A New Approach To Breast Cancer: Smarter Screening, Better Treatment, Healthier Outcomes Transcript

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Introduction and Guest Welcome

Hello! Welcome to this episode of Bioidentical Hormones and Mental Health overcoming anxiety, depression, ADHD, and brain Fog in women. I'm your host, doctor Cassie Smith.

I'm a holistic endocrinologist. Today I'm interviewing doctor Jen Simmons. She is going to give us a ton of information about bioidentical hormones and how it actually does not cause cancer.

We're also going to talk about the benefits of bioidentical hormones, not only for whole body health, but for brain and cognition. So Doctor Jen Simmons is a breast cancer surgeon who turned integrative oncologist on a mission to change how we diagnose, treat, and screen for breast cancer.

This is why I love her. You guys know I'm very into the holistic realm of things. Her bestselling book, The Smart Woman's Guide to Breast Cancer, is changing the narrative around breast cancer and will undoubtedly change the lives of millions of women worried about or affected by breast cancer diagnosis.

She's opening the first Perfection Imaging Center, which Aquila accurately screens for breast cancer using revolutionary new technology without pain, compression or radiation.

No more mammograms, ladies. So I posted about this on social media, and I had a lot of people in Oklahoma City there who are super excited about this technology.

So help me ensure or welcome Doctor Jen Simmons to the back to the Basics podcast. Well, I am so delighted to be here and I will just correct my bio a little bit in that.

We're open AI perfection imaging is open. We are we are seeing patients were booked through. We're booked out a couple of months. But you know, for anyone interested in coming to the Philadelphia suburbs or coming to Nevada, California, get on the list.

Because the longer you wait, the longer you're going to wait for your scan. Yeah. Yeah. So that is super exciting. And so for everyone that's just, you know, doesn't know what we're talking about.

Let's talk about that. So can you explain to them like what this imaging is how it works. So lutely. Absolutely. But I think I would rather start on why this imaging is important because we actually have a very broken, dysfunctional breast cancer screening system right now.

And we've known for decades how broken and dysfunctional it is. And yet we have allowed industry to dictate what is happening here and there. Such a loud voice that people are convinced that what they're saying is true.

And I so I would love to share with you where the program came from and what the true facts are.

Why Mammogram Screening Is Broken

So the Mammographic screening program was birthed in the 1970s, and at that time it was built on these foundational understandings, and the understanding was breast cancer growth was both linear and predictable.

And what that meant was that breast cancer started really small, grew to some critical size, at which point it was more likely to metastasize. And if you could find it before it reached that critical mass, you could save lives and save breast.

This is a totally, totally noble cause, and if all that were true, it would be amazing. The problem is, it's not true. Breast cancer growth is neither linear nor predictable.

So what that means is that there are very small breast cancers that are very aggressive. And it doesn't matter when you find them, they are going to behave aggressively.

And you cannot be fooled by their size, right? So finding an aggressive breast cancer small doesn't help that person. There are larger cancers that have no tendency to metastasize, and so it doesn't matter when you find them, it almost doesn't matter how you treat them.

They're going to do fine. And then there's everything in the middle. And so the fact that we are screening everyone with mammogram, if mammograms save lives, we would expect to see a reduction in the number of women that die of breast cancer.

But the problem is we're not seeing now. We're not seeing that at all. And in fact, no matter how many mammograms we do every year, the same exact number of women die of breast cancer, no matter how many mammograms we do every year, the same exact number of women present with aggressive disease.

So we are not impacting the bottom line. And we are not saving lives with mammogram. Let me tell you what we're doing when you look at the Canadian breast cancer screening study.

This is a study of 90,000 women. They're young women. They're women aged 40 to 59. This is the age group that we are the most vocal about, right? Get young women to get mammograms because it saves lives.

Right. So 90,000 women age 40 to 59. Half of them are in the group that is going to screen with mammogram. Half of them are in the group where they're just doing self cross examination.

The exact same number of women die of breast cancer in each group, the exact same number of women. So not saving women from dying from breast cancer. This is what happens in the group that screens with mammogram.

You have a 20 to 30% increase in diagnosis of breast cancer. Now, what that means is that we are diagnosing women with breast cancer and and obligating them to breast cancer treatment for a disease that would have never presented itself clinically.

So we are making them into cancer patients when they would have never, ever died of the disease. This is a huge problem because we're talking about huge numbers.

If we're going to diagnose nearly 300,000 women this year in the United States with breast cancer, 20%, that is 600,000. I mean, is 60,000 women, right?

Flip it over and talk about we have 4 million women in the United States living with a breast cancer diagnosis, 800,000 of which never needed to be diagnosed and never needed to be treated.

So we are not saving lives. We are creating customers, which is happening all over the medical system, and mammogram is no exception. Now, I started off by saying that they believe that mammogram would save lives and save breast.

So we know it doesn't save lives. But if it if what it did was save breast, that's a noble cause, right? If less women had mastectomy as a result of screening, that's a noble cause.

But unfortunately that's not what happens. What happens is that when you screen with mammogram and find these meaningless things and give a woman a diagnosis of breast cancer, what happened?

She's terrified. She's terrified. And very few professionals are sitting down with that woman and explaining to her that there's no survival advantage to mastectomy.

So women are terrified and they do what they think is the most, because everyone wants to do the most. And the mastectomy rate while screening with mammogram is up 20%, 20%.

So we're not saving lives and not saving breast. We're creating, an enormous population of women who are treated for breast cancer unnecessarily. And breast cancer treatment is not benign.

Breast cancer treatment accelerates heart disease, accelerates brain disease, accelerates bone disease. These are all the number one threats to women's life anyway.

