

WUNForWellbeing
Empower All -
Menstrual & Female
Hormonal Health

Tuesday 13th
October 12pm
Online Event



Dr. Rebecca Tomlinson
Dr. Kate Burns



FOR
WELLBEING



www.thewun.co.uk

Welcome – the session will begin shortly



Karen Anderson
Executive Director
WUN



Dr. Rebecca Tomlinson
Empower All Training



Dr. Kate Burns
Empower All Training



<https://thewun.co.uk/>

Join today - free to join, free to attend events



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The utilities sector is lacking in diversity with many women being generally under-represented, particularly in senior roles.

WUN was started in 2018 when a group of likeminded women, working in utilities, united around a common cause. The founders were not only passionate about the industry they worked in, but also passionate about the contribution women were making and could continue to make in the future. We now have over 12,600+ members and 80+ partners.

**12,600+
Members**

**Regular
Events &
Content**

**Mentoring
Programme
& Network**

**80+
Partners**





WUN Events: Coming Up

- **21st Oct 2026 12:00** WUNForWELLBEING – Empower All – Menopause Awareness for All (virtual)
- **2nd Nov 2026 12:00** #IAmRemarkable Workshop (virtual)
- **Coming soon: 17th Nov 2026 10:00** #SpeakUp Workshop – What to say, when it matters (virtual)
- **18th Nov 2026 17:30** Early WUN launch event, London
- **Save the Date – 2nd July 2027** Women in Utilities Awards

Further events for the coming months will be announced shortly

Join the free WUN Mentoring Programme



“Being a mentor has been hugely rewarding. While the period of mentoring was short, this was because the mentee was focused and determined and just needed support to organise and validate her plans. The real value of the mentor scheme has been the long-term connection made, that broadens horizons and thinking for both parties as our career paths evolve”.



*Jane Reeves -
WUN Mentor*

WWW.THEWUN.CO.UK

WUN offers mentoring to women at any stage of their career in the utilities sectors.

We are hugely privileged to have over 240 fantastic experienced mentors within the WUN mentoring Programme.

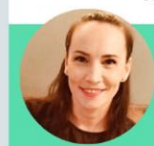
With growing numbers of Mentors and Mentees we are delighted with the community and support fostered within the mentoring programme

MENTORING TESTIMONIAL



“Jo was an amazing mentor, understood my long term goal, wasn’t afraid to challenge me and push me out of my comfort zone. Provided me with really good suggestions on how to achieve my goals and steps to take towards it. As a result I have managed to secure promotion at work.

Thank you for all your help”



Monika Snow - Mentee
Jo butlin - Mentor & WUN Board Member



WWW.THEWUN.CO.UK

If you are interested in becoming a Mentor or Mentee, please visit our website: <https://wun.onpld.com>



Menstrual Health Problems

Dr Kate Burns & Dr Rebecca Tomlinson

WELCOME

About Us

- A combined total of 30 years GP experience
- Longstanding interests in Women's Health
- BMS & CoSRH accredited Menopause Specialists and Trainers
- Specialist Menopause Clinic experience
- We aim to empower everyone to better understand, navigate, and advocate for menstrual, hormonal & menopausal health
- We strive for accessible, high quality, and compassionate menstrual, hormonal & menopausal healthcare for all



Dr Kate Burns



Dr Rebecca Tomlinson

WELCOME

Objectives



'Normal' Menstrual Cycle



Endometriosis



Adenomyosis



Fibroids



PMS and PMDD



Progesterone Intolerance



PMOS – Polyendocrine Metabolic Ovarian Syndrome
(formerly PCOS)



Menstrual Health in the Workplace: Impact and Support

A Note on Language



Why we say 'women'

We use 'women' and 'female' mainly when quoting research that uses these terms.



Who menstrual health problems affect

Everyone assigned female at birth – including trans men and non-binary people, and all whose gender may differ from their biological sex.



Our commitment

To be fully inclusive of everyone experiencing menstrual health problems or supporting someone through these – and to keep learning.

The Science Bit (1)

To truly understand menstrual health disorders, we first have to understand what is 'normal'.

- We are born with ~1 million eggs in our ovaries – no more are made after birth
- Eggs do not mature or start to be released until the menstrual or period cycle starts (menarche)

Menarche = eggs matured and released regularly, ~1 egg per month until menopause

Menstrual Cycle = Regular process designed to prepare for pregnancy. Carefully controlled by hormones produced by the brain and ovaries.

The Science Bit (2)

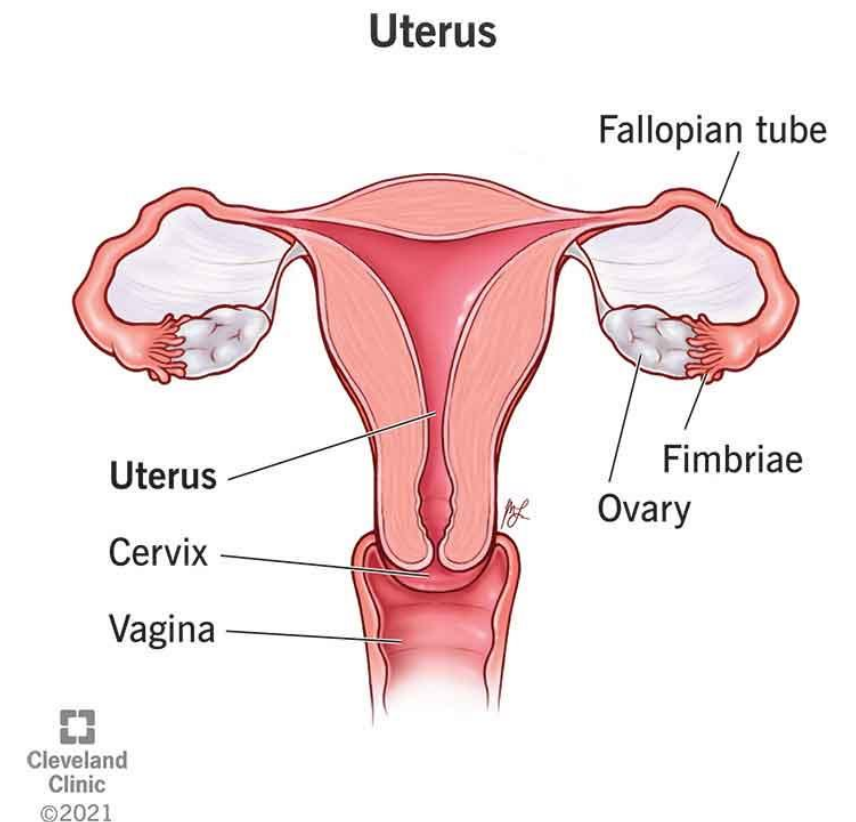
Brain releases Follicular Stimulating Hormone (FSH) and Luteinising Hormone (LH), which stimulate the ovaries to release an egg each cycle. 2 main phases, ovulation in the middle.

