Introduction to Nafysa Parpia and the menopause metals topic

All right, everyone, we are going to be talking to Nafysa Parpia and it's going to be a really cool conversation. So, first of all, thank you for joining us.

Thank you for having me. Thank you for doing this summit. It's going to be great. Yeah, it's going to be awesome. And your piece in this massive puzzle is really important because we're so we've been talking about a lot of the big topics like fasting, menopause, fibromyalgia, etc..

But we're going into a little bit more nuanced with you today because there's a very specific problem that are women are experiencing. They get lost because it's so specific.

And within the world of menopause, that time in your life where you are entering a new phase of your life, there seems to be this challenge with heavy metal toxicity, and it's a different challenge than the early stage and other times of your life.

So we need to understand it in that context. And that's what you've done such a good job, up job, and we're happy that you're here to share with us. So thank you again.

Thank you so much for having me. Yeah, it is. Yeah, it is a big deal. Menopause and metals especially land. So we all know that women in menopause lose bone.

Mm hmm. But when you're when your bones turn over, you release stored metals in your body, especially land and salt. So this is. This is why it's such a big piece for women in menopause.

Yeah. And that's where, like, the context is different. It's not like, what am I exposed to? You're making them like it's coming. It's internal. Right.

So let's dove into that a little bit more. How was the metal threat during this time? Different than the everyday, you know, teenage metal threat. Right.

So I want to talk a little bit about about exposure, because the it all starts the same the every day teenage mental threat or even baby metal threat.

It it actually grows into something bigger as as everybody ages and we start to lose our bone. So so I want to get a little background on lead exposure in the U. S., where we get it from to begin with.

So the major source of lead in the U. S. environmental has been from leaded gas. Now, that was phased out of use in 1973 and then banned in 1995. And then we can get deteriorating lead based paint from weathered surfaces.

They produce highly concentrated lead debris and dust.

How lead exposure accumulates and gets stored in bones

Then we can have a combination of corrosive water and lead pipes and that can that can get led into the distribution system of cities and in individual homes.

And then that can create localized zones of high lead in the water. The other thing about LED is it doesn't degrade in the environment. It's not organic matter.

So then it's transferred continuously, transported through the air, the water, the soil just by natural means. Right.

So then we're still getting recycled lead in the environment.

We're still getting exposed, even though it's now banned from use. And it's so toxic and it doesn't degrade, we still get exposed to it. So I love the way you you brought in teenage metals and in and in older people's mouths like it's actually a it's a really important point because everybody gets exposed.

But then what happens is that the the lead once once it's been in the blood, it has a half life. So the half life of lead is only about a month. So somebody gets an acute exposure of lead, that exposure and the blood levels start to drop within 30 days.

So that was cut in half, 30 more days. It's kind of half again. Then by around three months, about 90% of that lead is removed from their bloodstream.

So where does most that blood lead go? 90% of it goes to the bones. So those babies that are being exposed, those teenagers that are being exposed, it goes into their bones.

And we think it's fine there for now. Right. Well, actually, cadmium gets stored in the bones and it causes it can cause toxicity to the bones. But you led led is the big one that that gets.

That's the big repository. So lead is going to sit there is going to be okay. But then when there's bone loss around osteoporosis, sorry about around menopause, women tend to osteoporosis.

That's when women can become our own risk of lead exposure due to the bones starting to turn over. And so this is interesting. So what you're saying is that there's this 30 day cycle our body goes through to protect us and eliminate lead.

But it's not like other toxins or peeing it out or pooping it out. We're storing it. So the protective measure is, let's put this somewhere, get it out of the blood.

And 90% ever get stored. Yeah, 90% gets stored in our bones of lead. So the metals the other metals get stored in in the cells of our organs, your thyroid or kidneys or liver, and then other environmental toxins like pesticides, mycotoxins, insecticides, microplastics, they get stored in our fat cells.

So there's so much there's so much here. So will, poop, sweat, sweat out metals and and other other toxins. But some people are going to hang onto them more.

And this is where your great work comes in, right? When we think of people's genes of detoxification, when I'm looking at people's genes of detoxification and I'm looking side by side at their at their heavy metals, I see some people hoard metals or they hoard chemicals, and they're doing that for a number of reasons.

