if there's restrictions or things that don't work, I mean a cranial osteopath will tell you that that they can affect the pituitary, the hypothalamus, but that's not what I'm necessarily claiming is going to change. But obviously whether it be on HRT or not, menopausal, perimenopausal, postpartum, their bodies produce

physical symptoms. So it's not in place of what you do, but it's to complement and have their body ultimately in the best place that they can be and whether it be a pelvic adjustment or whether it be teaching them pelvic floor exercises or whether it be actually releasing tension through their bladder or around their uterus or just through their adductor muscles and their hips, and I mean the hip and the piriformis and the obturator are sort of the key to the pelvis, especially leading up to having a baby. And so therefore they also need to be really important postpartum as well.

(00:35:36):

So really I suppose to compliment every other physical part that you (Nikki) are helping the inside of, we just help the other parts of the inside.

Steven (00:35:48):

It is a refreshing to hear that someone such as yourself, Nikki is thinking, yeah, there's a physical component to what's going on here as well, where others can do some magic.

Nikki (00:35:59):

Absolutely.

Steven (00:36:00):

And not just looking at pelvic floor exercises. As you said, it's looking at the whole body and we osteopath, we're always going on about how blood flow is really important, the rule of the artery and all that stuff, but of course it is, it's important for the health of everything going on in the body and it's something that I think we can help with, whether it's through what you've described or through craniosacral therapy or sacral occipital therapy from our chiropractic colleagues.

Jane apparently thinks that in France testosterone is given automatically when prescribing HRT.

Steven (00:36:32):

Any ideas on that? I mean, I personally think that in France they sort of throw the book at everybody. It's very easy to get medication in France.

Nikki (00:36:39):

Yeah, I know there are clinics in the UK that do very similar things as soon as they start someone HRT, testosterone is already automatically there. In my experience so far, not everybody needs it.

And actually what I prefer to do is see how someone responds to HRT first because if they respond really well to it and actually the issues go, then there's no need to add more. But if it still feels like there's something missing, we've got really good levels of

oestrogen and the testosterone is the only thing we haven't tried. I don't see any reason why we couldn't try it. It's just that I find it difficult to know what's working if we throw everything at them at the same time. And patients generally will agree with that. Not everybody. Some do want to start it straight away and they've already read about it and they're very happy to do that and that's fine. I'm a bit more cautious.

Steven (00:37:26):

Okay. I'll try and crack through. Predictably an awful lot of questions coming in on this topic, and I guessed there would be long before we started. Pip wants to know how a woman would know if she's on the right dose of HRT, especially if they've got less obvious symptoms of menopause.

Nikki (00:37:41):

Oh, it's a really tricky one because you could do their oestrogen levels and it might be 500, 400, it could be any of those. If it's above 250, then we know that we are protecting our bones. So that's a given. I think for the woman, it's about what she's feeling and you can always do it, I mean, to test it out. I say, right, okay, you are on this dose, let's try a little bit more and just see what happens. If it makes no difference, then we go back to it again.

Steven (00:38:11):

How quickly do they see the change?

Nikki (00:38:12):

Some, I mean it's very quick. Others, it will be a longer slower burn. So hot flushes tend to dissipate really quickly. Other things like the brain fog might take longer. And actually we know that brain fog's not just about hormones, it's also about what quality sleep are you getting? Are you eating a balanced diet? Are you exercising? There's so many more things to it, and I think that's where the physical therapy aspect also comes in because it's not just about me throwing hormones at you, it's how are you living your life and what else do you need to do? So it depends on what the symptoms are. So it's hard to know that's the problem. There isn't a blood level that will tell me that's the right level for you because everyone's so different.

Steven (00:38:51):

It must be a bit of a challenge there. You are talking to a woman who's looking after a pack of small children, talking about her getting to the gym and doing some exercise and eating a balanced diet rather than snatching a fish finger and also getting good quality sleep. That's a bit of a challenge For you.

Nikki (00:39:03):

Oh, absolutely. A hundred percent. I know I've got two goals, so I completely understand. So I think it has to be what can be done with the time that you've got? These are the guidelines, what can we do towards that and how can we fit it around your lifestyle as best we can.

Steven (00:39:18):

Do you do any NHS work now or is it all your work private?

Nikki (00:39:21):

I do some NHS work. Yeah.

Steven (00:39:23):

The reason I ask is because you mentioned, I can't remember if it was before we came on camera or not, but I mean you were talking about the economic impact of poor women's health as a result of all the issues that we've been discussing. So it made me wonder just what financial emphasis the NHS puts on this. I'm guessing from one of the things you said that they're not putting much on it at all.

Nikki (00:39:44):

No, there was a thing that government were pushing about women's health hubs and they threw money to all the different PCNs and NHS England to create these hubs. And they do exist and they do work really well. The problem is that I think something like 75% of that money just disappeared. It wasn't ring-fenced. So in Milton Keynes, they seem to be having a meeting about a meeting, about a meeting. Eventually something will happen, but it's taken a long time to get to this point, and in which time 75% of the money's gone. And I started a clinic and unfortunately because all the PCNs now have pulled out apart from two, it's no longer financially viable. So that nurse and myself, I have no job to go back to do that.

The women that were being looked after were having testosterone, they were having pessaries fitted. They were having all the things they needed without having to be referred into a gynaecologist. So yeah, it is tricky because as soon as the funding disappears, it seems to be these specialist clinics are the ones that go.

Steven (00:40:55):

And also, I mean, it kind of goes without saying, doesn't it that the poor woman who's on benefits is not seeing you as a private gp?

Nikki (00:41:02):

No,

Steven (00:41:02):

She's not getting the right care.

