

Dorset Women CIC DR EMMA BONUS EPISODE 1_mixdown v1

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SPEAKERS

Dr Emma Hayward, Anjali Mavi, Marianne Storey



Marianne Storey 00:00

Emma. Hello and welcome to our special bonus episode with Dr Emma. Emma is our resident GP women's health expert who we'd love to chat to after our interviews with our guests to get into the detail of what we've been talking about. Welcome Emma, hello. Thanks for having me. Anjali's here too. Hi Angali.



00:28

Hi everyone. Hi Emma. Hi Marianne.



Dr Emma Hayward 00:31

So yeah, hi. I'm Dr Emma Hayward. I am a GP. I'm practising NHS GP in Dorset, and I'm also a senior academic at Bournemouth University, lecturing and also conducting a PhD in women's health,



Marianne Storey 00:45

a very particular type of women's health. I understand. Emma.

D Dr Emma Hayward 00:48

Yes, so I'm doing a feminist inquiry into how hormonal contraception impacts women's sexual pleasure.

M Marianne Storey 00:55

Blimey, what makes it feminist please?

D Dr Emma Hayward 00:57

The way I analyse it. So it's more instead of doing more of a biomedical approach. I'm looking at sociology and bioethics and looking at the feminist research from a sort of feminist in the academic sense, as well as in the sort of more well known sense.

M Marianne Storey 01:12

Love that. And just please, for the listeners benefit, please tell them what you have around your neck.

D Dr Emma Hayward 01:17

Oh, I have a vulva necklace, yes

M Marianne Storey 01:19

Which isn't one that you usually wear, because usually what do you have around your neck?

D Dr Emma Hayward 01:23

Oh, I sometimes have a glycerus necklace, but it depends on who asks what I say. They're both quite abstract. So it's either an opportunity for education or saying it's a wishbone or a piece of art or a flower, because I do like flowers as well.

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Marianne Storey 01:35

You never miss an opportunity, though, do you ever to educate? Educate women sexual health, excellent. That's why we love them. So today we are talking about menopause. We've had a really great conversation with two of our local experts, Dr Tim Hillard and Rowan, who runs Dorset menopause support. So we wanted to catch up with you and talk about menopause in the GP practice. So maybe you could just help us understand what is the role of the GP in menopause, and what are the kind of things you see in your practice.

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Dr Emma Hayward 02:07

So as you know, in the NHS, GPs are often the first port of call to access help about anything that people think is medically or that they might want some help with their symptoms. And like you say, we have Tim, who's amazing. We're really lucky in Dorset to have his clinic, which GPs can ask for advice in or refer more complex cases to, whereas actually a lot of women can have the care they require with regards to menopause at the primary care level, and we have quite a lot of really interested GPs in this area. So I would recommend always asking if you are booking appointment, if the receptionist know of anyone in the practice who is interested in women's health. In women's household menopause in particular, because then, by proxy of that, they might see more cases of menopause. They might have done more education. I know part of the menopause awareness campaign nationalists should try and get a menopause champion in each practice. And it might not be that it's a GP who's well versed in menopause care. It might be that it's an advanced nurse practitioner, for example. So GPs really are the first port of call, and we're there to, you know, talk to you about your symptoms, make sure that we you know, if it depends how women present, women present might present saying, I think I'm going through menopause because X, Y and Z. Or it might be that they don't think or have awareness about the fact that they are going through menopause, but then they come with a list of symptoms, and you think, maybe this could be and could be and you have that discussion with them. So there's quite clear guidance by the British menopause society about when we would do any further tests, about whether we are concerned about there being another condition that might be causing the women's symptoms. So we might do some extra tests. Then to say, like, could it be a thyroid issue that we medically think actually might be causing these symptoms, and it depends on the age of the women, whether you do any hormonal tests. Is something called follicle stimulating hormone is one, particularly if you are under 45 but showing menopausal symptoms, we might do to diagnose that. So there's the diagnosis if that's something that the GPs can help with, but it's also the management that the GPs can help with, and that might be what lots of women come looking for is HRT, and then we might talk to them about the risks benefits, see if there's any contraindication, so any medical anything in the past, medical history of the woman, that would mean that we think that. And when I say we I mean nice guidance. So the evidence base suggests that actually the risks outweigh the benefits of HRT, or if, in fact, actually HRT is very suitable and could be something the women wants to explore. And then we would go through the menu of options with them about sort of the types. And it really depends where they are in the menopause journey, what style of HRT you give them, whether it's sort of what we call sequential so when HRT you have oestrogen all the way through the month, because that's what provides your symptom relief. And then you have the progesterone as well. If you have a uterus, because that is protecting the uterine lining from that oestrogen we're giving you. Also, if you have endometriosis and you've had the wound lining outside the uterus, then you might be having progesterone as well. Even if you've had a hysterectomy, it's just some of the risks and. Benefits of the room lining being present