FOLLICULAR

- Starts with the ovary follicles (sacs) releasing Oestrogen
- This causes the womb lining to thicken ready for a fertilised egg
- Ends with a mature egg releasing into the fallopian tubes – OVULATION

LUTEAL

- Starts with the now-empty follicle releasing Progesterone (+ more Oestrogen)
- This leads to a more favourable womb lining
- Ends with either a fertilised egg embedding – PREGNANCY, or an unfertilised egg, womb lining passing – PERIOD



The Science Bit (3)

Period: If the egg is not fertilised, oestrogen and progesterone levels suddenly decrease. Without high hormone levels to maintain it, the womb lining breaks down and sheds – your PERIOD. First day of bleeding = Day 1 of the Menstrual Cycle.

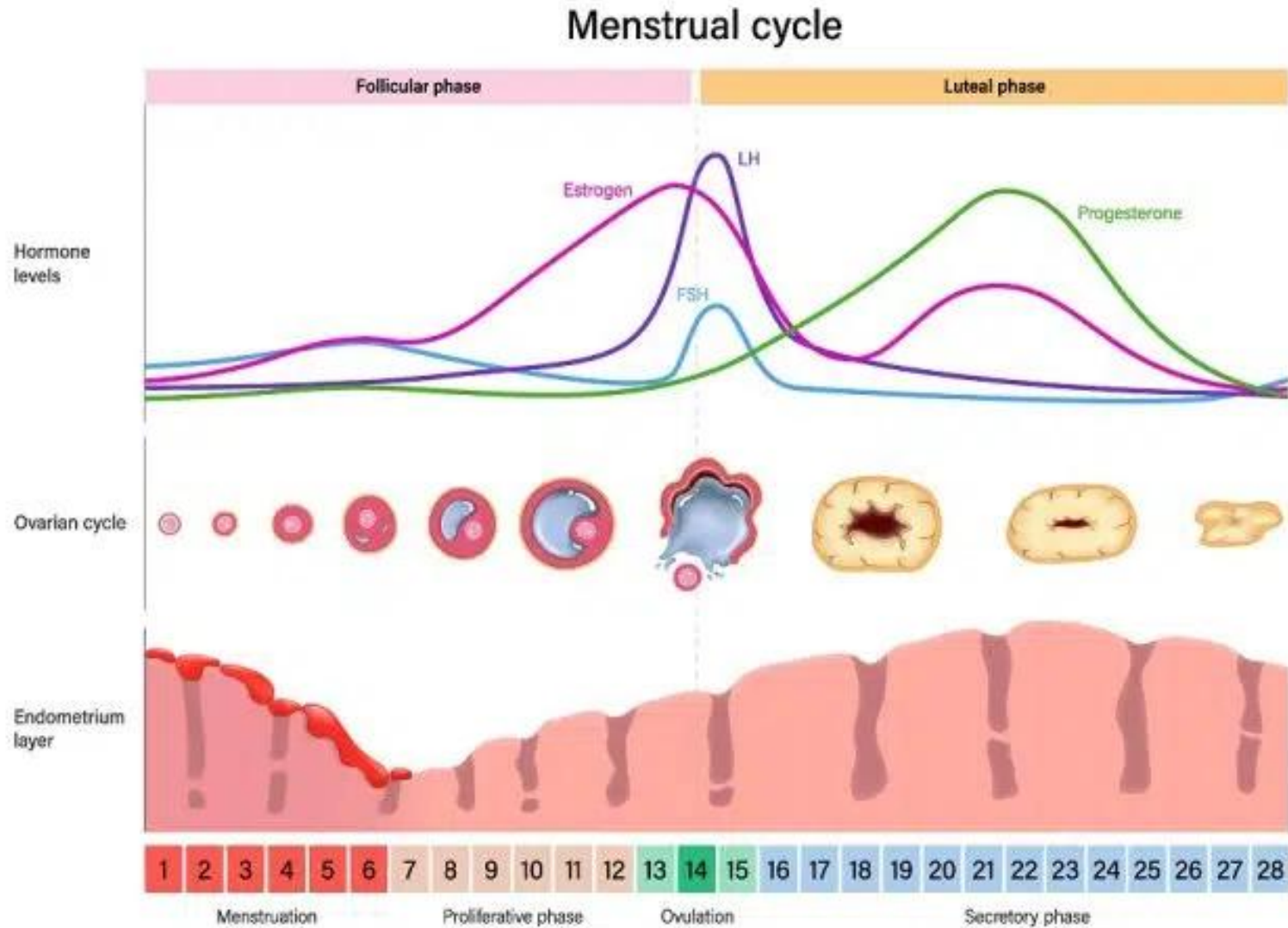
Oestrogen

- Lowest on Day 1, increases in the follicular phase, with a second smaller peak in the luteal phase
- Reduces in the lead up to a period and drops further when the bleed begins

Progesterone

- Barely present in follicular phase (until ovulation) but the dominant hormone in luteal phase – the ~2 weeks before a period
- Levels suddenly drop when the period begins

Hormones Across the Cycle



What is 'Normal'?