Nikki (00:41:04):

And that does worry me. And it's something that I, one day, what I would love to be able to do is have some kind of pay it forward scheme or free pot or something that I can then gift so many appointments

Steven (00:41:18):

Or in an ideal world, demonstrate to the government that the return on investment for paying for good women's healthcare comes back many fold in economic development.

Nikki (00:41:28):

I'm sure they probably already know that.

Steven (00:41:31):

Yeah, but they only think in five year cycles.

Some more questions. Somebody known as number 36 says, do you aim to eventually cease HRT to allow the natural menopausal process to continue, or do you see HRT as a preference to the natural menopause?

Nikki (00:41:46):

So the way I describe it to patients is, if you think about it, menopause is kind of a manmade concept because a hundred years ago, women were dying in their early forties in childbirth. They weren't really getting through menopause. So actually we are prolonging the life of women and we are putting them in a 40 year menopause because of that. I don't think there's any coincidence that more women are living with disabilities later in life compared to men. I mean, yeah, men are dying earlier, women are living longer, but most of that is in a nursing home or with poor health. I don't think there's any coincidence there at all. So for me, HRT is preferable over menopause because technically we need our hormones to keep our brain, our bones healthy in my view.

Steven (00:42:41):

Right. Okay. Pip says, how do you assess when it's the right time for a woman to come off HRT? Or can you just stay on it for decades? A related question, I Suppose, isn't it?

Nikki (00:42:49):

Yeah, we used to say five years. We used to say 10 years. Now it's women's preference. I try to make sure that she's on the safest route I possibly can. I mean, our risk of blood clots, stroke and things increases as we get older anyway, so I try and go for transdermal oestrogen long-term I try and go down to the lowest oestrogen dose that I can, so the lowest dose patch or even half a patch, making sure we're on the right type of progesterone, so not cycling all the time. We're giving a constant source of progesterone, trying to go for body-identical versus the synthetic versions, making sure the woman's having a regular mammogram. She's aware of what her breasts feel like and how they change. I don't see any reason why someone couldn't be on it, just she has to be the one that makes that decision and that choice.

Steven (00:43:35):

Interesting that you say what you just did there because the only time I've had a complaint lodged against me, it was lodged by one of my fellow osteopaths, and it was because I raised the possibility that routine screening for breast cancer was not necessarily advantageous, and it wasn't my opinion, it was Professor Peter Gøtzsche from the Nordic Cochrane Institute. And there's a hefty sized book, which goes into all the research behind it.

You obviously think it is.

Nikki (00:44:05):

Well, the difficulty is that you've got that person in front of you with those worries in the back of their mind. What happens if this occurs? Not every woman's confident to know if anything changes and having that reassurance that you're having a scan, maybe it's misplaced because sometimes you can miss things on mammograms.

Steven (00:44:25):

But I think his Point was that you would catch the slow growing tumours, which are largely harmless. You'd miss the fast-growing ones, which are the dangerous ones, and the evidence suggests, and seriously very high quality research, His evidence was that if you tell a woman that she has a tumour in her breast, first of all, the moment you say the C word, they don't hear anything else.

(00:44:48):

So they're now going to worry endlessly. You're compelling women, I say compelling, but you're convincing women perhaps unnecessarily in many cases to have mastectomies or whatever else and putting through an awful lot of stress, which actually you might be better doing regular breast examinations and spotting the lumps, the changes and so on. And that is a good indication to then go and get scanned. And I realise that there's a discussion to be had about that, and I'm now

waiting for the second complaint to come in about me because I've suggested that routine scanning is not necessary.

Nikki (00:45:23):

I mean, the problem is there's no screening programme that's perfect. I mean, it's the same with PSAs and prostates and we've discussed that. So yeah, nothing is perfect. I think a lot of people like the reassurance of it, and I guess as clinicians, we like the reassurance of it. If you've got a normal scan in front of you, it can feel reassuring, but you always have to caveat and say, make sure that you keep checking, make sure that you raise any changes and you make sure we see you. So yeah, it's a tricky one, but I'm not going against the screening programme at this stage. No,

Steven (00:46:00):

No. And I'm not asking you to.

EDS has said, can either of you corroborate the theory that vigorous exercise increases testosterone levels? And if so, does it also increase oestrogen? It being an androgen?

Nikki (00:46:12):

It's really interesting, isn't it? What do you think?

Brooke (00:46:15):

Well, there's a thought that peri and menopausal women shouldn't do high cardiac output exercises, that you should lift weights and do low level. I'm not sure if it's related. I haven't heard that it's specifically related to testosterone production or oestrogen production. I don't know. I dunno if you know a little bit more, but there's certainly the areas of thought that you should exercise differently as you head into menopause and perimenopause.

Nikki (00:46:49):

Well, I mean the British Menopause Society recommend 150 minutes a week of cardiovascular exercise and two to three times a week of weight training or something like that. Whether or not it's specifically aimed at raising testosterone levels, I don't think that's their goal with that. I think it's just keeping their heart healthy. I have heard people say that if you do lots of intense vigorous exercise, it does help to increase your testosterone levels naturally. That being said, unfortunately with women, they also tend to produce a lot of stress hormones as well. And I think that's also what's behind the weight. Things like weight gain doesn't help shift your weight. And for a lot of people, they still believe that if they run and

they cycle and they do all the cardiovascular exercise, it'll help them lose weight. And unfortunately that often just makes things worse.

Steven (00:47:38):

Possibly one of the contributory factors is that once a thing like that appears on Facebook, it'll be shared as a fact across millions of people. Then you'll hear it from another source and you'll think it's now been confirmed. Actually, it's just the same old rumour going around. It'd be interesting to see if there was any hardcore evidence to say that it was beneficial or otherwise.