Cardiovascular disease is exponentially the number one threat to a woman's life. The same exact number of women die every year is a complication of fracture.

And they do have breast cancer. Incidence of Alzheimer's is skyrocketing. We are not helping these women. We cannot trade one disease for another for these women.

And yet that's what we're doing for 20 to 30% of the breast cancer population. Now, I want to be clear, I am not saying that breast cancer isn't a thing.

I'm not saying that no one dies of breast cancer. I'm not saying that it's not a terrible disease. It is. But we have to look at it biologically, like the disease that it is.

And we have to do a far better job of separating out those women that need treatment from those women who do not. And we have to stop calling things that aren't breast cancer, breast cancer.

So there will be 90,000 women this year diagnosed with something called DCIs, ductal carcinoma in situ, 90,000 women. And those women will get treated.

So we're taking a disease that has 100% survivability. No one dies of DCIs and we are decreasing the quality and the quantity of their lives. We're taking women who would have never been affected.

We're giving them heart disease. We're giving them dementia. We're giving them osteoporosis. What are we doing? What are we doing? I see a lot of those women.

We're also giving them depression and making them, you know, anxious because we take away their hormones. Yeah. They don't feel well. Yeah. So that's that that's the title to my next book, The Forgotten Woman, because we treat these women for breast cancer.

And then we say, oh, you should feel grateful to be alive. And don't get me wrong, like they're grateful to be alive. But alive is not how they feel. Because they're depressed, because they're anxious, because they can't sleep, because they can't think they have brain fog.

They have word search issues. They're having palpitations. They've gained weight. They're having digestive problems. Their bones ache, their joints ache, they're leaking urine.

They have no libido. The vagina is dry. Their skin is dry. Their hair is dry. Their everything is dry. Sex is painful. Their relationship is suffering.

It's hard to feel grateful. It's hard to feel grateful when all of that is happening.

Overdiagnosis, Overtreatment, and Life After Breast Cancer

So we need to do a far better job of determining who does and who doesn't need treatment. And then we need to do a far better job after treatment of helping these women to live the life that they deserve, because that life that I just described to you, that life is not worth living.

And so what we want to do once we get people through the initial treatment phase, when we know that they don't have cancer in them anymore, they certainly don't have an abundance of cancer in them anymore.

We need to be evaluating them for bioidentical hormone replacement. They need that. They need the same options as everyone else are people too, and they don't deserve to suffer.

That is music to my ears, Doctor Jen. So I see these women, you know, so I see a lot of I do a lot of bioidentical hormones and I see these women. I saw one yesterday who had triple negative breast cancer.

You know, that's a whole different story. Obviously not. DCIs, but triple negative breast cancer. Who is having issues with brain fog. And like you said, vaginal dryness.

And she already has heart disease issues. She's got high cholesterol. All these things. She's miserable. And she said, well my oncologist says I can't have hormones.

And I said, well yeah. And she said, well, because I had cancer. And I said, you had triple negative breast cancer, like, and so if we don't give you hormones, then your risk of developing heart disease and all these other issues is much higher.

And actually, you know, your risk of developing any cancer is going to be higher because you're going to become obese and insulin resistant. And, you know, and so it's just it's crazy.

And I don't know where I don't know when the oncology world is going to get on board. But I deal with this with women all the time after breast cancer.

You're right. It's like, yeah, okay. Well you've lived you should be grateful to be alive. But they're miserable. They're miserable. And, you know, I would just love for someone to explain to me how that scenario makes sense.

So I get it that most medical oncologist. Well, first of all, let's just call a spade a spade and that they have zero training around hormonal health.

They don't know anything. And I can tell you that because I'm one of them who made it her mission to learn and be educated and understand hormonal health.

But medical oncologist, surgical oncologist, they do not know, they do not know, and they always confuse. I don't know with no. That's happening all day, every day.

They confuse I don't know with no. Now, even if they believe that estrogen plays a role in breast cancer development and propagation, which, you know, I could make the argument that that also is not true.

But even if they believe that that is that is what is fueling the cancer, then how do you explain not allowing someone who has a triple negative cancer, who by by that kind of real basic understanding, if that tumor is not influenced by estrogen or progesterone.

So what would be the reason to not allow that woman to have hormone replacement? Like, I get it that they can't think outside of the box and they can't get past the you have a hormone positive cancer.

You can't take hormones. I get it that they can't like, take that extra step and understand about alpha receptors and beta receptors. And you know, what's actually happening on the cellular level and how you can affect what's happening in the breast as opposed to what's happening in the rest of the body.

Like, I get it, it's like 17 steps that they don't want to take, but this is like one step. If it's not hormone positive, what do you care? What do you care?

And also, you know, they give this poor women like they give them doxorubicin. They give them these things that

are terrible for their heart too. Right.

So not only did you you took their breast. You gave them all this terrible chemo radiation. I think she had 40 some rounds of radiation. And now you tell her, okay, well, just live with all the symptoms and you can't have anything back that makes you feel better. And that's.

I just am a mind blown. I'm like, yeah, I don't understand, you know? And then of course, I as their, you know, endocrinologist I'm kind of I get it. The patient's in this weird spot because their oncologist is saying no, no, no.

And I'm saying they're crazy and they don't know what to do. And it's just really disheartening. And I, I hope that at some point, like, do you think those the oncologists are going to change their mind?

Are they going to be you guys are going to get together and come up with some new guidelines, like. I highly doubt it. And this is why our medical system, our conventional medical system, it's so fragmented, as you very well know.

And so the heart guys are taking care of the heart and the gut guys are taking care of the gut, and the bone guys are taking care of the bones, and the neurologists are taking care of the nerves.