Starting age

Typically begins between 9 and 15 years old (average 12y)

Ending age

Typically ends between 45 and 55 years old (average 51y)

Cycle length

21–40 days (range: 21–35 days)

Length of bleed

2–7 days

Blood loss

Up to 80–90ml (1–5 tablespoons)

Pain

Some discomfort/mild tummy cramps, starting shortly before bleeding and lasting up to 72 hours, improving as the bleed progresses

What is NOT 'Normal'?

Unusually heavy bleeding

Clots, flooding, double protection, or changing more frequently than every 4 hours

Prolonged / persistent bleeding

Greater than 7 days

Bleeding in between periods

Intermenstrual bleeding (IMB)

Bleeding with intercourse

Post-coital bleeding (PCB)

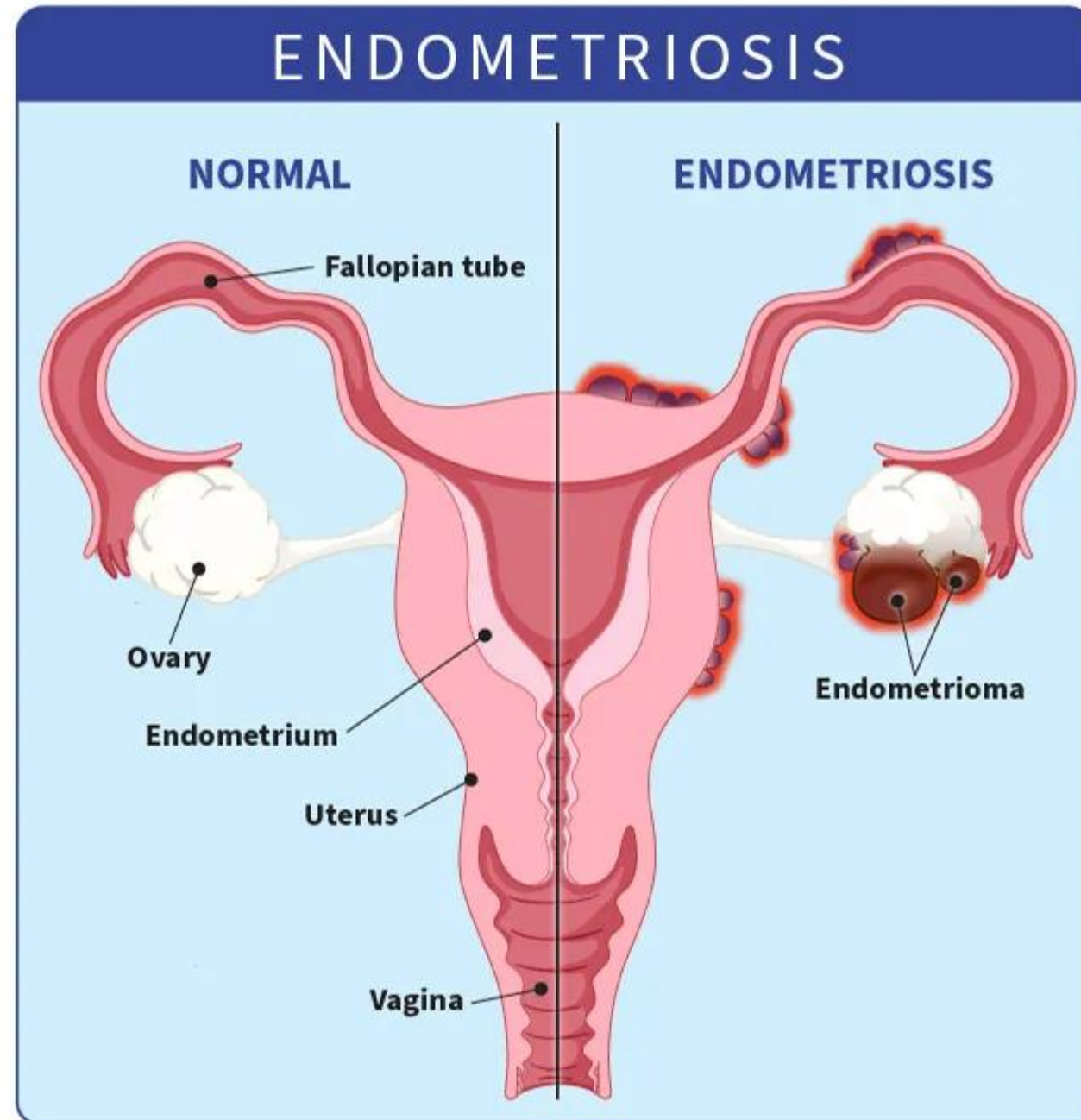
Period-related pain

Severe and/or debilitating – impacts daily life and activities, or begins days before bleeding and persists beyond its end

What Is Endometriosis?