Kim wants to know whether either of you think that deficiencies either hormonal mineral or vitamins are not tested for first in a postmenopausal women as a first look at her problems. If so, why are they not the first form of investigation?

Nikki (00:48:11):

Yeah, again, that's another thing that people ask. Can I have my magnesium levels checked? Can I have my zinc levels checked? The problem is you don't always get accurate pictures from those sorts of things. So magnesium's so tightly controlled in the blood that you don't know if your bones are deplete of magnesium, which tends to be where the magnesium's coming from apparently. So if you test and it's normal, what are you going to do with that information? Do you say? Don't take, I mean if she's got dangerously high levels, of course you're not going to start on something, but I think it's worth trying to see how somebody feels. The issue I have is if somebody's trying it for such a long time, they haven't actually thought, is this helpful to me or not? And they're spending a lot of money on supplements that do nothing.

Steven (00:48:57):

So do you routinely suggest magnesium?

Nikki (00:49:00):

It's one of the ones that's been known to help with things like sleep anxiety. So if somebody can't have hormones, they don't want to start hormones yet, they want to just have supplements, then that is something they can try.

Steven (00:49:11):

So you said you wouldn't give it to someone who had dangerously high levels. What would be the indicators to make you think, I better check

Nikki (00:49:18):

Now you're testing my biochemistry. I think it's going to have something to do with how they feel themselves. If they've got lots of bone pains, they feel jittery. I'm not a hundred percent sure. I'd have to look it up, but if I was worried that they had

something wrong with their bones, for instance, I might not start jumping to giving them calcium, vitamin D and magnesium. I imagine

Steven (00:49:36):

It's fairly rare, isn't it?

Nikki (00:49:37):

Yeah, exactly. I don't think that's going to be the sort of thing that people would worry about. It's more overdosing on things like vitamin D. That's more common. We're all supposed to be taking vitamin D in this country. We don't get enough sun. But for some people they're taking it to the extreme and they're taking very high levels of vitamin D, which actually has a detrimental effect as well. So

Steven (00:49:57):

At what point is it a dangerously high level?

Nikki (00:50:03):

If someone's taking say 10,000 international units a day, I mean that's how much you'd take a week if you would deplete. Maybe not if you were taking it on a daily Basis.

So 400 international units is probably about right. For people that have got darker skin, or they're inside a lot more maybe up to 800 international units, but certainly not in the thousands.

Steven (00:50:25):

I seem to recall we've had, again, it was another doctor on the show who was saying, well actually if you're out in the sunshine for 20 minutes, you're going to get thousands of international units of vitamin D anyway. So it was arguing that it's very hard to overdose on it.

Nikki (00:50:42):

I have seen it. I've seen people that take far too much and you have to say, look, just stop yourself else.

Steven (00:50:47):

Well, we're in society that seems to take things in pill form. We want all the remedies to be in a simple pill form that will fix us overnight.

Pete's got a question for you, Brooke. Pete says, do you work with women who have prolapses? And if so, what kind of things do you do?

Brooke (00:51:03):

Yes, I do, but it depends on the degree of the prolapse. So understanding potentially why is it a weakness? Is it what sort of prolapse? Obviously understanding whether it's rectal, whether it's uterine, whether it's vaginal is important. And then understanding what's happening above those structures through the abdomen, through the thorax. That could be adding pressure down because it's not just a matter of lifting everything. And that's where there's lots of things to consider before someone goes and has surgery

(00:51:43):

Or that you just prescribe exercises. You want to understand basically the pressure systems through all your diaphragms from here all the way down to see if any of that outward, outward or downward pressure is coming from above. And if you're for all that, that's not a problem. As well as understanding, obviously history to see if there's any trauma or anything that may have created the weakness, it's then helping whatever tissues you can to help everything bring back up, whether it's through the bladder or the abdomen or through the pelvics itself. And then if nothing helps, then obviously referring on, and you can also do that in conjunction with referring on

Steven (00:52:28):

To make sure, I was going to say you probably refer on for some cases as well, but again, it's not just about pelvic floor, is it? There's those

Brooke (00:52:33):

Other things and yeah, if anything, actually it's more about what's happening above, but it's very important to understand what sort it is before you start delving in.

Steven (00:52:44):

And Nikki, What are you going to do?

Nikki (00:52:47):

So vaginal oestrogen is what I like to prescribe. I advocate for moisturisers and lubricants and other things as well as the pelvic floor exercises and devices. Actually, I've got one if you want to have a look at it. So that is quite a large ring Pessary. That's a big size. That's really big size actually.

So we would just try fitting one, essentially. I like to give vaginal oestrogen first because they can be uncomfortable to fit and then see how she gets on with 'em. Maybe try it for a week or so if she feels okay, it hasn't fallen out or it's not becoming uncomfortable, certainly not if it's stopping her from passing urine - that's far too big. Often that will just relieve that pressure as well as working on all the other stuff at the same time. And that can really help. It's particularly good for bladder prolapses rather

than rectocelees. But there are other ones like shelf pessaries, which I don't like fitting from a GPs perspective. I'd rather they go and see a surgeon at that point because if they're needing a shelf pessary, it's really restrictive to your lifestyle.

Steven (00:53:58):

You're using some terms, which I'm afraid I Don't Understand. I suspect many people watching won't understand what's a shelf pessary.