And, you know, this kind of really fragmented way of approaching. And so I don't think that there's going to be a scenario where medical oncologist are going to become hormone literate.

I think that it takes someone like me where you have to have your own diagnosis and your own impetus to go and learn and, and become knowledgeable. Because without that, you know, medical oncologist are trained to give chemotherapy.

That's their job. Their job is to give chemotherapy and a really good medical oncology. This is someone that knows all the drugs, knows all the side effects, knows the drugs to prescribe, to go along with them to minimize the side effects, you know, no, no matter that half of the things that they do increase the patient's risk of recurrence.

I mean, you think about it. And if you're giving steroids, along with chemo therapy to prevent the side effects of chemotherapy, your include increasing blood sugar, increasing insulin, increasing insulin like growth factor, suppressing the immune system.

I mean, this is a recipe for recurrence right. And the more steroids you get during breast cancer chemotherapy, the higher your risk is of recurrence.

And yet what do they give along with all chemotherapy dexamethasone. It's so crazy to me. But they're not thinking about it because they don't have any knowledge of the endocrine system.

And because they think it's separate. Yeah, I think that's one of the biggest problems I have with medicine is, like you said, the heart guys, look at the heart and the nerve guys.

Look at the nerve and the gut guys look at the gut. But they don't even look at that doctor. And they look at like, what can I give you to make the symptoms stop?

They don't even look at like, what is causing the problem? Even if, you know, if you want to stay in your lane. Yeah. And say, okay, you have heart problems.

What is it like? Nobody looks at it. And that's where I think I get so frustrated when people come to me and they talk. I just sometimes I find myself shaking my head and I don't mean to and my eyes are like, what?

And I'm like, I'm just so appalled at what you're telling me right now that, you know, nobody is like, we're looking at this tree instead of this big forest.

And it's so frustrating in these women with with breast cancer. And to your point, you know, I have this conversation

with women as well.

Hormones After Breast Cancer and Oncologist Misconceptions

And I would love you know, I do want to talk to you about does estrogen cause breast cancer because I tell women this all the time, they're alpha cell.

They're alpha receptors and beta receptors in the breast. I think of alpha as awful beta as protective. Right. And so depending on the type of estrogen you have depends on what stimulates what receptor. And if you give people bioidentical estradiol it stimulates alpha and beta equally.

And so beta cell beta receptors are are protective. If you give women testosterone with semester it actually down regulates the alpha cells. Right. And so it actually help decrease your risk of breast cancer.

And so it's very easy basic you know physiology. And ezreal is directly a beta receptor. The interceptor only. Agonist. So you know, if they only understood we need to first of all stop using estrogen.

Right. Because that is like a catch all term that describes three actual substances in the female body. I think there's a fourth during pregnancy, but we don't really talk about that one too much.

And so when you're when you're lumping them all together and talking about estrogen and then blaming estrogen on things you cannot possibly believe that the endogenous estrogens, the ones that are produced by your ovaries, you cannot possibly believe that they cause breast cancer, because if that were true, that would mean that every woman was put on this earth for the purposes of developing breast cancer.

If that were true, then why don't we see breast cancers commonly in the periods of life where those estrogens are so abundant? Why don't we see it in teenagers?

Why don't we see it in pregnant women? I mean, we do, but it's absolute rarity and the vast majority of breast cancers are seen in women who barely have any estrogen to measure.

Right? Like anyone who sees post-menopausal women try to measure their estrogen, there's like nothing there unless they're really, really obese. And then even in the obese women, it's just a little bit.

It's very rare to see a postmenopausal woman with measurable levels of estrogen. It's just an absolute scarcity. But breast cancer certainly isn't scarce in that in that population.

So, you know, I don't think that androgynous estrogen, our native estrogen, has anything to do with the development of breast cancer. I think it's quite the opposite.

I think what happens is, as our native estrogen starts to wane and remember, we are in a time now where there is so much endocrine disruption. There are so many things interfering with our endogenous estrogen production that as estrogen starts to wane, I think of the estrogen as being like the calm, the equilibrium, the the right of the ship.

And when that estrogen starts to go away, the entire environment, they get nervous. This is a bad transfer machine for this environment. And I do believe that breast cancer certainly multifactorial.

There are a number of things going on. We have all of these toxicities in our environment that, as it turns out, because the breast, no matter how much tissue density you have in your breast, there's still a significant amount of fat cells.

And fat cells are where we harbor our toxins, where we hold on to our toxins. And so, you know, the glandular cells of the brass, they're sitting next to these fat cells, and these fat cells have toxic substances in them.

So it is going to cause cellular damage. It is going to cause DNA damage. But the dysregulation is about not having

the normal stimulatory components around and not having the normal regression in components around, because we build up our breast tissue in the beginning of the month and we let it go at the At towards the end of the month.

If there has not been, a pregnancy conception. And so really what's happening is we have a loss of estrogen, a loss of our, our normal feedback loop. And the cells are mutating to put more estrogen receptors on it because they're just trying to figure out, like, where's my mom?

Where is the teacher? Where is the person that's supposed to be instructing this class? Because I'm missing that person. I'm trying to look for that person.

And I really think that that's what it's about. And when we look at the data of people that use hormone replacement, either pre breast cancer, because quite frankly, people who use hormone replacement are going to get breast cancer.

People don't use hormone replacement are going to get breast cancer. So when you look at the data of the people that are using hormone replacement and then get breast cancer, they have better outcomes.

There is no way that the hormone replacement is causing breast cancer. Now, I do have one exception to that, and that's birth control pills. Birth control pills I do believe are a problem.

And they're a problem because there are like 30 estrogens in those birth control pills that are not recognized by the human body. They they are generally isolated from, pregnant horse urine.