- Endometriosis = cells/tissue similar to those in the womb lining, growing outside of the womb
- Usually found around the womb, in the pelvis (ovaries, tubes, bladder, bowel, peritoneum), but can be anywhere e.g. scars, lungs
- Each cycle, these cells react in the same way as those in the womb – building up, then breaking down and bleeding
- But as endometriosis tissue is outside of the womb, there's no way for blood to leave the body when hormones trigger shedding
- This can cause inflammation, pain, bleeding, and the formation of scar tissue wherever the endometriosis is located

Where It's Found



<https://www.webmd.com/women/endometriosis/endometriosis-causes-symptoms-treatment>

The Facts



Endometriosis Is Common

- 1 in 10 women of reproductive age in the UK suffer from endometriosis
- UK: 1.5 million women living with endometriosis – a similar number to those affected by diabetes
- 2nd commonest gynaecological condition (after fibroids)



Cause & Risk Factors

- **Cause:** unknown – theories exist but nothing definite
- **Risk factors:** family history, early menarche, not having had children, other conditions - adenomyosis and/or fibroids

Symptoms

May be asymptomatic – the symptom mix depends on where the patches of endometriosis are.

Cyclical Symptoms

(related to period only)

- Severe period pain that may prevent normal activities
- Heavy periods
- Pain or bleeding when you open your bowels or pass urine

Non-Cyclical Symptoms

(any time during the cycle)

- Pain in the lower tummy or back
- Pain during or after sex
- Extreme tiredness (fatigue)

Complications



Difficulty getting pregnant

Infertility rates are 30–50%



Low mood or anxiety



Chronic pain



Fatigue / lack of energy



Difficulty fulfilling work and social commitments



Diagnosis



Often Not Straightforward

- No diagnostic blood test
- Often not visible on simple examination nor ultrasound scan
- Diagnosis can only be made definitively with pelvic laparoscopy
- Symptoms overlap with other conditions
- Tolerance of symptoms



Often Delayed

8 years and 10 months

is the average length of time to diagnosis

Treatment: Medical

No cure. Aim is to reduce symptoms and improve quality of life. Do nothing if asymptomatic or mild symptoms.

Non-Hormonal

- Pain relief medications
- Medications for heavy periods – Tranexamic or Mefenamic Acid

Hormonal

- Combination oral contraceptive pill / patch
- Progesterone-only contraceptive pill / implant / injection / coil
- GnRH analogues – put patient into temporary menopause:
Zoladex®

Treatment: Surgical & Support

Surgical

- Laparoscopic (keyhole surgery) excision (removal) or ablation (destruction) of lesions
- Cyst removal, ablation and drainage
- Hysterectomy +/- removal of ovaries

Patient Resources

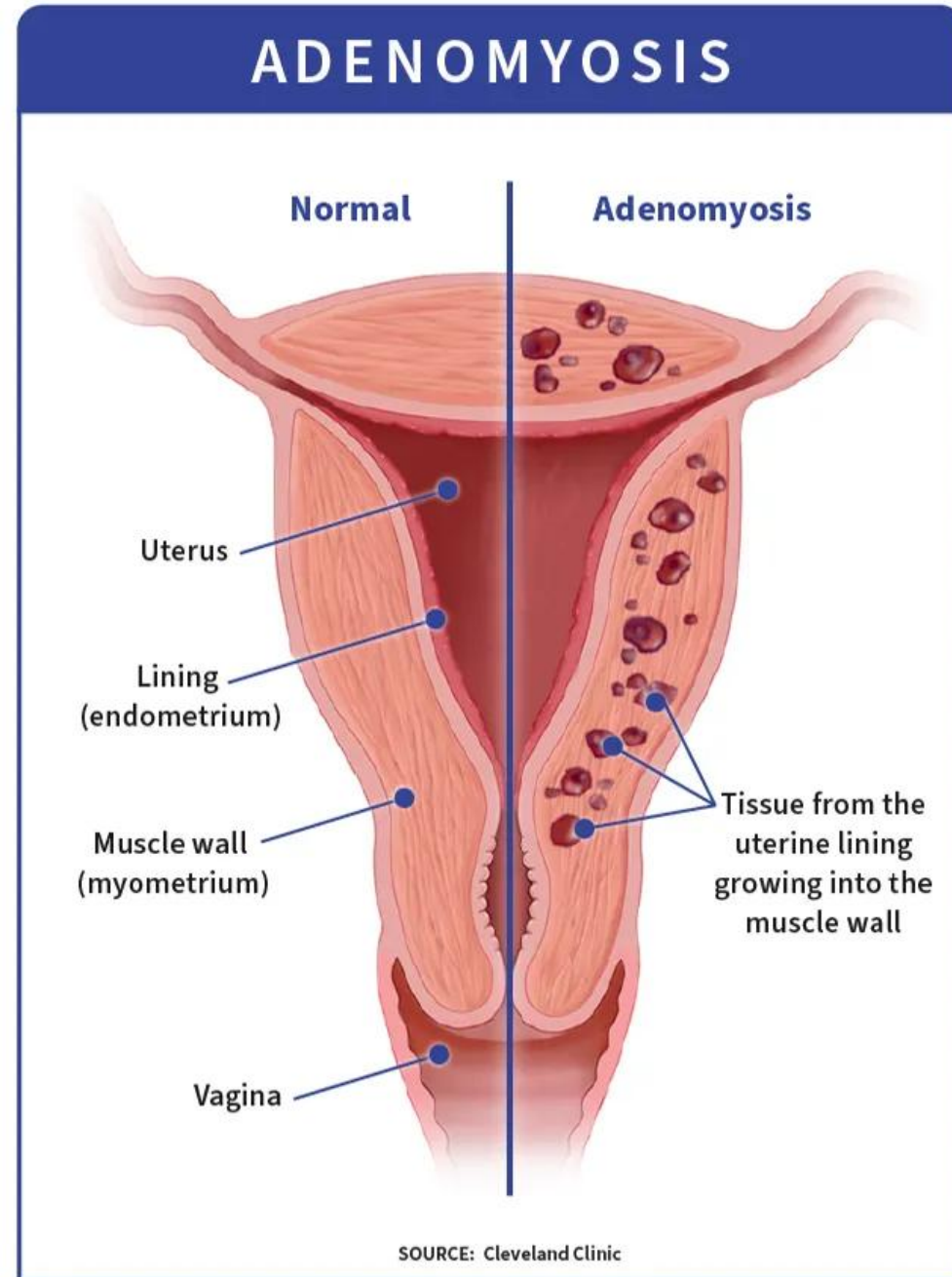
- NICE Patient Decision Aid
- **Endometriosis UK:** endometriosis-uk.org/get-support
- **My Menstrual Health Project:** menstrualhealthproject.org.uk – consultation questionnaire and symptom tracking diaries available

What Is Adenomyosis?