Nikki (00:54:04):

So a shelf pessary, you may even be able to get a picture up while we're talking. It's basically they look a bit like this, but they've got a flat surface and then they've got kind of a peg hanging off the end of them and they push everything up when you put them in. But you tend to give them to people that don't want surgery at all. They're not sexually active. Older women that are not suitable for surgery, you wouldn't normally put them in a young fit, healthy perimenopausal woman because it's very restrictive. So if somebody's needing something along those lines, I think it's much better for her from a risk benefit perspective to actually go to see a surgeon To actually have it fitted.

Steven (00:54:49):

Okay. This might be a really stupid question, and I'm slightly embarrassed that I'm asking, but what physically is that ring pessary doing?

Nikki (00:54:58):

So it's sitting where the pubic bone is just behind the cervix. So it's literally just pushing everything up. So when you've got a bladder prolapse that's hanging down, you are hoping a bit like that picture that you just saw with the chair, it's helping to straighten everything out

Steven (00:55:16):

And push it up and it's held in place simply by its own pressure.

Nikki (00:55:21):

So that's where pelvic floor exercise and things actually can really help because if they've got a very weak pelvic floor, it doesn't hold as well. So it's not perfect. It's just a way that we can help.

Brooke (00:55:35):

Ultimately, everything's a combination. Exactly your approach. Whatever approach you take, it sort of needs to be done in combination.

Steven (00:55:41):

We often argue in physical therapy that if you give someone a brace to wear, then actually what you're doing is you are reducing the muscle tone that would otherwise support those structures. Would you see that as a temporary option while we try and sort out all those other problems that you already mentioned, Brooke? Or is that going to stay there forever?

Nikki (00:55:59):

I mean, again, it depends on the person. For some people they don't mind having it changed every four months. There are silicon ones, you can get the burn out longer, but for some people they really just do not want surgery or they don't have the time for surgery. They don't want don't to go through it. So yes, they will keep it in and they'll perhaps do all the other things as well. But you're right, there is a chance that they might not do the other things and the ring pessary is sufficient them.

Steven (00:56:25):

And as for the shelf pessary, we have an image of a shelf pessary.

Nikki (00:56:28):

There we go. It doesn't go in like that!

Steven (00:56:37):

Well, congratulations to Justin for finding one in the time we gave him to do that. Really good, but I don't want to speculate. I think we now had a picture of that and we can send it away again.

Nikki (00:56:54):

But unfortunately they do have lots of problems with them. If they're not change removed when they should do,they can cause erosions into the bowel. So they're not very nice. I don't like them. I'm not going to fit them. I will send them onto a surgeon.

Steven (00:57:13):

Nesco says, are there health risks to starting HRT after the age of 60?

Nikki (00:57:18):

This is another really grey area. Unfortunately, there isn't robust studies around this either. It's not going to do any extra harm. So we used to think that by starting HRT, often a 60-year-old woman, it would cause her to have a heart attack. It would disrupt the cholesterol plaques in her arteries and then she'd end up with a heart attack. That's no longer the case. If you start oral oestrogen, yes, we are increasing

her risk of clots or stroke, that kind of thing. If we're giving transdermal oestrogen, we're not increasing her risk above her already natural risk. So people will say, oh, there's no risk. No, she has her own risk. We are not adding to it by giving her oestrogen.

(00:58:05):

Actually there's now studies that are suggesting that if you're giving someone HRT, it can help them recover from an MI or heart attack much quicker in a better way than if you didn't give it to them. The other part of it is the progesterone. So if you're giving someone progesterone as well, you're slightly increasing their risk of breast cancer. So you do try and give them body identical type. So this Utrogestan type rather than something synthetic, which you might find in your contraceptive pills or something like that. So from that point of view, you try and tailor it as best as you can, and then it's the dose. So we start low and we build up slowly rather than going straight onto a high dose, which perhaps I do with a younger woman, and then she has to make her own choice. So there are some studies that are suggesting that if we are giving HRT later in life, we are increasing someone's risk of getting dementia and we're accelerating the process. But there are other studies that are suggesting we're improving someone's dementia risk. So actually I don't think anyone really knows the answer to that one yet. But you always obviously have to tell the patient that there is that potential. And then it's her choice at the end of the day, what she wants to do.

Steven (00:59:14):

It's such a difficult choice to make.

Nikki (00:59:16):

It Is, but I've started it in women in their seventies and they describe it as life changing. So why not try it? And if they really don't get on with it, I have had that as well. I mean, I've had lots of horrible side effects, even on the lowest doses I can possibly give them. It's fine. It's too much for you. Let's stop it. Let's look at something else. Make sure your blood pressure's okay. For instance, make sure that everything else in your blood tests, and of course

Steven (00:59:46):

What we don't have and no one could expect you to have is evidence to show that woman who described it as life changing didn't go on to get earlier dementia than she might otherwise have got. There's just no way you can advise her on that, isn't It?

Nikki (00:59:58):

No, that's the problem. And I think what will happen is because of this swell of people that are having HRT now will have a lot more data in 20 years time, but we dunno what that's going to be until we get there.

Steven (01:00:08):

Okay. Lou says, could you talk about the interrelationship of balancing thyroid function and advising on HRT therapy?

Nikki (01:00:20):

Yeah, this is another thing that starts around perimenopause and menopause time. A lot of women find that their thyroid also starts to have an issue. So I think my personal preference is to make sure that we've got the right dose for them. It might not necessarily be down to their blood tests. Again, a bit like HRT, there should be a level that it's acceptable that we all follow and that's how they get monitored in a GP surgery. But from what I'm understanding of some women, that level isn't quite right for them and they might need to go slightly above the dose that they would traditionally be given. So again, it's about tailoring it to her. So some women do need slightly more as they get older, but you have to balance that with what are the risks to her heart and things like that. Later on, if we're giving you too much and actually you are suddenly becoming tachycardic, your heart's racing, you are developing atrial fibrillation and what else are we doing with this high level of levothyroxine? So yeah, so that's my personal approach to it.