One of one of them could be that they have snips and their genes of detoxification and they don't have optimal detox capacity or or they don't have adequate nutritional status.

They don't have enough amino acids or minerals or B vitamins. Those are the cofactors for detoxification or they're under a lot of stress. They've got a lot of immune dysregulation.

So they're going to hang onto their metals more. So I don't think anyone will deny that light is bad news. But if you ask the average person why, they probably don't know.

So what's the problem? You have this lead being released from your bone during menopause. What's the exposure going to cause? Right. So. So lead is it's going to cause a lot of of I just want to make a distinction between acute acute poisoning.

Right. And chronic low, low levels of of these metals. So and also, I just want to say, we're not we're not talking only about lead. We're talking about mercury and cadmium as well.

They all those also get stored in the bones, but let is the one because storing the bones the most. But just say we have an acute high level versus a chronic low level exposure to the acute high level that's going to put somebody in the hospital.

Right. It's going to make someone dizzy and nauseous and vomit and acutely ill. And that's not what I deal with in my patients. What I'm talking about is chronic low level exposures over time that build up in the body.

Who is most susceptible and why detox capacity matters

So the presence of metals doesn't equal poisoning. Almost everyone has metals in their blood or their urine just by virtue of being on the planet. So it's my job to figure out the heavy metal burden is contributing to their illness or not, but lead is going to cause a lot of immune dysregulation.

It causes memory issues, cognitive issues, very particularly so that at these chronic low level exposures. So then what are I when somebody is reaching that age, is this like a given that it's just going to happen because you happen to live in the United States and you're exposed or they're testing they should do?

I think definitely there's testing they should do. There's lots of testing that we should do. So actually, it's important to test their acute exposures as well.

And I do like to test their body burden. So in acute regarding acute exposures, the agency of Toxic Substances and Disease Registry, that's a sub agency of the CDC, they formulate a registry on environmental toxins.

It's called the NHANES data. This list is really important. It's a combination of how toxic the substances, how frequently it's found in the Superfund sites and in people, and how many people are exposed.

So it's a scoring system. Yeah, it's a scoring system. It's looking at the top environmental toxins, blood in urine is a percentile in the US population.

Oh wow. And so they can access that. Yeah. Right. And so when we get to 75th percentile, I'm testing my patient's blood and urine just straight up from the standard lab, just lab core.

So if I'm then comparing that data to the reference data from the CDC, not the reference data from the labs that represent on the labs is based on OSHA scores.

I really care about about this data, this database that the CDC put together, because that's what's telling us what a toxic level is. So when we get to 75th percentile, it's assumed that we start to have, at the very least, health effects from that toxic exposure between 75th to 95th percentile.

We need to consider an acute exposure and an acute high exposure, like maybe water or food. So what are there's very specific sort of functional tests or things that are or is a standard.

I go to my doctor and ask for testing, good or no? Yes and no. So the standard I go to my doctor, I'm going to ask for testing now. Hopefully they'll do it right.

The doctor definitely needs to be trained in these things, trained in environmental medicine and trained in heavy metals. Right. They can, though. I mean, any doctor can run this test from LabCorp looking at Mercury in the blood, in the urine lead, in the blood, in the urine, arsenic, cadmium, aluminum.

All of these ones actually are available on LabCorp, even. QUEST That's just looking at an acute exposure. And then if if it is high, then we could do another test.

That's where we provoke the metals in the body, provoke the metals out of the bones, using chelation therapy and looking at what the body burden is. And we want to compare the data from the CDC with data from the body burden.

And if it's if it's higher, if it's around five times higher than it could be justification, depending on the patient on an escalation of therapy is appropriate or not. Mm.

Okay. Yeah. And collation can be a messy thing. Meaning that I find some people going through it. Obviously it is a great answer, but the process can be, you know, problematic sometimes.

And yeah, we have to be prepared for what you're about to go through. Absolutely. It can be it can be such a messy process and it needs to be the doctor needs to be trained very, very specifically and to have certification in it.