- Inner womb lining (endometrium) grows into the uterine muscle layer
- Problematic because adenomyosis tissue cannot shed away like normal womb lining
- Can affect the whole womb, or just one part
- May cause the womb to noticeably enlarge
- Can exert extra pressure on surrounding organs

Where It Develops

https://img.lb.wbmdstatic.com/vim/live/webmd/consumer_assets/site_images/article_thumbnails/BigBead/what_is_adenomyosis_bigbead/650x870_what_is_adenomyosis_bigbead.jpg



Who Gets It, and Why?



Common

- Affects up to 1-2 in 10 women of reproductive age
- Typically those over 30 years old who have had prior pregnancies



Cause

- Unknown
- No known way to prevent it



Risk Factors

- Prior pregnancies
- Injuries to the womb, e.g. caesarean sections
- Genes, hormones and autoimmune disorders
- Strongly associated with endometriosis

Symptoms & Complications

~1/3rd of women with adenomyosis have no symptoms. Symptoms often stop or significantly improve after the menopause.

Common Symptoms

- Heavy (40–50%) and painful (30+%) periods – the commonest symptoms
- Premenstrual heaviness or pelvic pain
- Pain during intercourse
- Pain on opening the bowels
- Urinary symptoms
- Bloating

Complications

- Anaemia (from heavy bleeding)
- No evidence of impact on natural ability to becoming pregnant, but seems to reduce the chance of successful fertility treatment in those who have struggled to conceive naturally



In Patients' Words: Living with Adenomyosis

“Many women live with this condition without ever having a diagnosis made.”

“A lot of women with adenomyosis have such bad periods that they have to put their lives on hold for that time of the month. It affects quality of life significantly. It can lead to anaemia due to heavy bleeding and extreme tiredness.”

“It’s a difficult condition in that until a few years ago, it was only a diagnosis that you made in a pathology lab – once you had the uterus under a microscope, only then could you see the symptoms were caused by it.”

Treatment

Depends on symptoms, age, patient preference and the wish to conceive.

Non-Hormonal

- Tranexamic Acid or Mefenamic Acid to reduce pain and heaviness of bleeds
- Pain relief medication

Hormonal

- Combination oral contraceptive pill / patch
- Progesterone-only contraceptive pill / implant / injection / coil
- GnRH analogues – temporary menopause: Zoladex

Surgical

- Uterine Artery Embolisation
- Hysterectomy
- Endometrial Ablation (uncertain role)

What Are They?

Fibroids are non-cancerous growths in or around the womb, also known as MYOMAS or LEIOMYOMAS. They are made up of muscle and fibrous tissue.

- Considerable variation in size – pea-sized to melon-sized
- Common to have several of various sizes, but can be singular

Different types, depending on where they are found in the womb:

INTRAMURAL

Within the muscle wall

SUBSEROSAL

From the outer wall into the pelvis

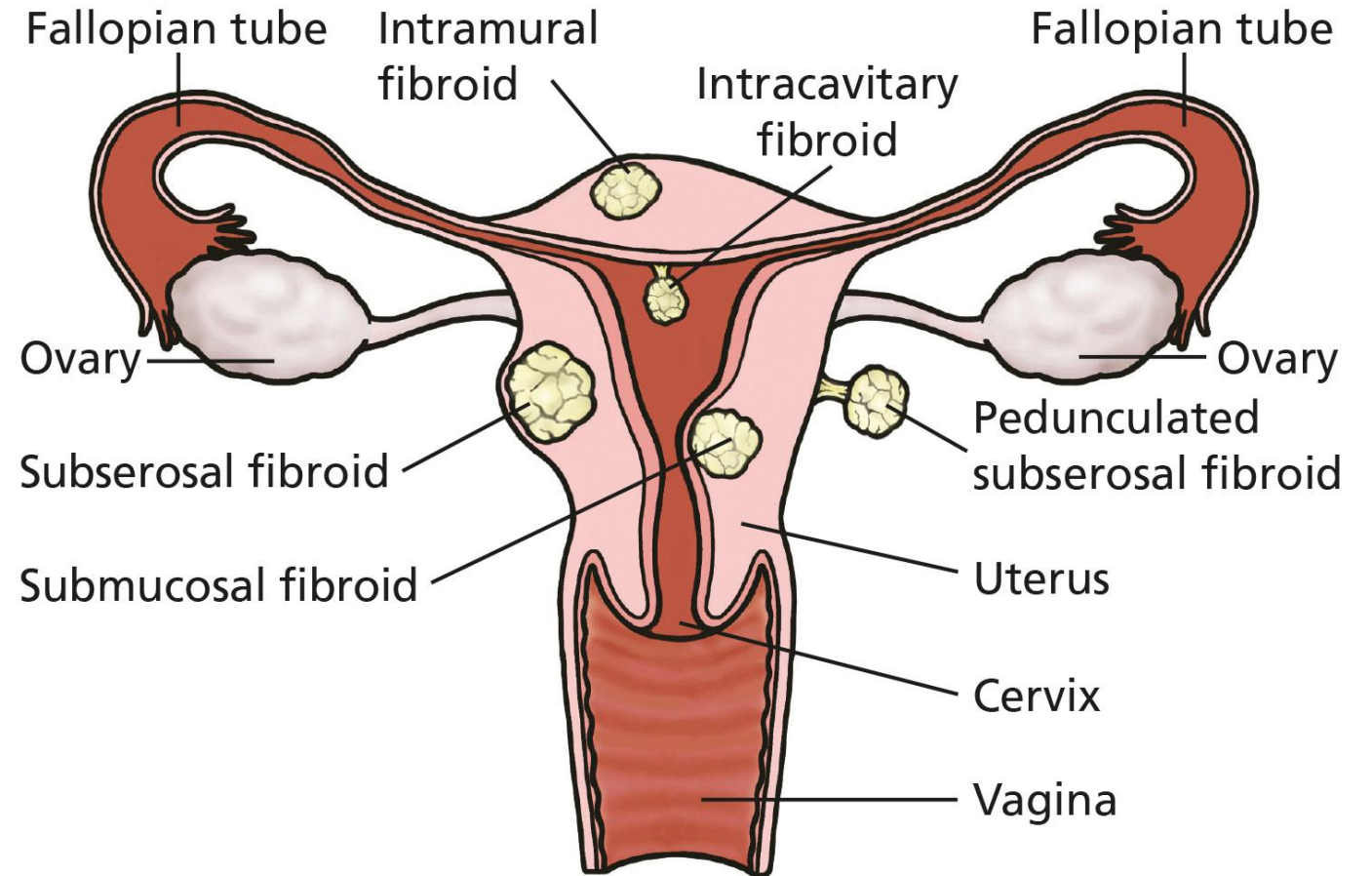
SUBMUCOSAL

Develops in the muscle layer and grows into the womb cavity

ANY CAN BE PEDUNCULATED

Attached to the womb by a narrow stalk of tissue

Where Fibroids Develop



<https://www.leedsth.nhs.uk/wp-content/uploads/2023/12/LN004445-5.jpg>

The Facts



Common

- 2/3rds of women affected in a lifetime
- Peak age = 30–50 years old



Cause

- Unknown, but likely linked to hormones
- Usually develop during reproductive years, when hormone levels are highest
- Generally shrink after the menopause
- Can increase, decrease, or even disappear over time



Risk Factors

- Increasing age
- Early menarche
- Older age at first pregnancy
- Obesity and hypertension
- **HRT use** – reduces the chances of shrinkage at menopause, and can increase growth
- Family history
- **Afro-Caribbean ethnicity** – larger fibroids appearing earlier and giving more symptoms

Symptoms



Heavy periods



Painful periods



Abdominal or pelvic pain, pressure or discomfort



Bloating



Pain or discomfort during intercourse



Lower back pain



Urinary symptoms



Bowel symptoms

Treatment

Depends on symptoms, age and patient preference.

Non-Hormonal

- Tranexamic Acid or Mefenamic Acid to reduce pain and heaviness of bleeds

Hormonal

- Combination oral contraceptive pill / patch
- Progesterone-only contraceptive pill / implant / injection / coil