Steven (01:01:19):

Alright. I'm told that Justin's also got an image of a ring pessary in place for us to have a look at as well, so we can see where it goes. Right. Okay. Now I have a better idea of why it stays in place. And also that's a fairly good indication there of how the wrong size could actually seriously impact your bladder function, isn't it? So, we've got another one of your shelf pessaries showing there As well.

So a really good image. When you fitted one of these, presumably you pay some pretty close attention to what happens as a result of that in the immediate aftermath.

Nikki (01:02:00):

Yeah, yeah. So the problem I had when I was doing this for the NHS in obstetrics and gynaecology is you see the woman in clinic, you fit one. If it falls out or she has problems, it's very difficult for her to then get help. GPs don't always fit them. They don't always want to offer advice on them. If it falls out, she has to then wait for another appointment. You generally try and make sure they can pass urine before they leave the clinic, but that was the extent of it. So what I'm trying to do with my clinic is I'm trying to make it as easy as possible. So people come in, they have their fitting done, and then as part of that, if they need another review, they can have another 10 minute appointment without cost just to make sure we've fitted it right. I don't want them feeling like it's been a complete waste of their money and their time.

Steven (01:02:50):

Why would GPs not fit it? Is it just not part of GPs training?

Nikki (01:02:54):

No, it's not. There isn't really, well, I mean they're starting to come through now for nurses, but there isn't really a training course as such for it. I didn't get taught how to do it other than on the job. It's kind of a, what is it, see one, do one, teach one. Literally how I learned. But there are now more formalised courses coming through.

Steven (01:03:14):

You said this is also something a nurse could do?

Nikki (01:03:16):

Absolutely, but not every nurse is being put on the training courses to do it. Same with menopause care. Some nurses are really good on it and they know what they're doing. Same with contraception, but if they haven't been given the training, they won't.

Steven (01:03:29):

So when something goes wrong, when there are consequences to whatever you might have done, are there situations where those patients might not go back to you but they might end up in Brooke's Care or someone similar with things that we ought to be thinking maybe we need to send them back to Nikki or maybe we should be thinking along these lines, what can we do about this

Nikki (01:03:53):

If someone hasn't had it changed? Definitely

Steven (01:03:55):

How often are they changed

Nikki (01:03:56):

Three to four months. And it depends on the type. These PVC ones should be three to four months. The silicon ones are about, I think they're about six months off the top of my head. So I think if they've not had a review of it at all, that needs to be reviewed because I have seen some women where they've literally embedded themselves.

Steven (01:04:14):

How would we know that?

Nikki (01:04:16):

I Guess from your questioning, you'd probably ask them, when did you have that fitted? How often do you have it changed?

Steven (01:04:21):

See,That wouldn't have occurred to me. Maybe partly because I'm a male practitioner and anything like this I would steer clear off. It is a factor in clinic, isn't it? So that's a useful bit of questioning to add into our case histories,

Nikki (01:04:35):

Pain, bleeding, discharge, all of those things can occur if it's not right. Smells, all that stuff.

Steven (01:04:43):

And none of those things were ever taught to me in my osteopathic training as being things that we ought to consider. I think the limit of our case history taking as far as women's health is concerned is are you having regular periods? I think that was about it because certainly for me, unless I understand why I'm asking those questions, I wouldn't go near it because it's just too personal an area, where you are leading yourself down a road that could lead to complaints. And that's what we all think about, isn't it? You won't get them because you are trained and everyone expects doctors to be able to do this sort of stuff. For us, we have to be much more certain in our communication with patients to make sure that they understand why we're asking those questions.

Lou says How much of an iceberg is the occurrence of women's incontinence? Do they hide it when they come to see a practitioner? How much of a problem is it and what can we do about it?

Nikki (01:05:34):

Well, the statistic that I have been led to believe is 80% of menopausal women have something going on with their pelvic floor. It's called genital urinary syndrome of the menopause. So it encompasses recurrent UTIs, prolapse, vaginal dryness, all of the above, but only about 10% are actually being treated. So there is a huge number of women out there that are hiding it or they feel that they have to just put up with it. And if you look at all of the Tena lady adverts, the incontinence knickers, incontinence pads, we are led to believe it's just a normal part of ageing. And actually there's nothing you can do about it because whoops, you've had an accident. But we know that that's not the case. There's lots of things that could be done about it.

Steven (01:06:23):

And again, dare I ask, can those things, would those things be dealt with through the NHS or are we excluding a huge population of women who can't afford private care?

Nikki (01:06:35):

It's postcode lottery. So there are services that are available for things like pelvic floor care, but I think they're oversubscribed. They're not in every area. If you don't have the GP asking those questions or the person hasn't brought it up to their GP, they're not even going to get the referral. So there are a lot of barriers in the first place. Yeah. So unfortunately there is that problem too.

Steven (01:07:02):

Yeah. Here's a challenging question for you, Simon, same Simon as before, says, what would either of you like to see happen in the medical community to help women go through the process of menopause? And he asks, because he says he's watched his wife suffer and he's seen patients go through surgically imposed menopause and he's used all of his osteopathic techniques in his arsenal and just feels that as a male, he's missing something.

Nikki (01:07:27):

I think collaboration and interconnectedness is what I want to see. So I love the idea of these hubs, but it shouldn't just be about let's put somebody on a pill, let's give them surgery. It should be incorporating other healthcare professionals, other people that are looking at the body in a different way because I think in my view, throw everything at it. Try everything. Why are we just focusing on pills? Why are we just focusing on surgery? That's what I want to see.