And as we get deeper this conversation, I definitely want to talk a little bit more about the detoxification processes, because it's so important. As you said, it can be so messy and it can be done wrong and it's better to just not do it at all if somebody not trained in it.

There's so many protocols. Where do you even start? You'll go to Google, Dr. Google, and you'll feel here ten different ways that it needs to be done right.

I strongly, strongly recommend getting training from Dr. Paul Anderson and Dr. Virginia Osborne. They have exhalation therapy, class and certification, and I strongly recommend getting environmental medicine training from Dr.

Lyn Patrick. And that's also a certification. So I consider this, you know, just like if someone has an issue, an autoimmune condition, they go to the rheumatologist, someone has a bone issue, they go to an osteopath.

It's it's a science and it needs to be treated like that. And I think that people treat environmental medicine like this, just a casual thing to be done.

But you need to go to specific doctors. We're trained because, boy, things can go sideways, backwards, wrong. If it's done casually, it's a medical thing.

Yeah. You start releasing heavy metals and toxins back into the blood and if you don't have experience or who knows what that where that could happen.

Exactly, it's just best not to do it if you don't have the training or the experience doing it. We're going to talk a little bit about your experience in detoxing, but I think before we get there, some people might ask, well, do I have to just wait for resolving it or connect?

Prevented the can is what can I do to just not go there and be healthy. Right.

Testing heavy metals and the risks of improper chelation

So there's I before before we get into let's talk about who's more susceptible because that that's also ties into prevention. So any levels of these are they're not good for us but with the wrong genetics, this is where your work comes in, right?

We need to use your lab and we look at people's genes of detoxification. So if they've got the wrong genetics or if they have when I say wrong genetics, I mean if they have a lot of snips in in their genes of detoxification, if their genes of detoxification are not optimal, they're going to have higher loads of metals.

So those people are going to be more susceptible if they don't have enough minerals, amine and amino acids and B vitamins. I if they're eating the standard American diet, well, you're not going to have the means to detoxify very well because amino acids, minerals, the vitamins, they're the cofactors for our detoxification processes.

So a doctor could be trying to pull metals or toxins out of a person till the cows come home, but that there's not enough nutrient support, cofactor support.

Those metals. Metals are just going to get recirculated. Right. Also want to make sure the patient isn't under a lot of oxidative stress. I can look at someone's glutathione on it.

If it's an oxidized state, that's not a good time to detox as well. So. So people who are more susceptible have have these issues. It's about exposure, genes, stress, oxidative stress, cellular stress, nutritional adequacy.

They all play an important role in determining who's at risk. And and now more about prevention. Right. So this such caution to doctors, if you have a post-menopausal female and she has bone loss or a man who has bone loss and you're trying to do collection, therapy or detoxification, you better make sure that you treat that bone loss or else you'll be detoxing forever.

So so we want to make sure that bone loss the way to one way is to make sure that bone loss is prevented. And then and then for for patients themselves, avoidance is key.

So eating organic foods, using green household products, green personal products, being aware of where you live. A lot of my patients live near I live near vineyards or or golf courses or they live freeways.

They're going to be exposed more. So we want to include just daily detox processes for patients like that and for patients to prevent bone loss, weight bearing exercises and hormonal support.

Permanent support. Yeah. Yeah, that all. I mean, when I listen to you, it goes back to like we have to have functional thinking because you go out and say, okay, heavy metal, scary, I'm going to support my liver, I'm going to detox protocol going.

But if you don't understand that it's not a singular process. Is the baton passed between all these things going on? And if you don't understand the full cascade here to Z, you don't really know if what you're doing is supporting, because there may be another part of the baton where that part is failing.

Like you speak about genetics. So, you know, people look at their methylation genes and they say, okay, phase two, detox going well, not going so well, but then there's Comt, which is the tail end of it.

And if you're not doing all the cont, okay, I'm methylated and everything, bring it to the door. But the door closed. Where does it go? Right or I've seen people, they haven't supported their comp and then they get they get angry, they get aggressive because the methylation pathways connected to the pathway, you turn the methylation and suddenly they're going to start producing a lot of adrenaline and they're going bananas, they're irritable.