And they have many estrogens in them that our our body doesn't know. They don't know what to do with those estrogens. And so they are toxic to us. And there are, without question, environmental estrogens that are toxic to us.

Things like plastic and nonstick and fragrance and phthalates and, sealants, like fire retardants, dry cleaning products, antibiotics, herbicides, fungicides, pesticides, all of these things act as these Zino estrogens, these these toxic estrogens in our body.

But that is a different story. And we understand how that's harmful. This is a different molecule. But our endogenous hormones are not causing cancer.

Yeah I would completely agree. So we did kind of talk about what does cause breast cancer, which is a lot of it's our environment obesity you know the our choices I think, you know obesity and age right are one of the top two top.

Yeah. Causes of breast cancer. But it's not your estrogen unless you're taking birth control. And I also am not a fan of birth control. And there's so many girls that are getting put on birth control.

Young girls because their periods are irregular or we think they have PCOS. And again, I think it's I don't know what to do. So they just put people on birth control, right.

Like they I don't know where. They're going to end if they're going to mansplain their hormones to them. Right. Yeah. We're going to we're going to force it.

And, you know, that happens at a number of steps along the way. And this is what's wrong with our conventional medical approach. It has nothing to do with root cause.

It doesn't even think about root cause. What it's doing is trying to suppress the symptoms, suppress the symptom, suppress the symptom. So if you have a young girl who has abnormal periods, what do we do?

We put them on a birth control pill to control that. And then they get down the line and maybe they have acne. Okay, birth control pill and paranoiac tone.

Don't think about why they have acne. And then they get down the line and they have infertility and we force a pregnancy on them and don't think about why they have infertility.

Like we're not thinking about these basic things. A menstrual cycle is health. Fertility is health. And unless you understand that very basic concept, you're going to miss the forest for the trees, you are going to miss it.

And it's being missed all the time. And it's being missed so badly that what happens is abnormal periods infertility, PCOS, and ten years down the line, or 15 down the line or 20 down the line there in my office.

Yep, 100%. It's so true. And then they're hopefully they're in your office though and not somebody else's. Because if they're in somebody else's and they get diagnosed with breast cancer, then they get treated and they're told to be grateful, and then they live a miserable rest of their life, right?

Without the proper hormones that they need. Yeah. So what I heard you say then is that HRT is safe after breast cancer. Is that correct? Without that, without question.

And we have a number of studies demonstrating that, in fact, there's only one study that ever showed that HRT after breast cancer was an issue and that was the habits trial.

And the habits trial was another trial similar to the Women's Health Initiative, and that it was stopped prematurely after five years, and it was stopped because they saw a non statistically significant increase in breast cancers in in this group of women that took hormone replacement.

But when they actually looked at the data, and this is something that I still don't quite understand.

How Estrogen, Testosterone, and Environment Affect Breast Cancer Risk

But when they actually looked at the data, it was only in women who were taking hormone replacement and tamoxifen. And for those of you who don't know or are not familiar with tamoxifen, tamoxifen is a synthetic estrogen.

It works on the estrogen receptor, but it has far more affinity for the estrogen receptor than estrogen does. So it kind of what we do with this drug is we flood women with it so that the estrogen that they have can't get to the receptors because it's all occupied by tamoxifen.

And while it can be protective in the breast, it is a known carcinogen. And when we look at the effects of it in the uterus, we actually see an increase in uterine cancer in women who are taking tamoxifen.

So I have no idea why they were both on hormone replacement and tamoxifen. But in any event, they were now of the 20 studies done on women who had breast cancer, who then took hormone replacement afterwards, only one of those studies found an increased risk of recurrence.

And it was the habits trial. And only and the women who were taking hormone replacement and tamoxifen the rest of the 20 studies. So 19 other studies confirmed that there is no increased risk of recurrence with breast cancer.

If you are taking hormone replacement after your breast cancer diagnosis and people lived longer and lived better. So better outcomes, better survival, better, quality of life.

And and these are lessons that we need to learn. And for the listeners that are listening, this includes women who had ear PR, positive breast cancer.

Some of the study. That's correct. That's correct. These were women who had er positive breast cancer. Yeah. And were then afterwards put on hormones including estrogen, estrogen and testosterone combination.

Maybe just one, maybe just estrogen. But those women were given estrogen and they did not have increased risk

of recurrent cancer. They did not die sooner.

They actually probably if you look at the, you know, the, quality of life, it was better, I'm assuming. Yes. Well, they have better survival because they don't they don't develop the heart disease, they don't develop the neurodegenerative disease, they don't develop the osteoporosis.

So they better long term survival, but more and almost more important than that is that they have a far better quality of life. Because, again, it's hard to feel grateful when you can't think and you're depressed and you're anxious and you can't sleep.

Your mood is terrible. You have no libido, your relationship is falling apart, sex is painful. And even if it weren't you, it's unwanted. You're leaking your bladder, your bones ache, your joints ache.

You've gained weight. Like this is. This is not the exception. This is the rule. This is what happens with people. And almost those are the lucky ones.

Because if you are treated for breast cancer, you are 2 to 3 times more likely to die of heart disease. So as compared to women who are not treated with for breast cancer.

So you know, if you are treated for breast cancer, don't die of breast cancer, but die of a heart attack. You know that death gets attributed to not not to breast cancer, that death gets attributed to cardiovascular disease.

So we don't even know the real numbers of the women that were impacted because we're like playing with the data. Like if you treat a woman for breast cancer and she has a heart attack as a result of the damage that you do to her heart from breast cancer treatment, that should be a breast cancer death.