Steven (01:07:54):

I wonder, again, Brooke, maybe you know about this. When someone goes to a GP and they think, oh, some pelvic floor would be useful, they then put you on a list to go and see a physiotherapist, which might, well, you might get to the top of that list in 18 months, whatever it might be. But are they going to go to somebody who truly understands what is going on and not just going to think back to a course they did 20 years ago where you squeeze yourself together and that's your pelvic floor sorted out? Do all physios understand pelvic floor exercises? I don't think all osteopaths do, to be honest.

Brooke (01:08:30):

No. No, I don't think they do. But again, it's that whole, even if you a little bit understand that it's ultimately just stopping yourself weeing. You could give that to someone, but you don't know whether that's actually what they need. That physio that they go to will unlikely be a women's health specialist. There are a friend of mine, one of the girls I did the course, she's a physio and an osteo, and she runs a

unit in Luton at Luton Hospital where patients can go get referred Specifically for women's health. But around here,

Steven (01:09:16):

The reason for the question was that it just reinforces this idea that nothing can be done. If the default setting is well go and see a physio, it could be a chiro or an osteo, and that doesn't solve the problem, then it just reinforces the idea as I said, that nothing can be done. I've tried the doctor and I've tried the physio and nothing happened. But if people understand, if we all understand that there are specialists you can go to where we can make a change that might at least help, it'll help those women who can afford it.

Brooke (01:09:47):

But it is also about expanding the conversation that you are having with patients or your friends or whatever. I mean, obviously Davina (McCall) has made a big difference to the conversation about menopause, and there's a lot more men who are now partaking in the conversation with their wives that Simon has mentioned, but also there's lots of people with daughters and aunts and friends and whatever who are female who've gone through it. And it's men now not going, okay, my wife's turned into a psychopath. Actually, Patrick, My partner has had a couple of his friends who've been like, oh, Brooke does women's health stuff and she have a conversation with my wife, or can I have a conversation with her, how can I help? And it is about expanding the conversation. Since doing the course, I have conversations about particularly women, about their sex lives, about when they started getting incontinence, and for a lot of women it was after Childbirth, And then you've got the women who haven't had children and suddenly there're questions about heaviness in their pelvis and they've started noticing they need to go for a wee more regularly at night and you're like, okay, well you might have a fibroid or actually is there anything else going on? So I think it is just about, it's about education and all that sort of stuff. But actually if people can start the conversation and then they can go to their doctor and go, alright, I've had a conversation and actually I'm concerned with incontinence, or I've noticed that I can feel something when I wipe or whatever, and actually they're not afraid to say, actually this is I think what I need.

Steven (01:11:36):

I can believe that it's important to start opening that conversation up because it's an area we don't talk about for both men and women, Isn't it?

Brooke (01:11:43):

So as male osteopaths, its not being afraid of it, and it is about patient's understanding. So yes, if someone's coming with the neck pain, you don't necessarily need to understand what their sex life is like. But actually if someone's

coming in with lower back pain or things that have changed, It's About having a conversation with them.

Steven (01:12:02):

I've got some interesting questions here, which we'll probably see us through to the end of this show actually. Karen says, what's the difference between patches and gels? I mean, I don't think she means what's the difference between a patch and a gel, but I mean in terms of effectiveness and why you would use one or the other.

Nikki (01:12:15):

So sometimes it's absorption, so some people will absorb the gels better than the patches. The patches have been shown to give you more of an even distribution of hormone Rather Than gels, which can kind of jump about a bit. What I like about the gels is that you can readily change the dose quite simply. The patient can do that themselves, but the downside is it can take about five, 10 minutes to dry. So if you are busy or you haven't got the time to do that, then that might not be the right option and you've got to do them every day. If you forget things, obviously that's hard as well. Whereas the patches you leave them on, you change them twice a week. So all you've got to remember is the two days a week that you change them and then whatever progesterone you're taking on top of that. So again, it comes down to preference the woman, what her lifestyle's like, those

Steven (01:13:06):

Things. Okay. Again, someone called mischief maker says, I have a patient who has a ring pessary and has been wearing it for years without it ever being changed or checked. I'm sure this is wrong and dangerous, is it?

Nikki (01:13:21):

Well, she's probably fine, but it needs changing. It does need changing. It shouldn't be left in all of that time. And also it may cause some pain and things after, once it comes out, if she's not using vaginal oestrogen, there's a good chance that there will be some issues there.

Steven (01:13:36):

I Think we've answered that question!

Nikki (01:13:37):

Yes. There we go.

Steven (01:13:41):

I guess whoever it is who has that in place will just go back to wherever she got it fitted if she's still in that same area. But otherwise, does it have to be a specialist?

Nikki (01:13:48):

Not necessarily. They can try the GP first. I mean, their GP ideally should try and take it out, but they might not want to. So then it would be a specialist.

Steven (01:13:56):

Yeah, yeah. Possibly after two years might have to cut some tissue away to get it out.

Nikki (01:14:01):

Yes. I have seen that

Steven (01:14:05):

Daniella says if a woman chooses not to use HRT, how can they manage menopause through exercise diet?

Nikki (01:14:12):

So we've spoken about the amount of exercise

Steven (01:14:16):

And the type of exercise,

Nikki (01:14:17):

Diet wise, again, it's one of those variable things. The one that the British Menopause Society talk about is the Mediterranean diet. Other people advocate for high protein, low carbs, or good quality carbs. Again, I don't think it really matters what you kind of follow as long as it's something that suits that woman, particularly as you've got more increased risk of fat distribution around your abdomen, which increases your risk of diabetes. So actually going high protein, low carb is probably a good combination to try and avoid that. But if you can't stick to it, then Mediterranean might be an option. So they're the kinds of things

Steven (01:14:55):

I'm not quite sure what a Mediterranean diet is, because I've seen some extremely fat Spanish people living on fried potatoes and things like that.