So yeah. You have to understand the functional nature. It's a single gene doesn't do a single job, like you said. It's it's methylation, it's neurochemicals.

It's also hormones. Right? You trade with your copy. Your hormones are going to change. Exactly. And I remember back in 2014 methylation was the sexy word, right?

The work in functional medicine and and sometimes patients still today might say, I don't I don't modulate very well and I say, you know, that's really important to know.

Thank you for telling me. Let let's look at the biochemical pathway, what your methylation is doing.

Pre-detox preparation and assessing elimination pathways

We need to look at all of your genes of detoxification because it's not just one gene. These genes, the genes of the different systems of your body, interact with one another.

They work in concert together, and that's what we need to look at and understand and then marry that with the biochemistry of what's happening in your body.

So is this why you talk about before getting into detox what you call pre talks has to happen, right? That what you're talking about? That's what I'm talking about.

Absolutely. So people may have seen my my pre talks e-book. I talk a lot about pretax because I've noticed that a lot of patients have come to me, they've done a detox and they feel terrible in the middle of the detox they had to stop or they felt worse after the detox, or they gained a lot of weight after the detox and they don't understand why.

So there's a lot there's a lot of factors we need to consider before we actually detox. I've talked about some of them, like taking care of bone turnover, making sure that there's adequate minerals and vitamins and amino acids because those are the cofactors for our detoxification pathway.

I've talked about looking at our genes of detoxification, even the genes of inflammation, looking at our hormones, all of this. But nobody does a detox with me unless I assess these things and optimize them first.

And also want to look at the organs of elimination. For detox isn't like it's a smaller detox before the detox is preparing the body to be able to benefit from the detox.

Right. Because a lot of people, their bodies are not ready. So I want to I'm really actually doing a scan of the organs of elimination. I'm doing this through the labs.

I'm doing this through taking a clear history. So, for example, the gut, if a patient is constipated and we start to pull toxins out of their system, those toxins are not going to get released from their body.

They're just going to build up. They're going to recirculate. Regarding the gut, if the patient has diarrhea, a lot of patients do or irritable bowel syndrome, then their guts inflamed.

It's not a good time to flush the toxins, do they can't handle it. What if the patient has leaky gut? Almost everyone has leaky gut. At least my patients do. Right.

So if someone has leaky gut and I pull toxins through, what's going to happen? The inflammation from the toxins or the toxins themselves can circulate through to the rest of the system through through the compromised gut integrity lining, the kidneys, recurrent urinary tract infections.

Women in menopause tend to get those due to lack of hormones. So what if that's happening and I try to detox and they've got recurrent UTIs, that's not a good time.

Or some people have interstitial cystitis, which is inflammation in the kidneys for a multitude of reasons. I think toxins could be one of them. I certainly don't want to talk then or some of my patients have a low filtration rate.

If the kidneys are infiltrating rapidly enough and I start to pull toxins out, what's going to happen? They're just going to recirculate again or liver enzymes.

Liver enzymes could be elevated if someone drinks a lot of alcohol or they've had a lot of antibiotic use over time and they're sensitive to these things.

That's a good hint that the liver is having a hard time or the thyroid, right? So I want to correct all these things as best as I can. The thyroid is very, very sensitive to inflammation.

It's it's I mean, the number of people with Hashimoto's is on the rise. I think that's due to environmental toxins, a combination of toxins and, and infection.

Yes, but I want to deal with that first as best as I can before I start the detox. So as you can see, I'm scanning the whole system to make sure the entire system is ready for detox.

And, you know, somebody that was sitting there with their detox bottle in their desk saying, I'm all right now, they

hear all this and it's like, Oh, man, overwhelming.

I didn't know I had to do all this stuff. But it sounds like, you know, there's this complexity, but it really comes back to a simplicity because what you're saying is not that all of this has to happen, but you're just going to focus on the exact thing that needs to happen so that what they thought they were going to fix actually works.

I'm so glad you said that because I realized that what I could be saying here could could sound overwhelming to people. Right? Because there's so many different pieces and not everybody has issues in every single one of these systems.