Yeah. So for women that are listening, when you talk about estrogen after breast cancer or just estrogen in general, after you transition through menopause, is there a certain estrogen you say you feel is better?

Are you more of like a cream or an oral estrogen injection stroke is, you know, there are lots of different estrogens. There are lots of different estrogens.

But we we know that the only way to safely deliver estrogen in the post menopause population. What I probably everyone but we're not doing it in the premenopausal population is topically because once you introduce estrogen into the gastrointestinal system, it has to go through first past metabolism in the liver, and it's creating toxic metabolites.

And the problems that we see along with oral estrogen, the blood clots, the increasing in heart disease, fat, things like that. That is not happening with transdermal estrogen.

And the reason is when you put it topically on, on your skin. And the reason is that when you do that, it gets absorbed directly into the bloodstream. It doesn't have to go through the liver.

It's not creating that toxic intermediary, that toxic metabolite. And so for estrogen and for testosterone, because testosterone is directly converted to estrogen in your body through an enzyme called aromatase.

So for estrogen and for testosterone, I only use transdermal delivery systems. So topical I choose to use the the menopause methods formulation. So it is it's a suspension in 100% organic essential oils.

Because I don't like to use solvents and I don't like to add anything to someone's routine. And you can do that with progesterone, too. But progesterone requires much higher doses than estrogen does.

And you're in general using 30 times the amount of progesterone every day that you're using up estrogen. And so to a point early on when the body is still making some progesterone, you can probably get away with topical progesterone, but eventually you're going to have to convert to oral.

But oral progesterone does not have the same side effects or, risks that that oral estrogen does. So you don't have to worry about that. So progesterone I use topically.

But then I do convert people over to oral when they have kind of exceeded their ability to get what they need topically. I do use testosterone. I also use DHEA, and I combine testosterone and DHEA in a topical formulation that that people just use.

You can use it on soft skin. You can use it in the perineum. So there are a number of options. If you're using it in the perineum, you just have to be careful with contact because you will transfer these to your partner.

If they're not given the opportunity to absorb first. So I agree with you. I think that estrogen orally is drives me crazy because of the first pass metabolism through your liver.

I'm also not a big fan of estrogen or testosterone injections either. I think that, you know, there's lots of issues with especially testosterone. But I have a lot of women who come to me and say, you know, it's cheap.

That's on my insurance. That's what I want to do, you know? And so we have to have that conversation of. Yeah, it. Might be cheap, but it's not what's best for you for sure.

Yeah. And, you know, the truth is there are still so many people out there prescribing oral estrogens, prescribing pellets, and, you know, we all see these people who are walking around in hormone euphoria.

That's what I call it. It's kind of like a somatic state. And they feel great, but they don't realize that they're putting themselves at risk. Because I want to be clear, our goal in giving people biotin to kill hormone replacement is not to restore hormone levels that are similar to women who are menstruating.

We're not trying to bring on ovulation. We're not trying to bring on a pregnancy. We're not trying to get people's periods back. Like that is not a goal of ours.

We are trying to meet their basic, basic needs in order to keep women out of wheelchairs, adult diapers and nursing homes. This is this is our goal. And you can do that safely, very safely and not overdose people.

So it is my practice that when I am prescribing for people, I will probably prescribe for them for a month or two months, make sure that they are not having any side effects.

But that goes both ways. Like I don't want them to have side effects of deficiency. I don't want them to have symptoms of deficiency. I also don't want to have them have symptoms of excess.

So when I feel like symptomatically they feel right on, I test them. And we do a 24 hour urine test to look at the hormone levels again, because we don't want people sub therapeutic, we don't want them getting below what they need to be healthy in the long run.

But we don't want them super therapeutic either because we don't want to put them in harms way. We want to do this responsibly because it can be dangerous if you're if you're over treating them.

And that's why it's so important to work with a hormone literate provider who knows what to look for, who knows what to do, who knows how to deliver these safely, and who knows how to follow you.

Yeah, I completely agree. I think that you have to get the right dosage, the right frequency, the right method for each person you know, and I'm not. Like I said, I'm not a fan of injections.

I'm not a fan of oral. I think if you're going to do pellets, you have to do very conservative doses. So very not not what the companies tell you to do.

Not these big, you know, women don't need testosterone of 300. They don't need estrogens of 250 like they don't. I

agree with you. They need to not have symptoms.

And we need to know that it's systemically being absorbed because we want the benefit of their bones and their heart, their brain and. Yes. Yeah. And so but we also don't want the bad side effects either.

And so it is it's very important. And I agree with you. You have to work with somebody who understands hormones like you said, so that if you are having side effects they know how to fix it too, right?

Safe Hormone Replacement Delivery and Monitoring

Because I clean up a lot of hormone messes and it's like, well, if they would have just listened to what you were saying and actually checked your blood work or your spit or your, you know, urine, if they did touch any, if they did any sort of tests, they would have been able to figure out what was going on, and they probably would have been able to figure out if they just listened to you, if they understood hormones in general.

Right? Yeah. And because everyone's a little different too, right? Like I have people who reach out to me and you may to like what is an ideal estrogen level.

Well, that's kind of hard because if you know, if my estrogen was 30, I would probably feel terrible, right? But if I someone 60 and her estrogen 30, she might not have the symptoms she came with. Right.

Like her hot flashes might go away. Her, you know, night sweats might have gone away. So you have to I don't think that there's an actual level that you can like, you know, use either.

It's more symptom based, right? It's more personalized. It's it's mostly symptom based. But, you know, there are some people who will for who will for you, who you think that you're probably at the right dose and then you measure them and they have nothing, or you think you're probably at the right dose and you measure them and they have excess.

So I do, I do think that, there is a Goldilocks place. We are not looking for average levels for a 29 year old, but we are probably looking for average levels for a 40 year old.