when we're giving you oestrogen. So there's a complex array of things that a medical professional will be thinking about, but it also will depend on where in the menopause journey you are from regards to, like I said, you can have sequential HRT, but it could be that actually you have oestrogen and progesterone every day or more regularly, so day one to 25 or the cycle to make sure that we're not giving you oestrogen without the progesterone, because that can cause more harm than good. So what I'm saying is that then there's the type of HRT you're having in terms of when you have what hormones, what hormones you need? If you don't have a wound and you haven't had endometriosis, you don't have to have the progesterone element. And then it's really like a menu of, do you want it to go through your skin, through the oestrogen, which has got the least health risks associated with it? But if you explain that to a woman, she still wants the oil, HRT, it's her choice, which form she has. And then so there's lots of different ways. You can have a patch, gel, spray, and then you could ask for your oestrogen. And then you could have progesterone, which most people take, micronose progesterone, which is more body identical. But there's other forms as well. And obviously there's the coil, which is the only form of contraception that's licenced to be the progesterone army of HRT and contraception so that can be beneficial for women if they are still under the age of 54 and sexually active with a man. So there's all this going through your GPS head, when they come to you and you say, I would like HRT, and then you have to kind of trying to go through the symptoms check it is that you agree that you think it's menopause. There's nothing else that you're worried about that you might some do some further tests with. Give all these options, ask them, what might she want? And then you would start that, if you she wanted to start it then, or you would say, Well, do you want to do some more reading? Come back and see me? And then there's some women who might not want to go down the HRT route and go down more the lifestyle route. So you could talk about that. There's some really interesting research. Interesting research about what lifestyle like, ways of living that can be beneficial for menopausal symptoms. So things like exercise, I know locally we live, we likely lived near the sea. So some people do cold water swimming, and find that helpful. And then there's sort of alcohol intake, being wearing of that, and caffeine and hot spicy food, some people might find that triggers their hot flashes. So it's kind of like learning what your triggers are. And some people might just want reassurance that actually they don't have any other condition. They know it's menopause, and they're happy to manage it independently. So it really depends on each individual woman who's coming to see you and what they want, and then you've got to try and talk to them about it holistically, come up with a plan and hope you haven't run over more

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Marianne Storey 07:22

than 10 minutes. The ultimate challenge for every GP appointment. Yeah.

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Dr Emma Hayward 07:25

I mean, I would love to have sort of like half an hour, or, you know, longer, with every patient, but that is dreaming. So, yeah. So that's kind of the first port of call. So really depends what the woman's seeking in terms of how the consultation goes. If she just wants to talk about HRT, some women might have done some research already and know what they want. Some people might just want to want to have a chat. And yes, and then, so that is the whistle stop tour through the systemic management of HRT. And also, really importantly, and one thing that I

