Stop Telling Women Their Long COVID is Menopause

From friends to medics, women are used to having their health issues dismissed, minimized or blamed on their hormones.

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“Are you sure it’s not the menopause?”

I don’t know if my friend noticed my eyes glaze over as she stared at me across the lunch table, one eyebrow raised in a quizzical fashion. It was a question I was bored of hearing — and one that, if landing on a difficult day of symptoms, made it hard for me to keep my irritation in check.

I contracted COVID-19 in October 2022. I tested positive for two weeks, but my symptoms ran the full gamut until March 2023: a constant headache, aching joints, racing heart, cognitive dysfunction and extreme fatigue. “Like someone had flicked your off switch,” a colleague remarked, after seeing me go into a leaden slumber within seconds of sitting.

Now, three years later, I still experience unbearable symptoms and exhaustion that no amount of rest or sleep seems to cure.

Along with the pain and frustration of feeling so utterly wrung out, there’s the added strain of trying to explain to people why I feel like this. And then batting off their unqualified — and unwanted — take on why I feel like this, because when you are a woman of 52, no one wants to acknowledge long COVID. Friends, workmates and medical professionals alike almost always conclude that I’m in fact in the throes of menopause, and that every symptom is “textbook change of life.”

In some respects, I can understand it when women immediately default to the menopause argument. In the past few years, menopause has become big business, with women bombarded with information, products, and endless magazine articles about it on a daily basis. Menopause is the latest wagon to which every midlife malaise is now hitched, and is a marketer’s dream.

While women should be talking about it — and I am not denying I am of the age for that conversation — we should recognize that there are other things affecting women in midlife, too. An estimated over 400 million people are affected by long COVID worldwide, with a 2025 RECOVER study finding women aged 40 to 55 were the highest-risk group compared to other ages and

genders.

Yet despite these figures, skepticism and disbelief still prevails. Women with long COVID not only endure a lack of support from friends and family, but from health professionals dismissing their symptoms and even denying long COVID's existence, too.

The first time I told someone I had long COVID, they asked how I could have it, because COVID-19 "wasn't even a thing any more." Then a family member claimed I was using it as an excuse to get out of doing things, and that all women of my age are "tired and run-down." Because obviously, by dint of being a woman, everything must be either hormone-related or in my head.

Of course, medical misogyny and dismissal of symptoms in women's health are nothing new — particularly when women present with fatigue or inconclusive symptoms. I experienced this in my early twenties: no matter what I went to see the (male!) primary care doctor about, be it tiredness, low mood, skin reactions, or menstrual issues, rather than listening to me and sending me for investigations, he repeatedly suggested the contraceptive pill as the antidote to whatever problem I was presenting with.

The thing is, I am very tuned in to my body and any changes in it. I take no pleasure in feeling unwell, or admitting that I am, and take care of my diet and health as much as possible.

I've always been an energetic, busy person. I am a journalist, and until I contracted COVID-19, I was also a broadcaster, regularly appearing on TV and radio as a social commentator. I no longer do so because I can't trust myself not to have a mid-sentence brain freeze, lose my train of thought, or attempt to communicate by describing the word I'm searching for.

Within the safety of my home, it's amusing if I say "the thing you put up to keep the rain off" when my sluggish brain will not produce the word "umbrella," but it's less endearing — or indeed professional — in a work situation.

"What have the doctors said?" is another favorite question skeptics like to put my way, directing it as though it's their "gotcha" moment. And it is an interesting one, as in my experience, clinicians are no different from anyone else when presented with an exhausted, achy, befuddled fifty something female with long COVID: disbelieving and dismissive.

On every occasion I have sought medical advice for something unrelated to long COVID — but mentioned it during the course of the consultation — doctors have smiled kindly and told me (patronizingly) the disease was "much more likely" to be the start of menopause. Explaining that my symptoms started with COVID-19 would cut no ice, and each time the doctor encouraged me to "explore my options" around hormone replacement therapy (HRT) as though it were some miraculous cure-all. Each time, I immediately got contraceptive-pill déjà vu.

This would also happen despite me explaining I had no menopause symptoms. I still had a regular

menstrual cycle, and far from having hot flushes, another symptom of my long COVID is that I constantly feel cold, to the point I often wake in the night shivering, even with piles of covers and a heated blanket on. But no matter what lived experience and evidence I presented, the doctor would shut me down with a condescending “Well, it wouldn’t hurt to have a chat about HRT.”

Of course, I am pleased that the National Health Service (NHS) in the U.K. is engaging more actively with women about menopause, but it does concern me that we’ve slipped into a menopause monoculture, an echo chamber. And it feels ever thus: women’s knowledge of their bodies sidelined, their intuition dismissed, their symptoms pigeonholed into the medic’s preferred diagnosis — which, once you hit midlife, is almost always menopause.

But it does look like change could be coming, despite the mass closure of long COVID clinics in the U.K. over the past year. The Royal College of Nursing — the professional body and union for nurses in the U.K. — now recognizes there is an issue when it comes to women presenting with symptoms that could apply to both menopause and long COVID. Their latest guidance states, “Women are disproportionately affected by Long COVID, and as the peak incidence occurs between the ages of 35 to 49, there may be overlap with symptoms of perimenopause and menopause.”

The guidance also acknowledges just how severe and debilitating long COVID can be: “The impact of long-term breathlessness, fatigue, insomnia and lack of concentration/cognitive dysfunction can be extremely disabling and has been recognized as such by employment tribunals.”

But it’s this line in their guidance that makes me most optimistic: “It is particularly important to listen to the patient’s unique experience and elicit which symptoms are the most problematic,” they write, “to personalize and develop an appropriate management plan.”

I hope this recommendation becomes ingrained not only in NHS culture and practice, but also generally in workplaces, families, and social circles. So that when a woman says she has long COVID — or indeed any other infection-associated chronic condition — she is listened to. Because we really do know our own bodies best.

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