Nikki (01:15:01):

Yeah, it's salad, salad and the meat and the fish. Exactly. Yeah.

Steven (01:15:08):

Okay. Al says, do you have any experience of women using is a red light devices for vaginal dryness and improving incontinence?

Nikki (01:15:16):

Yes, I've heard of these and yeah,

Steven (01:15:19):

I'm Always suspicious when someone says red light devices. It sounds almost as though it's a gimmick on the internet, but what do you think?

Nikki (01:15:27):

I mean, I'm not familiar with the specifics of this one, but I know some of them that the idea is that they make these little micro tears in the tissues and it stimulates collagen production. So it's meant to then revitalise the tissues, help to tighten and strengthen them, and women get really good results from them. So yes, they are out there and people are trying them, but again, it's a cost, isn't it?

Steven (01:15:51):

Yeah. It makes me wonder, and I don't suppose that you'll have any more idea than I do about this Brooke, whether our medical grade laser equipment could be used to some effect. We'd probably want a different applicator for the one we use in the clinic At the moment, and Some careful procedures in clinic. But seriously, laser could be very useful, couldn't it, given the way laser is said to work.

Jane asks whether you have heard of the menopause exchange as a source of information for women?

Nikki (01:16:21):

I haven't, but I will look it up. That sounds really interesting. But there's lots - Menopause Matters is one of them, the Women's Health Concern website that I've mentioned,

Steven (01:16:30):

Is there a problem with some of them that they spread misconceptions or myths rather than

Nikki (01:16:35):

Yeah, there's a lot of Facebook groups as well that people are in. And depending on the quality of the answers you get, yes, there is some misinformation that goes through on those. You do get a lot of really good information as well. There's one

that Davina sponsors, (The Menopause Charity – www.themenopausecharity.org). That tends to have good quality information in there. So yes, I've seen both, but it depends on what one you're in. So this one is, I think it's about 10,000 plus women in there. It's huge.

But You do tend to get some really nice answers as opposed to Strange Things that people read on the internet.

Steven (01:17:16):

When we spoke before, when we were planning this show, you said you were interested in expanding your network amongst physical therapists generally. So what should we do to help you do that? Obviously we have a phenomenal resource at my own clinic here in Highland Ferrers. She's sitting next to you, but you're getting a feel for the sort of training that Brooke's done and the experience she's got and what she can offer. What about all those people watching us this evening? What should we do? Should we try and collect some names and share them with you so that you can

Nikki (01:17:49):

Yeah, and it's also education as well. So it's something that, because I've got a team of a few doctors that work with me, so it's me being able to say to them, this is what an osteopath does, this is what a chiropractor does, this is how they can help our patients. If there is somebody that you think would fit this or they're open to it, why not suggest they go to one in their local area? And that's one of the things that I really want to look at is it's not just about Milton Keynes. I've got one doctor that's in Newcastle, one that's in Gloucestershire. So actually it's having practitioners in lots of areas as well.

Steven (01:18:23):

Yes. Okay, well, we've got 475 people watching us live this evening. There'll be more watch the recording. So what I will encourage them to do is to let us know that they want to be connected with you. Presumably you primarily want people who have got some expertise in women's health, not just a bog standard chiropractor or osteopath, because we all know how you can find those.

Not that any of us is bog standard! I shouldn't have said that. I'm going to get more complaints now, aren't I?

Nikki (01:18:50):

Yes. I mean, women's health is what I'm passionate about and it's what I want to be able to share

Steven (01:18:56):

Okay. I'll try and get through these last few questions before we run out of time. Valerie says that her doc has put her on DHEA and progesterone mixed into eight part vitamin E and then rubbed on my gums before bed. Is that a protocol you use? Obviously you don't use it by that expression on your face!

Nikki (01:19:12):

No, I mean that sounds like a bioidentical type HRT. So it's something that's been concocted based on whatever tests have been done.

Steven (01:19:21):

I Guess the proof of this particular pudding is in whether Valerie feels better as a result of it.

Nikki (01:19:25):

Yeah, absolutely. There are DHEA pessaries that I can prescribe for women that have got particularly bothersome vaginal dryness, which really are very effective. So I can do that. It's just not in that way.

Steven (01:19:38):

Okay. And this is a long one. Liz says, my sister's just had an end colostomy procedure done. They removed her sigmoid, colon, rectum and anus. She had to explain to her GP why she wanted to be referred to a woman's health physio for assessment. They just couldn't fathom why she wanted her pelvic floor assessed. Luckily, they did refer and she's been diagnosed with a uterine prolapse. So an observation rather than a question there.

(01:20:05):

HCC says, I have recently been diagnosed with POI privately and I've been put on HRT and it started to make me feel myself again. I've been so tired with lots of brain fog, angry, emotional, and my poor family have had to deal with my mood swings, not to mention the aches and pains. Gosh. I'm 38 years of age, eat well and exercise. The NHS Gynae said I might as well've had a hysterectomy. I was horrified. There really does need to be more specialists like Nikki available, especially on the NHS.

Nikki (01:20:33):

Yeah, I agree. And the comments, oh my goodness, the comments. I mean, we've got a podcast called the Premature Menocast for specifically for POI, and we did an episode on the inappropriate things that healthcare professionals have said to you, and it's very eye-opening. I mean, I've had a few of those myself, and I'm a doctor and they knew I was a doctor when they said those things. So yes, it can be very

inappropriate. I'm pleased. Just make sure you've had a DEXA scan. One thing that gets missed all the time.