always ask women about, but I don't think either women necessarily are aware can be related to menopause. I think there's been some amazing education going on so more women are but sometimes I might not feel comfortable bringing it up, but often are very grateful when I do is talk about genital urinary syndrome and menopause. So that is the particularly the pelvic symptoms of menopause, which is what often, most women will talk about. It's like vaginal dryness. And so I can ask women if they've had any vaginal dryness, and if they're sexually active, if that is painful, because vaginal dryness can cause sexual pain. And then we really want to manage that, because that can not only impact women from a sort of sexual side of things, but holistically in all areas of life. It might get to the point that women are concerned about, you know, wiping themselves off the toilet because it just hurts so much, or walking with trousers like you can get that severe. But also we know that genital urinary syndrome of menopause predisposes women to urinary tract infections, which you know later on in life, can end up causing sepsis and fatal so it's actually really important that we talk about genital urinary syndrome and menopause, and that's when I think not having a taboo about your genitals or pelvic health is so important to be able to have these conversations and awareness of The issue. So in some cases, if we start systemic HRT. So that's the patch gel sprays with the oestrogen and then progesterone. If you have a room to protect that lining that may resolve some women's genital uni syndrome and menopause, so that vaginal dryness, however, in a lot of women, because of the number of oestrogen receptors down there and then, if you're using a patch or a spray, it's really trying to go everywhere else in the body. It might need that you need some additional oestrogen, or it might be that a woman doesn't want systemic HRT. She doesn't have any systemic symptoms, she doesn't have any hot flutters, she doesn't have any mood issues, she just has vaginal dryness. In that case, targeting her problem where her problem is is actually going to be both more beneficial. So in that case, vaginal oestrogen is really useful. We tend to start it every day for two weeks, and then it's twice weekly. From then, you could have it as a pessary. So that's annoying me. In medicine, sometimes there's lots of there's one word, and it's used in lots of different ways. So we can talk about pessaries in terms of pelvic organ prolapse and support for that. But actually in this case. Pessary means like a small tablet that you put up into your vagina with an applicator, and that can be supportive. Some women prefer a cream, and a cream can be really helpful if you have more vulval symptoms, because you can really work it in around the vulva and so your external genitalia, as well as internally with the applicator. And that can be really game changing, because not only can that help support lubrication in terms of if you are sexually aroused, we know that in menopause, the vaginal lining thins dramatically, and without that lubrication and that thinness, you're more likely to get minor trauma or and it's much more friable the tissues, and that obviously is an increased risk of STIs, so we really need to be careful about that. And also it's just painful. But also we know, I'm not sure if people have heard about the vaginal microbiome, but we've got a gut microbiome, which I think more people are aware of. But we also have a vaginal microbiome, which is why it's really important you don't douche, because actually we it's self cleaning, and it's really and with when you've got a high load of oestrogen, in terms of more of a physiological pre menopausal oestrogen load, that really supports the healthy bacteria called lactobacilli, and that really helps to fend off pathogens like E coli or which is one of the most common causes of UTIs or candida, which is also called thrush. So if you have low oestrogen, that lactobacilli level drops, and you can get more opportunistic infections with UTIs or Candida. So women might find that they're more predisposed to UTIs, maybe post coitly So after sex, or just generally, throughout their life, and more predisposed to thrush later on in life. So that's where the vaginal oestrogen can really support it's not just for the lubrication and bringing up the vaginal wall. It also helps with the synergy of your vaginal microbiome.



11:39

Wow, oh my that's a lot.



11:42

Sorry, yeah, that is a lot of information.



Marianne Storey 11:45

It's fantastic. Emma, as always, you're fantastic. Huge mine of information. Women are very lucky to hear everything that you have to say. I suppose my question to you is, do women have to go to the GP? I mean, is it something you recommend, or it can women just kind of sail through without you know, we're not saying that you have to go to the GP.



Dr Emma Hayward 12:01

Or one thing I really would recommend so we do have vaginal oestrogen over the counter now, which I think is great. However, I would say, if someone says they have genital uni syndrome or menopause to me, I will always offer to examine them, and they might say no, and I say, well, let's give that a go. And this is what I would say if you buy oestrogen over the counter as well, is if it's not helped within three months, make sure you do get examined, because although it is likely that this is gender uni syndrome or menopause, there are other conditions which are really important that can present in a similar way that actually is really important to rule out. So something called lichen sclerosus, which is it looks white and shiny and can be a bit grey it around the vulva. Now that is really important to treat, and it's a completely different treatment to vaginal oestrogen. And if we don't treat that, it can change the vulval architecture. So it can be really painful. It can fuse together some of the labia, minority your inner lips, or it's just quite painful. But also it don't want to worry anyone, but it can, in the long term, predispose you to verbal cancer and change into vulval cancer. So obviously that's really important to treat properly. And it's normally treated with topical steroids and quite potent topical steroids, which is obviously different to the vaginal oestrogen. So if you are self managing your menopause, I'm all for that, because I think, you know, it's really important that women feel that they can support themselves and not be reliant on GPS if they don't want to go and see them. But actually, I really would recommend it if what you're using over the counter doesn't work. And that's the same if you go and get sort of cystitis release from the pharmacy or anything that's not helping, go and seek some help correct.