My patients do because I focus on patients who have complex, chronic illness. The mystery illnesses like chronic fatigue syndrome, post infectious diseases, Lyme disease, long haul COVID syndrome, autoimmune conditions, fibromyalgia, things like that.

So that patient population in every single system, we're going to find some some kind of imbalance right now in in in people who it's not so bad, they're just a little bit inflamed.

They've got low grade inflammation. This is a much simpler process. I still strongly recommend that that their whole system gets thoroughly evaluated by the doctor, including the genes.

Right. And and and the toxins looking at them on the labs and then going from there. But it'll be a lot a lot more simple with somebody when it's just low grade inflammation, that's for sure. Mm.

But I'm sorry. And then you get to this place where you know exactly what to do. You've tested, you know what the threat is or the multiple threats with possible, you know, some of the more complex people you're, you're dealing with.

And then you take all of that and put it in the context of menopause. So that's what we were talking about, right? A very thick time, very specific person.

So outside of the consideration of the bone loss and, you know, bringing toxins back in, are there other things to think about in that time that are unique instances?

Yeah. Thank you. Thank you. So absolutely so due to lack of of hormones, women in menopause are already prone to inflammation. Now these metals cause immune dysregulation they cause and account disruption.

Women in menopause are already going through these things. So due to insufficient hormones and menopause, every virtually every system of a woman's body is affected.

Menopause, inflammation, and broader toxin burden

We'll get hot flashes, night sweats, volatility, lowered mood, that optimism, depression, cardiovascular disease, stress, incontinence, insomnia, headaches, all of this due to not enough hormones.

Now, arsenic is the number one toxin on the CDC list. And arsenic, too, that arsenic or arsenic is it causes immune dysregulation. It causes endocrine disruption.

It's it's it's a carcinogen extraordinaire. And that, too, to somebody who already has a lot of inflammation and inflammation in every system of their body because not enough hormones.

I'm talking about menopause. We're going to have some more problems and add the metals from bone loss due to osteoporosis on top of that. And we can get even even more inflammation.

But I really want to make sure that I bring this really talked about. I want to bring it back. But who's susceptible? Right. This is not it's not everybody.

Again, it's the genes. It's what you're eating. It's the amount of oxidative stress your body's under, the amount of inflammation you're already under.

Some people it's a lot. Some people not so much. Well, and then you're then some people also get into so when you go down this journey of I want to do something and be healthy and get better, usually there's some element of weight loss.

And there also and then you're releasing other forms of toxins that are and even estrogens and things that are in your fat. So I don't know, that complicates things further.

But how do you prioritize like it's metals, it's mice with toxins. It's more like it's everything, right? It's everything. So it's really everything. And that's why I test everything in my patients.

So the people who will test everything are usually in two camps. The people who are really in the longevity health world, they're looking to and they're looking for anti-aging and a lot of them are they're biohackers.

That's everything. And the other people look at everything are people with complex chronic illness that will be patients, people who don't fall into those two categories.

They don't they don't tend to look at everything they don't want to know. Doesn't doesn't matter. And I think that's okay. Right. And so when I'm helping my patients, I am I am looking at everything.

I'm looking at their mycotoxins. I'm looking at their environmental toxins, which includes the pesticides, industrial solvents, other chemicals, looking at glyphosate.

And I'm looking at metals, the acute exposure. And then I might, if it's indicated for that person, do a body burden exposure where I'm testing the metals that they have stored using chelation therapy.

So where do we start? I start by by. It's a lot. It's a long question. I start by modulating their immune system first because once they can modulate their immune system, then I can start to detox or them, then I can start to kill the infections that they have.

Because when we detox, we create more inflammation that just comes with the territory. So I use a lot of peptide therapies actually to modulate the immune system first and then I can move into into detox.

I'm often figuring out which which toxin they have the most of. Right? I might start there and then I might rotate between the two. Between when I say the two, I mean between mental metal detox and detox of other chemicals.

The way we detox other chemicals is very similar. That's the way we detox. Mycotoxins So it's very specific ways, but I'm rotating and looking at the labs and just it's a long process.

And you know, we've had a lot of discussions about fasting, but mostly in the context of overall health. And just as a habit. But you're you're looking at it as a therapeutic tool in part of those detox protocols.