Yeah, right. And using that as your as your basis for guidance. Yeah. And the other thing that I do that I don't know if it's your practice or not, but I do ask people to take a break every month and it's anywhere from 1 to 5 days.

And when they take a break, I ask them to pay attention for symptoms. And if they get symptoms on day three, then I tell them next week, just take break for two days.

And if they get have symptoms on day five, next week, just next month, just break for four days. But I do tell people to take a break every month because I think it's physiologically true.

And I, I think that we need to give the receptors a rest and an ability to reset. And if we're constantly, constantly giving them hormone, I don't think that they have the opportunity to do that.

So I do believe in taking physiologic breaks every month. And I do require things of people who I write hormones for. So I am asking them to get breast imaging every year.

I'm not asking them to get a mammogram. I am asking them to do self breast examination every month. I am seeing them once a year and doing a professional breast examination.

And I'm asking them to have a CT scan. So CT scanning is what I believe will completely revolutionize breast imaging. And this is a test that uses circumferential sound waves transmitted through a water bath to create a true 3D reconstruction of the breast.

So unlike mammogram, which uses radiation and compression, unlike MRI, which uses a magnet and gadolinium,

this is just soundwaves transmitted through a water bath.

There's no pain, there's no compression, there's no radiation. And yet we have 40 times the resolution of MRI because it collects 200,000 times more data points than MRI.

And to me, the most important part, the most interesting part about this technology is that it has functional capability. And what I mean by that is if we see something that is ambiguous, obviously, if what we see is a cancer, we tell people to go get treated.

But if we see something that is ambiguous, we ask them to come back for a short interval study. We reemerge, we remeasure the volume of the lesion, and we can actually determine a doubling time.

And we know that cancers have a doubling time of less than 100 days. And things that either aren't important or aren't cancer have a greater doubling time.

So if we have someone who has a lesion that has a doubling time of 200 days, I'm not telling that person to get biopsy it. I'm telling that person to come back in a year because we as a medical community, we are over by it.

Seeing people. And 75% of breast biopsies are benign, 75%. And these women, once you tell them that they have an abnormality in their breast, you can't ring that bell for them.

They think that they're abnormal, they think they're always abnormal, and that is going to drive more disease. So I want to get away from over biopsy and what we're also doing is we're kind of eliminating those biologically meaningless tumors because listen, we all make cancer cells all day, every day, all of us, from the very young to the very old, everyone in between.

We all make cancer cells. And the only ones that are important are the ones that are biologically aggressive. So if we're going to find these things that are just like sitting there doing nothing, your body's taking care of it.

Why would I want to treat that? Why would I want to do that to a woman? When we just talked about all of those things, all of those side effects that they take with them after breast cancer treatment.

So I think that's what's so amazing about this technology is it allows us to determine who doesn't, doesn't need to be about to be biopsied. So that eliminates a tremendous number of falsely positive studies.

It eliminates all of those unnecessary biopsies. And it's going to eliminate a significant amount of overdiagnosis and overtreatment, because we are not looking to identify every single breast cancer.

What we're looking for is the meaningful ones, the ones that are going to be clinically relevant. Those are the ones that we want to intervene in. I completely agree, because you know what happens with women, especially here in Oklahoma City, what I have found is you send them for a mammogram, they get a mammogram.

It's abnormal. They're losing their mind. Right. Like, yes. And the worst part, the worst part that I think in this city, which is why you and I are going to talk, is I get an abnormal mammogram.

It can take three weeks to get these people back in. So then they're mentally a mess for three weeks, right. Like, oh my gosh, I have this abnormality.

And then like you said, 75% of the time they end up with biopsies that are benign. And by the way, once they get back for their repeat then they're like, oh, that's abnormal.

Then it's another two weeks before they can get a biopsy. So now you've put this woman through hell for six weeks. She's stressed, she's anxious, she's she gets this biopsy, which hurts.

And by the way, the mammogram hurt to begin with. And then all of that's over and it's like, oh no, we're just

kidding. You're fine. And then she's like, am I really?

And then, you know, like all these things are going through her head and I feel terrible for them. You know, I'm like, this is this is not acceptable and so many levels.

And so to your point, if you can keep someone from all that unnecessary stress and pain, why would you not? You know why yet. Why do you not? Yeah, I agree. With you 100%.

And I and I unfortunately see it more than I want to because I'm the same way as you are. Like, if you're going to do hormones with me, you don't get your hormones unless you do your mammogram.

And then there are a lot of people who don't want to do their mammograms because of radiation, this and that, which I understand. But I'm like, we still have to do some sort of imaging.

Yeah. And so I end up ordering a lot of mammograms. And then when they're abnormal, my heart always breaks because I'm like, I know it's going to take forever to figure out what is actually wrong.

And then, you know, I don't have a functional oncologist in Oklahoma City I can send these people to so that I know when they go to the oncologist, if they do end up with breast cancer, it's going to be my ectomy and chemo and radiation.

And it's, you know, full force ahead. And I'm like a year ago. And, you know, I tried to get them to go see, I did before I met you a couple weeks ago, I would try to get them to go see Doctor Goodyear.

I know, you know Doctor Goodyear, I love Nathan. Yeah. I'm like, please go get another opinion from somebody who has a brain. And I mean that with the utmost respect, but, you know, like, I'm like, get a different opinion from somebody else before you get depressed off radiation.

And because I'm just an endocrinology, you know, I tell them this, but then the oncologist, what does she know? She's just an endocrinologist. Well, anyways.

Well, now what you can do is give them my book, The Smart Woman's Guide to Breast Cancer, because this has all the answers that they're looking for anyway.