Surgical

- Myomectomy
- Hysterectomy

Terminologies

PMT

Premenstrual Tension

PMS

Premenstrual Syndrome

PMDD

Premenstrual Dysphoric Disorder

PME

Premenstrual Exacerbation – of an existing condition

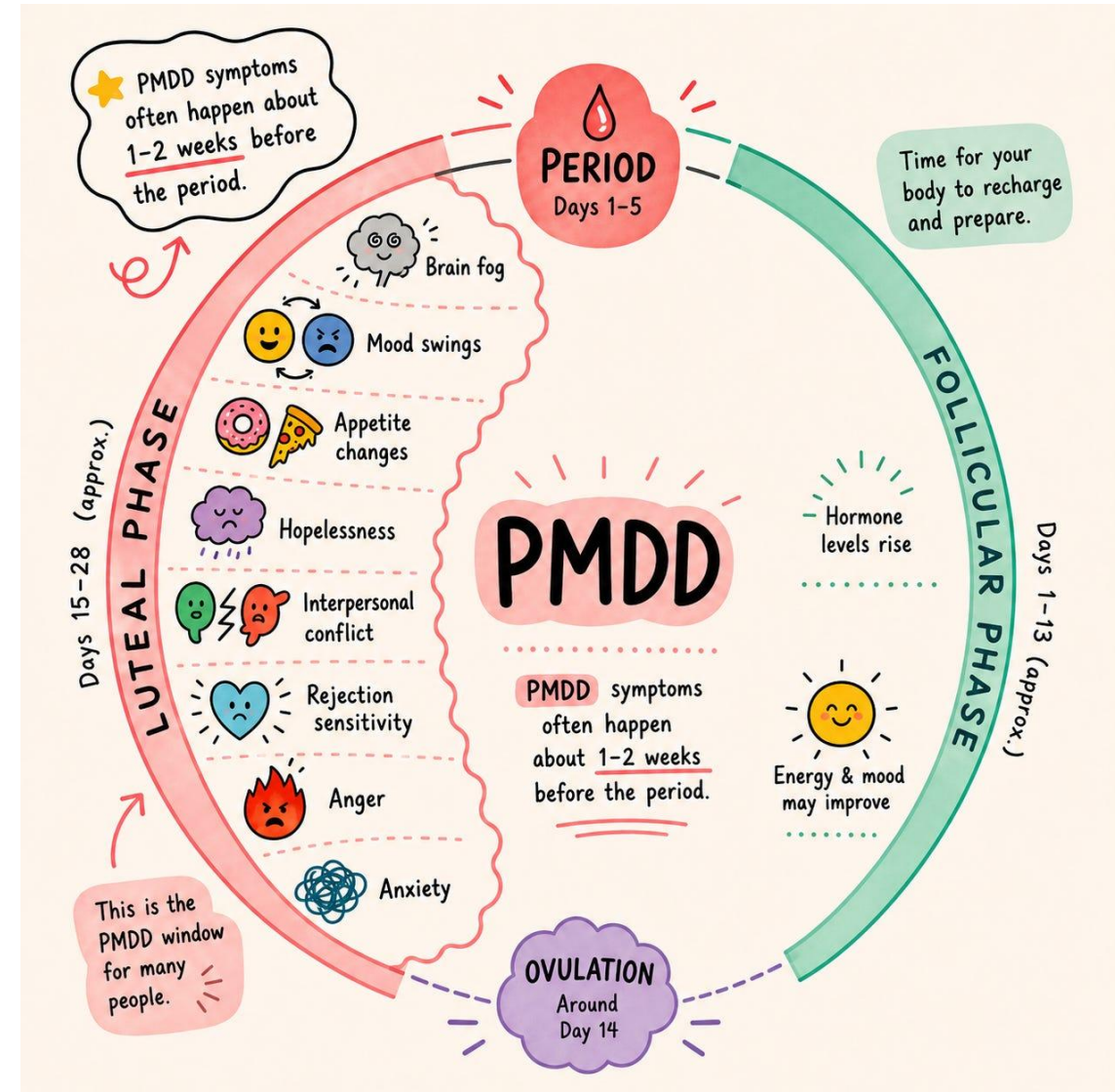
PIPD

Progesterone-Induced Premenstrual Disorder

PDAM

Premenstrual Disorder with Absent Menstruation

Symptoms Follow the Cycle



[https://substackcdn.com/image/fetch/\\$s_!RV2!!f_auto,q_auto:good,fl_proggressive:steep/https%3A%2F%2Fsubstack-post-media.s3.amazonaws.com%2Fpublic%2Fimages%2F91eb0155-0f16-402f-8bc9-4daea5de7a60_1254x1254.png](https://substackcdn.com/image/fetch/$s_!RV2!!f_auto,q_auto:good,fl_proggressive:steep/https%3A%2F%2Fsubstack-post-media.s3.amazonaws.com%2Fpublic%2Fimages%2F91eb0155-0f16-402f-8bc9-4daea5de7a60_1254x1254.png)

The Facts

90%

of women will experience some type of PMS symptoms

33%

state that PMS impacts daily life each cycle

5%

feel 'disabled' by their symptoms – this is PMDD

PMDD is classified as a mental health disorder.

Diagnosed using DSM-5 criteria (Diagnostic and Statistical Manual of Mental Disorders). Commonly misdiagnosed as Emotionally Unstable Personality Disorder (EUPD).

PMDD: Diagnostic Criteria

In most menstrual cycles, at least 5 symptoms must be present in the final week before the onset of the period, start to improve within a few days after the onset, and become minimal or absent in the week after.

At least 1 of these MUST be present

- Marked affective lability
- Marked irritability, anger or increased interpersonal conflicts
- Marked anxiety

1 or more can make up the 5 symptoms needed

- Decreased interest in usual activities
- Subjective difficulty concentrating
- Lethargy, easy fatigability, or marked lack of energy
- Marked change in appetite; overeating or specific cravings
- Hypersomnia or insomnia
- A sense of being overwhelmed or out of control
- Physical symptoms: breast tenderness/swelling, joint or muscle pain, bloating, weight gain



PMDD Across Life Stages

Symptoms can become more prominent with significant hormonal flux.



Puberty



Postnatally



Perimenopause

As periods become more erratic with the perimenopause, the luteal phase can lengthen – increasing PMT/PMDD symptoms considerably.

PMDD: Accessing Diagnosis & Support

Keep a Diary of Symptoms

- A diagnosis can be made via symptom tracking
- Looking for cyclical symptom patterns

Make an Appointment with Your GP

- Blood tests cannot diagnose PMDD, but can rule out other causes such as thyroid disorders
- Symptoms could indicate PMDD if severe enough

Get Support

- **iapmd.org**
 - The International Association for Premenstrual Disorders
- **pms.org.uk**
 - National Association for Premenstrual Syndromes



PMDD Treatment: Lifestyle & Therapies



Lifestyle

- Nutrient-rich diet high in fibre and plant-based whole foods
- Minimise saturated fat, processed carbohydrates, caffeine and alcohol



Complementary & CBT

- Agnus Castus 20–40mg/day – do not take with hormonal contraception or HRT
- CBT has been shown to reduce functional impairment in PMDD



SSRIs

- Sertraline or Fluoxetine, etc.
- Taken continuously, or sequentially in the luteal phase
- Shown to significantly reduce symptoms in 60–75% of patients

PMDD Treatment: Hormonal Options

Drospirenone-Containing Contraceptive Pill

- Yasmin, Lucette, Eloine and Slynd – prevents ovulation and reduces hormone-related fluctuations

High-Dose Oestrogen Patches + Progesterone-Releasing Coil

- Evorel 100mcg patch + hormonal coil can work well if PMDD is more prominent in the perimenopause – allows contraception (coil) plus ovarian suppression (patch)

Injections: Prostag and Zoladex

- Work by reducing oestrogen levels and affecting hormone release via the pituitary
- Usually need HRT 'buy-back' to reduce induced menopause symptoms

Hysterectomy and removal of ovaries – a definitive option in severe, refractory cases

PCOS Is Now PMOS



Polycystic Ovary Syndrome (PCOS) has been officially renamed **Polyendocrine Metabolic Ovarian Syndrome (PMOS)**.