So how do those things integrate together? Right. So so I'm looking at intermittent fasting because I want to help increase autophagy for my patients.

I have a lot of patients with with long haul COVID, and it appears that they might have high levels of spike protein. So we think that autophagy increases helps increase the removal of of spike protein.

So detoxing from spike protein is very different process than than the typical detoxification therapy. So autophagy is one way to help with with detoxing from spike protein so that we increase autophagy by, by intermittent fasting.

A lot of my patients are too sick to do a full full on 1 to 3 day water fasts.

Fasting, autophagy, and detox support before weight loss

So we do intermittent fasting and if people feel worse doing intermittent fasting, I think that that's a hint that the we haven't done enough pre talks or that the patient hasn't done enough pre talks because when we lose the fat cells and you alluded to this earlier when we lose weight, so when we lose weight, the fat cells shrink and then we get released stored chemicals, not metal so much because metals don't metals don't bio accumulate in the fats as much.

But the other chemicals do that microplastics that the glyphosate the mycotoxins so so when when we fast and the fat cells shrink and we release these toxins we can feel worse.

So it to me this goes back to to pretax so for my patients before I'm having them do any intermittent fasting, I'm making sure that all the pretax support that I discussed earlier is, is set.

Amazing. And then so you're it's like there's multi benefit because your your someone's coming to you saying I feel this and the feeling this is like the outcome of them being toxic.

But you can't help them feel this until you get their body kind of homeostatic and perfect. And so it's not only like fixing this, but a new version themselves.

At the end of the year, you're unveiling this like, look at you. I think. It's true. So what's very interesting is, you know, I talked earlier about people in the longevity world. Right.

They're the people who might follow Ben Greenfield and the biomarkers and all that awesome work they're doing. What's very interesting is the work that we do at our clinic for patients with complex chronic illness is the exact same work very often that the Biohackers are doing.

What we do is biohacking for complex chronic illness. Then once we get them into a new homeostasis into say 70 or 80% of normal, we, we bring on more tools, could be exosomes, could be different peptides.

And as we do that, they become a longevity patient. Right? So you're literally taking them to the promised land that they didn't even know they could get to, which is like, you're came here for a cure, but not only cure, I'm going to get you better than where you started.

It's true. It happens. That's so cool. It's so cool because we have all this. All this great medicine at our fingertips. We're so lucky. So you talk about some regenerative stuff like exosomes and peptides I know is a little bit off topic, but where do we get to the point where it's, you know, peptides and exosomes are turned off and somebody needs stem cells.

So the stem cells in our patient population isn't usually the best thing for them because our patients have low level or sorry, low grade chronic infections or they have infections that are recurrent.

And what we've seen is that when patients have had stem cells, but they've had chronic infections, things have gone backwards or just not or just not worked at all, whereas Exosomes are just the growth factors from the stem cells.

And so when, when people are sick, we can just give them just the growth factors they seem to they seem able to handle that better. So we don't give stem cells to our patients.

Actually, that. Would be the outcome. They just would. What would they feel. A lot of them have just felt worse or a lot of them have felt nothing. Right.

Some some of my patients have gone to a stem cell clinic after I've got them to 70% after the infections have been killed off, after I've detoxed them.

And then they've then they've they they've really improved actually. So it's but prior to the advent of peptides, I might say, okay, you know you go off to a samples test, if you want to go to stem to the stem cell clinic, you can go off and try that.

If I if we've gone to 70% and we're just not moving the needle after that, I'm talking about sick people, fibromyalgia, chronic fatigue syndrome patients.

Peptides, exosomes, and treating complex chronic illness

But with the advent of peptides, I can get them faster, way better, way better than 70%. Now. So a lot of times people don't even need to go to a stem cell clinic, which is pretty amazing.

And so you said for peptides and you said things like fibromyalgia, fix and etc.. So are you is your cocktail around the innate hormone issue or is it specifically like the fibromyalgia itself?

Or how do you put things together? Okay. So say a patient comes in with fibromyalgia that I think we think of that as just a wastebasket term, right. Like that means the medical establishment doesn't know why have so many so much pain in your body.