So it is a comprehensive guide to understanding your diagnosis. So, you know, you get that piece of paper that that pathology report which you know, might as well be in Greek.

Sorry if anyone's Greek is great if you understand Greek, I don't. And so this allows them to understand and and interpret that pathology report. But more importantly, I explain all the conventional treatments.

What questions to ask the medical oncologist, the radiation oncologist, your breast surgeon, your reconstructive surgeon, your integrative oncologist.

Perfection Imaging and Better Breast Screening

And, then I'm talking about the thing that everyone needs because everyone who gets a breast cancer diagnosis is going to get a treatment plan, right.

That's a given. But the truth is, what everyone needs when they get a breast cancer diagnosis is a health plan. And so I'm essentially giving them this roadmap to health where they can take back control.

They can do the things that you need to do to drive health. And they can know that health does not happen in a doctor's office. And chemotherapy be sweet and a radiation sweet.

Health happens at home with the things that you do every single day. And when we focus on health, that's what

grows. And now, conversely, when we focus on disease, that's what grows.

And that's what's growing in these medical oncology centers and these radiation centers. Right. But when you focus on health, health grows. And so that's why it was so important to me to write that book, The Smart Women's Guide to Breast Cancer, because I really wanted everyone to have an option.

And to know that you have so much more power than you think. You have so much more control than you think. Here's the way you're getting it. Yeah, our bodies were made to heal.

I tell people that all the time, like they were made to heal. You give it the nutrients it needs, the sleep it needs, the things that it needs. Your body will do some pretty amazing things.

Yeah. Yeah, absolutely. Give it. What you did was take away what it doesn't. And you are met with health. Yeah for sure. And radiation and chemotherapy are not on the list of.

Things it needs. And you know, what we need to essentially understand is that breast cancer is not a surgery deficiency. It's not a radiation deficiency.

It's not a chemotherapy deficiency. It's not an aromatase deficiency. It's not a tamoxifen deficiency. It's not. It's not. And people think of breast cancer as a foreign invader.

But the truth is the breast cancer is a part of you. It's the part of you that's telling you this isn't working. And we have to figure out what this is.

And so, you know, you can have surgery and you can have chemotherapy and a can of radiation. But unless you figure out why you're making cancer, unless you figure out why your body is responding that way to the environment, both the macro environment and the micro environment, what is stopping the cancer from coming back?

Or what is stopping the next manifestation of disease? Because, you know, breast cancer is just a result of chronic inflammation. It's an environmental shift that's happening in your body.

It's a normal response to an abnormal environment. And what we have to figure out is where is that environmental shift coming from? We have to correct that.

We have to take ourselves from the chemistry of stress, which allows for the development of disease, and we take ourselves to the chemistry of joy. And when you do, that, disease truly does go away.

But what you need to do, and this is this is the work of Doctor Thomas Loti is we need to stop making cancer. Does we need to do we can take care of it in these various ways.

We need to stop making cancer and in order to stop making cancer, you have to create health and health as you very well know, it's not a destination. It's a journey.

And it's one that you have to stay on all the time. And I'm sure you have a pain to progress. Story. I have a pain to purpose story, and I'll just tell you from my part of it.

I walk the line and I have to. If I don't walk the line, I'm going to fall back into disease, which is not where I want to be, because I want to live.

I want to raise my children. I want to raise my grandchildren. I want to travel the world with my husband. I want to do all of these things at the same time.

I have a big lift. I'm changing the world. I am forever changing how we screen for breast cancer. I need to live, and if I'm going to live it, I'm going to live because I'm walking on.

Yeah, I have a saying that's on my refrigerator at work and it says health is not owned, it's rented. And the rents do every single day. Every day I look at it, I look at it every day, you know, because it's easy to let life, you know, give you excuses for, you know, to not get up and walk and to not go to the gym.

And but like you said, you everyone is put on this earth for a purpose, right? For a big purpose. And no matter what that purpose is, you can't fulfill that purpose if you're not 100%, you know.

And so you have to put yourself first. And we were we were given this precious life by God. And our repayment to God is to fulfill our purpose. And I think that that's that's why so many people experience illness or frustration.

It's because they're not they're not living joyfully and purposefully. And that is such a big part of healing. Because when you have reason to be, when you live your life with purpose, your life is going to be longer and more meaningful.

And, it doesn't mean that you don't have to save the world. You want to be a doctor. You don't have to be a, you know, master of industry. You don't have to be any of that.

Like some of that. Some of the most amazing people I know are just awesome mothers raising incredible humans. And that's their purpose. And that's amazing.

That's amazing. Right? Didn't didn't Ethel Kennedy just die like, a day or two ago? I believe so, yeah. Yeah. Yeah. And she died at 96. God bless her.

Lived this whole full life. And she raised some amazing humans, right. You know, like, that was her purpose. And she did it so well. So well. So I think that we need to stop comparing needs, stop judging one another, need to stop saying like, oh, well, you know, what I'm doing is not important enough.

You're doing exactly what you're supposed to be doing. And if you're unhappy and feeling unfulfilled, it's because you're not doing exactly what you're supposed to be doing.

And that is what where your work is. That's what you need to examine. That's not what. That's what you need to think about. I completely agree. So I have three questions I end every podcast with okay.

So I'm going to ask them to you. The first one is if you have to pick one food that's most beneficial, what would it be and why? Oh my God, that's such a hard question.

But I the answer came to me quickly, so I'm just going to go with it.

Health, Purpose, and Closing Advice

Medicinal mushrooms and the medicinal mushrooms are, divided up into the culinary and non culinary, but medicinal mushrooms, these are actually like Mother Nature's miracle in that they take rotting and decaying matter and they convert it into this fruiting body, this beautiful fruiting body that we consume.