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Anjali Mavi 13:38

You have said so many things, which has covered a lot of my other questions. But I think one thing I want to ask you, because it happens with me. It happens recently with me, when I called my GP, and my GP was not available, so I've got somebody else was taking my call, and then I start discussing with this GP, who is a male GP. I'm emphasising this because sometime, being me, I was little uncomfortable because I was trying to explain my problem. And the one thing he was keep repeating is when I told him my my period cycles are absolutely fine. My periods are always 28 days, and there is no problem with my periods, but I could see there's another symptoms of menopause, and he was not ready to register me for menopause problem because he said, your periods are fine. So I, like, literally won't believe first time I said, Okay, I want to disconnected this call, and I want to rebook with my own GP, which I'm not. I am not having any issue to talk with any doctor, either male, female. I have no problem in that. I was very happy, at least I got appointment. But after 15 minutes, when I was not able to convince this GP, there is other problem also in menopause. It's not only about periods. And then when I spoke to my own GP, was a female GP, and. I explained that exactly the same, she straight away told me, okay, let's book to your blood test, and let's book the appointment I want to meet you. So I don't know what was wrong there. I'm sorry. I'm just having another way of saying it. But is this right to if your periods are right, like cycles are fine, but still, you have other symptoms, so you definitely might be going to the pre menopause or menopause. So that's my question is for all the listeners, actually, yeah.

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Dr Emma Hayward 15:29

So I would say I'll take it generically, because obviously I can't give personalised medical advice without being your GP or having access to your notes. But taking a generic approach, I would say it is really individual, and we do know that popular changes are one of the first hallmark symptoms of menopause, but not always. Interestingly, they tend to get heavier and more frequent first before getting less frequent. But it's not always. It's not always clear cut, because some women are still using hormonal contraception, which masks their natural cycles. So that's also a consideration to take into place, because actually, if they're on progesterone only medication and say they've got a coil in place, they might not have any cycles at all. So it is one of the defining features that we would look for, but it is not the beyond lental of a diagnosis of primary menopause is the menstrual irregularities.



16:25

Got your point. Thank you so much.

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Marianne Storey 16:27

I think the question you raised, Anjali, is really good example, Emma, of why we embarked on this women's health programme in the first place and had menopause as one of our work programmes. Because of this maybe inconsistency of information advice. And women are getting advice and information from so many different places. And what we were trying to do, were trying to do with the women's health programme was to train GPs to be very consistent across the board, to make sure that you do actually get the same advice from the same person. So exactly that was partly why we're all here in the first place, to try and change second, I

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Dr Emma Hayward 16:55

do think, you know GPs, we are generalists, and we can't all be specialists in everything. Yes, yeah, no. So that's when I think I do know that menopause affects 51% of the population, if we're lucky enough to live old enough so and not everyone will have symptoms. But you know, a large majority of women will have some sort of symptoms, whether they choose to speak to their GP or not. So it isn't a niche topic, and I'm very much respect that. But we all will have special interests where we know a little bit more. And therefore, I think it is frustrating if you have to wait longer, I think to see a GP, but that has that special interest, but that's way, maybe, where you get someone who has that up to date information. But also, I would say, if you are struggling and you really think your needs aren't listening to that's where the website can be really good to go and get that information to, then know the information to then even take that to the clinician. And there's the British menopause society have sort of a public facing arm called women's health concern, and there's some really good information about menopausal

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Marianne Storey 17:56

there too. Thank you. Thank you, Emma today for that whistle stop tour around the menopause. It's really great that women can hear from the expert about what goes on in the

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Dr Emma Hayward 18:06

GP. I think Tim's the expert.

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Marianne Storey 18:11

Yes, yes, maybe. But you clearly are very, very knowledgeable on the subject, so it's been a real privilege today to hear you talk about that and but most importantly, what to expect when women come to the GP and the kind of things that you're dealing with. So thank you for today, and we'll see you next time. Lovely to be here.



18:26

Thank you. Thank you, Emma. You.