Steven (01:21:03):

Yeah, and indeed, DEXA scans are not the gold standard in bone strength monitoring either. We've done a show on that. Were you involved in that show with Nick Birch?

Brooke (01:21:13):

Oh yeah,

Steven (01:21:14):

With the REMS, which is a much more accurate way of assessing bone strength. We'll share the resource with the email that goes out after the show, but he points out the flaws in DEXA scanning and why this is better. He's a private consultant and he's selling his services, but he had good evidence behind it and I trust him.

We haven't got a lot of time left. I wanted to ask about endometriosis, and adenomyosis as well. Is that something which we are going to come across primarily, or will that always go to someone like yourself? Will we recognise signs, symptoms in that?

Nikki (01:21:48):

Yeah, absolutely. I think you could recognise signs and symptoms with it, and unfortunately it's taking so long for people to get a diagnosis that they will often go to other practitioners because they're not getting anywhere with their own GP or with their specialist or whoever it's they've seen. So you will definitely be coming across it, I'm sure.

Steven (01:22:07):

Right? What should we look out for?

It's going to be Pain again, isn't it?

Nikki (01:22:10):

Well, yeah, it is. I mean, the endometriosis can be pain anywhere and it can be pain at any point. It's not necessarily just related to the periods, but the period can exacerbate it. So if she's having cyclical symptoms, chronic pain, it's been there since she can remember having periods, it's getting worse with time, issues with fertility, painful intercourse, all of these things can all be symptoms. Adenomyosis is very similar except that it's not anywhere else in the body, it's just the uterus. So again, it might be, I mean, I've diagnosed it in someone as young as 17, so it's not

just about age, but as a woman gets older, she's more likely to have had it if she's had children, if she's had any kind of instrumentation…

Steven (01:22:51):

Do you have any idea how prevalent adenomyosis is?

Nikki (01:22:55):

Oh, now you're asking. I think it probably is more prominent than we realise. I just don't have the percentage

Steven (01:23:01):

Sorry, I shouldn't spring a question like that on you. My own experience of endometriosis, not personal experience,

Nikki (01:23:09):

but men Can have it too.

Steven (01:23:10):

But it isn't my personal experience – my experience of endometriosis is that it's not well handled.

Nikki (01:23:15):

No, unfortunately there seems to be this thing where women, I dunno if you've experienced this before. We assume that women are anxious before we assume that there is something physically wrong. If she's having chest pain, she's anxious, not she might be having a heart attack. So yes, unfortunately there are women that are made to feel like the pain is all in their head and that they just have to go out for a vigorous walk and have some CBT and take fluoxetine or whatever it is to feel better when actually she's got something physically going on. So it's poorly Understood.

Steven (01:23:49):

I think we've just about run out of time here. In terms of your guidance for the 475 people watching us, what would you suggest that they do that's different as a result of what you've had to say?

Nikki (01:24:07):

Well, I mean, I like everything you were saying about expanding the conversation, asking beyond just are you having normal periods or not? There is a question there that I'm also going to share with you, which is the things that the woman can fill out herself and give to her GP. So things in there about HRT, about whether or not her

GP prescribes testosterone, sort of empowering her and the symptom questionnaire as well. So I suppose it's just looking out for these things and being brave enough to ask the questions.

Steven (01:24:38):

And what about from your point of view, Brooke? I mean, you've taken it on yourself to go and do Renzo's course. Presumably you did that partly out of your own personal involvement with women's health problems, but is it something which we ought to be taking more account of as physical therapists?

Brooke (01:24:56):

Oh, absolutely. I think part of the reason I sort of went into women's health is because I was getting older, but I was feeling as though, well, my patients were obviously getting older, but as my patients were getting older, they were also becoming more female based. And I was just noticing the trend, and obviously you've still got all your pregnant women and all that sort of stuff, but actually from doing the course, it was the women's health side of it, not the pregnancy, but the post pregnancy stuff, all this stuff aside from pregnancy, that was really,

Steven (01:25:28):

It's not something you get in basic training, is it? And that's not a criticism. There's only so many things you can cover, just as GPs don't cover don't cover women's health in the depth that you have.

Brooke (01:25:37):

Yeah, it was I think partly through my own experience, but yeah, that's what I was seeing in clinic. I was seeing more women and we were all getting older.

Steven (01:25:46):

Yeah. Very last question and hopefully simple and short answer, how is endometriosis diagnosed asks Kim?

Nikki (01:25:58):

Well, symptoms - laparoscopy is meant to be the gold standard, but it has to be done by somebody who knows what they're doing.

Steven (01:26:06):

I Would like to think anyone doing a laparoscopy knows what they're doing. Is That not always the case?

Nikki (01:26:08):

Not always, no. Unfortunately, if you get a general gynaecologist that just does a cursory look, they don't necessarily spot the subtle signs. So you ideally want someone who knows what they're looking for. You can diagnose it on MRI and ultrasound, but they need to be big enough lesions to be able to do it. I think last time someone told me it was about a centimetre,

Steven (01:26:27):

But you could have symptoms before that presumably.

Nikki (01:26:29):

Yeah. So I think it comes down to how that person is feeling, what's happening, when is it happening?

Steven (01:26:35):

Thank you both for giving up your time this evening. It's been an outstanding show. It's been very informative and obviously the volume of questions reflects that, and hopefully we'll get a lot of interest from people who want to be connected with you Nikki.

Nikki (01:26:45):

That'd be great.