And everything that they do in nature, they actually do in us. So they take the things that are broken, the things that are not working, the things that need restoration.

And that's exactly what they do. They restore them. And so for me, I make sure that I consume medicinal mushrooms every single day. There are culinary and non culinary.

So the culinary are like shiitake and my taki and lion's mane and hen of the woods and oysters. These are all the culinary mushrooms that you can eat because they're very, very, very delicious.

Always cook your mushrooms. Don't eat mushrooms wrong. But even like button mushrooms have medicinal value in that they are aromatase inhibitors and help you to balance your hormones.

But then the non culinary ones like reishi and chaga and turkey tail and cordyceps. These are these have such amazing properties. Everything from immune to helping to regulate your immune system.

If it's underactive making it more active as opposed to overactive making it less active. So they're adaptogenic. They help with brain, with sleep, with anxiety, with depression.

They help lung function, gut function, joint function, bone function. They help your skin to be healthy urinary tract like they're just absolutely amazing.

So that's that's my that's my pair are that are the medicinal mushrooms. No one has picked mushrooms. So that is I like that. What is one thing that anyone that's listening can do that's free.

Ideally that will help benefit their health. So we are creatures who are completely tied to circadian rhythm. And I don't know if you can recollect a time where you like, stayed up all night and just think of how you felt the next day, right.

Pretty awful I would guess. Yeah. And so in as much as we can live in agreement with circadian rhythm, and I know it doesn't always work because, you know, sometimes you're traveling and this and that, but know that we are creatures of habit.

And as much as we live in accordance with our evolutionary nature, because though we are modern beings, we are living on a very old gene code. So in order to have optimal function of your body, I tell people, start off every day within ten minutes of waking, get exposure to sunlight.

That's what you would have done. You would have come out of the cave when you woke up in the morning, right? So get exposure within ten minutes to sunlight and then try to see the sun midday and try to watch the sunset, because all of this will help the normal natural hormone.

Levels of your body to regulate. It's this is signaling. This is your brain signaling. Signaling your endocrine system that this is what it's supposed to be doing, and it's giving it those cues that it needs.

Because, again, we are so tied to the rhythm of the sun and the rhythm of the moon. So I think that in as much as you can respect that and see the sun first thing in the morning, midday, watch the sunset, sleep when it's dark, be awake when it's light.

I agree, I watch the sun every well. I walk every morning and look at the sun and then I. I walk when it goes down. So last question what is one thing that you wish you would have changed about your health 15 to 20 years ago that you know now, like I know better?

I wish I would have done this 15 or 20 years ago. Yeah, I actually, I was so dysfunctional that, like, there's so much I could talk about, but, my entire life, literally, I have struggled with my weight, struggled, struggled, struggled to I wasn't overweight, but it was just always, always a battle.

And what I didn't realize that it was only always a battle because my eating was so disordered and so dysfunctional, because I was not eating real food.

And I wish that I had learned long ago to eat real food. Not so much because of me, because, you know, I figured it out and I'm fine. But I wish 18 years ago, or a little more than 18 years ago, I would have figured it out, because now my children are going to have that same battle because they grew up eating processed food, because I didn't know any better.

And I wish that I would have recognized and then known them so that they would have grown up eating real food and wouldn't have the health problems that I know that they're going to battle because of it.

I think that's fair. I think most of us, I mean, same way with me. I grew up eating a lot of processed foods, but once

you switch, it's amazing how much different you feel, right?

It's amazing. It's amazing. And even even recently, I'll tell you, I, I clearly like don't eat a lot of processed food. I mean, I'm a very, very, very healthy and health conscious person, but I was eating a little bit of processed food up until a month ago.

Like I would have my dark chocolate after dinner every night. And, you know, on the weekends I would get those almond crackers that I love, like little things.

Maybe I would have red lentil pasta, little things. Now and again. And I had like 10 pounds, but I just couldn't get off that. I just felt like I should be thinner.

I should be this and I just decided about a month ago, I'm not going to eat anything that has more than one ingredient, like I'm just not going to do it.

I'm just going to eat an entirely unprocessed diet. I immediately lost 10 pounds sleeping better than I ever slept before. Nothing hurts. I can do everything.

And it's like, amazing. Like, why didn't I do this before? It's so not worth it. You know, I would be eating like vegan cheese and just stupid things that were inflaming my body for no reason at all.

So I guess we we're always constantly learning and we're constantly trying to figure out what's best for us and what's not best for us. And I know that what's best for me is to be, you know, a straight shooter, clean, clean, clean.

Yeah. Well, thank you so much for coming on this episode of back to the basics, doctor Jen Simmons, make sure you check out her book, The Smart Woman's Guide to Breast Cancer.

I'm going to definitely be giving it to some of my patients, but I do really appreciate your insight, and I know that people listening to this obviously you have women that you love or you're a woman yourself.

Please make sure that you share this. We're going to put all of Doctor Simmons information in the show notes. She also has a very active social media page that I follow.

So make sure and check her out there. We'll we'll do some collaboration on social media. But make sure that you send this anyone you think it would be valuable.

And then please leave us a review like subscribe and we will see you next week on back to the basics. So I'm going to do one more ending for the summit if that's okay.

And then they can just come. So so thank you so much for joining us for this episode of the Bioidentical Hormone Summit. We're very happy that Doctor Jen Simmons was on with us.

We appreciate all of her information about screening for breast cancer. And you know how estrogen affects breast cancer. And can you take, hormones after you have a diagnosis of breast cancer.

So again, we appreciate having her. And please make sure that you stay tuned for the next episode of our summit.