We don't know why you have all these symptoms. So we're just going to give you this tag on you. Let's call it fibromyalgia. It's a wastebasket term. So what we do at our clinic is, is we investigate the reasons why I'm looking for chronic infections or recurrent infections.

I'm looking for immune dysregulation. I'm looking for environmental toxins, looking for hormonal dysregulation. You know, when I'm talking about chronic infections, they can be anywhere and they usually are everywhere.

And it's never just one infection. These patients often have parasites. They have funguses in their gut. The microbiome is a mess. They often have sinus infections that can cause brain fog.

They they might have tick borne disease or their post line treatment, and they're still sick. So I'm searching for all of these things, but all of these things together are causing immune dysregulation in these patients that immune dysregulation can cause secondary illnesses.

The secondary illnesses are issues of the immune system. Right? Like massive activation syndrome or something like fibromyalgia or autoimmune conditions.

Those are primary illnesses. Those are secondary because inflammation caused them to happen. But what caused the inflammation? In my patients, it's usually a combination of infections, toxic that toxins, stress, structural integrity issues.

So I'm looking all of these things and it's very much a dance and then I'm layering them. All of the different diagnoses that lead up to this diagnosis of, say, fibromyalgia.

And typically I'm starting my patients off with peptides. First to modulate the immune system. My patients have a hyperactive immune system and a weak immune system at the same time.

So hyperactive meaning they have immune conditions, they have the nasal activation syndrome. That's an immune system that's overactive just in the wrong direction.

And then their immune system is weak, on the other hand, because they can't mount the appropriate immune response to kill off infections, they should.

So they have a hyperactive immune system, they have a weak immune system all at the same time. I'm using pump placed at a line that confused immune system.

Then it makes killing infections. It makes detoxification easier because the, the, the, the, the cytokine cascade that comes with killing off infections that comes with detox when the immune system is regulated with the peptides, they can handle that better. Wow.

This, this, you know, the last few minutes like this is what medicine should be, right? I love practicing this way. Right? I think that there's an acute care medicine, acute care model of medicine, and it works for broken bones.

It works for heart attacks. It works when when our bodies are at the scene, our bodies are going to act the same in certain instances when it becomes chronic, it's not A goes to B anymore because it's A goes to it goes to Y goes back to B, and that's what we have to follow and do our best to understand in each patient.

Because chronic illness is not supported by the acute model of care. That this is amazing. I feel like flying down to San Francisco right now to work with you.

I'm not even sure. You should come and visit us. Seriously, you will have so much fun. It sounds like a dream. Vacation peptides and looking over the bay, you know.

Yeah. Come anytime. This is it. I mean, like, truly amazing conversation because I think this is exactly what's needed. Right. And you've identified a very specific problem that's outside of most people's awareness, which is your there's a certain age where your body changes and there's a certain threat that we don't think about.

It's very specific to that time. And you're to lose bone density and you're going to release toxins that you've been storing that have been sort of tucked away in closing.

And the hibernation is going to end. Right, and raise the threat. And then then you blame it on the menopause and it gets blamed on hormones and your mood and your know there was actually a new toxic threat that caused new problems you didn't actually didn't have.

Right. So eye opening, I think, very important. And we have and I've heard I haven't heard this anywhere. So it's really, you know, thankful, I should say that you're opening our eyes is.

Thank you so much for having me I think it's so not enough spoken about topic that's for sure. Not enough not enough training out there, which is too bad.

But I've given I've given not just list I've given you resources of where to get the training. And it's it's phenomenal people to help people this way.

And if anybody wants to work with you, how do they reach you? So we're at Gordon Medical in the San Francisco Bay Area. We have patients come from all over the country, even other parts of the world to come and work with us.

And such an honor. And are you able to work virtually as at all in person? Yeah, I do work virtually all the time. I just need to make sure that my patients in other states have primary care doctors that they can work with over there who can write their prescriptions for medications.

Because my license is in California, so for people in California, I can write the prescriptions in other states, just have a doctor and they all do. It works out easily. Amazing.

Thank you so much. This is awesome. Thank you so much.