Why the Change?

- The old name implied the condition is defined by ovarian cysts – it isn't
- It overlooked the hormonal (polyendocrine) and metabolic features that affect long-term health
- The new name better reflects a complex, whole-body condition

What This Means for You

- Officially announced May 2026 (The Lancet), led by Monash University with the Endocrine Society, AE-PCOS Society and Verity PCOS UK
- PCOS and PMOS will be used interchangeably for ~3 years during the transition
- The condition itself, and existing diagnoses, are unchanged

What Is PMOS?

- The exact cause is unknown; often familial
- Affects around 1 in 8 women – the most common endocrine condition in women of reproductive age
- Commonly diagnosed in women in their 20s–30s, often when trying and failing to conceive – PMOS is the most common cause of anovulatory infertility

A Whole-Body, Not Just an ‘Ovarian’, Condition

PMOS involves abnormal hormone levels (e.g. insulin, testosterone) and can affect reproductive, metabolic, dermatological and psychological health – not just the ovaries.

Diagnosed with blood tests and ultrasound scan – both may still be normal.

Diagnosis: Updated Criteria

Rotterdam criteria, updated in the international PMOS guideline – AMH blood levels can now be used as an alternative to ultrasound.

Adults: 2 of these 3

- Oligo- or anovulation (irregular/absent ovulation)
- Clinical and/or biochemical hyperandrogenism
- Polycystic ovaries on ultrasound, OR elevated AMH

Adolescents: both required

- Oligo- or anovulation, AND
- Clinical and/or biochemical hyperandrogenism

Ovarian morphology and AMH are not used in adolescents, as normal pubertal development can mimic PMOS on ultrasound.

Symptoms



Irregular Periods

- Ovaries do not regularly release eggs (ovulation), so cycles can be erratic, irregular or absent



Excess of 'Male' Hormones

- Excessive hair growth
- Central weight gain
- Thinning hair and hair loss
- Acne and oily skin
- Darkening of skin, and skin tags

Associated Health Risks

Because PMOS affects the whole body, long-term health risks span several systems.



Type 2 diabetes



High cholesterol & increased cardiovascular disease risk



Sleep apnoea



Non-alcoholic fatty liver disease



Anxiety, depression and other mental health impacts



Pregnancy complications (e.g. gestational diabetes, pre-eclampsia)



Infertility



Endometrial hyperplasia / endometrial cancer

Treatment & Ongoing Care



Lifestyle

- Losing weight, where relevant
- Dietary changes



Medical

- Hormonal birth control: combined pill / patches, or progesterone-only pill / injections / implant / coil
- Insulin-sensitising medication: Metformin



Fertility

- Clomid
- IVI / IVF
- Laparoscopic ovarian drilling

New UK guidance: NICE's draft PMOS guideline (out for consultation in 2026) recommends an annual review covering symptoms, and metabolic and psychological health.

How Menstrual Health Can Affect Work

Symptoms are often invisible – but their impact on work can be significant, and many people struggle in silence.



Pain & discomfort

Difficulty sitting, standing or travelling for long periods



Heavy bleeding

Frequent toilet trips, fear of flooding, needing to change clothes



Fatigue & anaemia

Exhaustion, low stamina and poor sleep



Concentration & memory

‘Brain fog’, difficulty focusing, slower processing



Mood & emotional changes

Anxiety, irritability or low mood – especially with PMDD



Absence & presenteeism

Time off, or working while unwell and less productive



Medical appointments

Investigations, scans, treatment and recovery from surgery



Confidence & career

Embarrassment, missed opportunities, or leaving work altogether

The Impact in Numbers

69%

of women report a negative impact at work because of menstrual symptoms

53%

have been unable to go to work at some point due to their symptoms

49%

never tell their manager the real reason for their absence

Only 12% say their employer provides any support for menstrual health.

61% of those with symptoms have worked when they didn't feel well enough, and 63% felt less able to concentrate. Of those with a diagnosed condition (e.g. endometriosis, PMDD, PMOS), 81% said it negatively affected them at work.

Source: CIPD / YouGov survey of 2,060 UK women aged 18–60 (2023)

Practical Workplace Support

Small, often low-cost adjustments can make a big difference – ask the individual what would help them.



Flexible Working

- Option to work from home on difficult days
- Flexible start / finish times or adjusted shifts
- Extra or longer breaks when needed
- Temporary changes to workload or deadlines
- Paid time off for medical appointments



Facilities & Environment

- Easy access to clean, private toilets
- Free period products and sanitary bins in every cubicle
- Desk near toilets; fan or temperature control
- A quiet space to rest; heat pads available
- Breathable, dark uniform options and spares



People & Culture

- Peer support networks or menstrual health champions
- Managers trained to have open, confidential conversations
- A clear menstrual health policy
- Sensitive recording of related sickness absence
- Referral to Occupational Health and EAP

Supporting Each Other: Next Steps



For Employers

- Normalise the conversation – include menstrual health in wellbeing policies
- Ask, don't assume – agree individual adjustments and review them regularly
- Record menstrual-related absence sensitively
- Signpost to Occupational Health, EAP and the GP



For Individuals

- Track symptoms in a diary or app to spot patterns
- See your GP – effective treatments are available
- Talk to your manager, HR or Occupational Health about what would help
- Find peer support, e.g. Endometriosis UK, IAPMD, Verity



Know the law: under the Equality Act 2010, conditions such as endometriosis, adenomyosis or PMDD may count as a disability where they have a substantial, long-term effect on day-to-day activities – employers then have a duty to make reasonable adjustments.



Thank You for Listening

Any Questions?

We really value your feedback so please take a few moments to share your thoughts.....



Thank you
We look forward to seeing you at the next WUN Event

<https://thewun.co.uk/>

