PCOS Hormones and Testosterone

Hello and welcome back to the Beyond Infertility Summit. Dr. Mitha, I'm so glad to have you here today to shed light on polycystic ovarian syndrome. What is this unique landscape that really manifests as such a wide variety of signs and symptoms that even a lot of doctors tend to miss?

Yeah, you know, when I really think about PCOS and now working with so many women, I think what's so interesting about PCOS is how this, you know, syndrome can be so complex.

But all women with PCOS, we kind of come back to this one hormone, which is testosterone. Right. And how testosterone has this relationship with so many different hormones in the body, for example, insulin, we know when high levels of insulin are present, it can actually increase testosterone.

And the other way around where testosterone can impact insulin as well. The other relationship testosterone has is with estrogen. Testosterone gets created into estrogen.

And when we have high levels of testosterone present, it actually impacts the ability for estrogen to make that nice rise, to get that ovulation going, to make that nice, beautiful follicle so that we can try to conceive.

Right. So I think that's another point where testosterone comes into play. Another area is high levels of testosterone because it's preventing ovulation.

In some women with PCOS, it's impacting our ability to make progesterone and even if we do make progesterone or the minor progesterone we might be making might not be enough.

And I think that has to really do with testosterone. Again. And then if I think a little bit more globally and look a little bit backwards or even further back, you know, another big area that we need to focus all of our attention on is the thyroid, because that has a huge, huge play and factor when it comes to PCOS.

But if I look and think about, you know, where I wish we look and what's that unique hormonal picture with women with PCOS, it's really figuring out a what's going on with their testosterone, where is it coming from, what relationships are?

Is it affecting in the body? Is it insulin? Is it estrogen? Is it progesterone? And then then looking at other organs as well. And I think I even if a person has like a history of how symptoms and signs and symptoms of high testosterone, we need to pay attention to that.

Right. Because testosterone changes as we age, too, which is really interesting as well. So, yeah, I think looking at testosterone is really important.

Mm hmm. And with women that have PCOS, is it that their body is making too much testosterone or is there an issue in the metabolizing of testosterone like what's happening there that really is creating this downstream effect on all the other?

Yeah, I think it's both. I think it's that recreating. It really depends on the person. But I think it could be both because we see that some women with PCOS have high levels of DHT.

Right. So testosterone can get converted to the converted into Dihydrotestosterone. Right. Or we have higher levels of androstenedione, which is like before testosterone gets created or we have high levels of DHEA as they come from their adrenal glands, then can become testosterone as well.

So I think it is kind of the metabolites, but then I think it's also patients could just be creating more testosterone and that already because of that picture of the how the brain is really connected to the ovaries as well.

Hmm. Yeah. Yeah. Super, super interesting relationships that all of these hormones have with each other. And like, we think of hormones as like, oh, this hormone one thing over here.

But there's so many impacts of that. One thing that really sets off a whole chain of reactions. Exactly. Yeah. And that's why I think to, you know, you could have a little bit of insulin resistance, you could have a little bit of an issue with progesterone and testosterone.

You know, you could have some inflammation there. Maybe there's an issue with androgen and it could be like 25% is 50% this 70% this time. It really can be a whole a whole variety of symptoms coming together when it comes to PCOS.

Nutrition, Insulin, and Fertility Foundations

But figuring out where is that root of where that testosterone is is I think the most important thing we need to do when it comes to analyzing, assessing and then treating women with PCOS.

When it comes to the PCOS and trying to conceive, what are the types of diet and lifestyle modifications or strategies that people can use to help restore ovulation, since that's one of the key things that's going to determine whether or not someone's going to be able to get pregnant.

I think honestly, every single woman with PCOS needs to look at their macronutrients in terms of how much fat and how much protein they're eating. And then the number one thing I think women overall, regardless of if you have PCOS, aren't eating enough protein or healthy fats.

And if you think about, you know, where do hormones come from? Well, the backbone of every single hormone is cholesterol. So we really want to make sure we're eating enough healthy fats throughout the day.

And this is something I talk about day in and day out, because even just saying, you know, this is a serving of a healthy fat and you actually need to double this in each meal.

You know, a lot of women are like, wow, that's a lot of fat. Like, I didn't know that's how much fat I need to eat or even protein. You know, I think a lot of women are walking around with low levels of iron and they just don't even know it.

And I think, you know, all love protein and amino acids. That's how we can create a good quality embryo. And so it's important to make sure that we can get these macronutrients, especially regardless of where you are on your HB A1C this is a marker that you know, looks at if you have diabetes or not or what you're fasting and or fasting glucose look like, it doesn't really matter.

Like put that aside. Like every single woman should be thinking about how much protein do I have on this plate? How much fat am I getting in that fiber and, you know, the carbohydrates are a whole other story.

But I think carbohydrates, even if you put that aside and just focus on the protein and healthy fats, I think that can really help fertility outcomes for sure.

Do you find that a lot of women with PCOS are getting inadequate levels of these macronutrients consistently? Yes, I really do think so. Yeah. And I think one of the biggest reasons why is because we have this issue with insulin and glucose.

No matter where you are in PCOS, if you're, you know, whatever body type you have right, because you can basically have any type of body type and still have PCOS.

Right? So regardless of where you are in your body type, you know, just every I think I would say every single patient who's come to see me has said they have sugar cravings.

I don't think there's one person who hasn't got them, but I know I can I can go without sugar. I'm perfectly fine. I think a lot of women of PCOS have these cravings.

I think it comes down to insulin and glucose and the fact that, you know, women with PCOS, we are naturally deficient in my own office. All right. And this this can really help us to balance insulin and glucose throughout the day.

So if we can get our macronutrients on the plate in a way that helps insulin and glucose, I think that's the first stepping stone to even just balancing mood, improving energy, helping sleep, you know, and those are the things that we need to get pregnant.

Those are the foundations of health. And I think if we focus on those pieces first, everything kind of just falls into place. Fascinating. Do you do you see often, like I've heard so many doctors say to women with PCOS to, oh, you just need to lose weight and exercise more.

And it seems I'm laughing because it's like such. It almost seems like silly advice if you have your insulin resistant or you don't have the right metabolic pathways and then your thyroid is a little bit or a lot of functioning, you're really like you're trying to climb Mount Everest.

Exactly. The same way and exercising more. It's just not something that is innate. And there's a lot of these within the body and within the physiology that are really working against them.

Yeah. When you said climb Mount Everest, I got chills because it's true. Like, you really feel like you're just like up against this wall and you just keep throwing it to get through and you just cannot you just cannot get through this wall.

And I think, yeah, I think, you know, looking at the body as a whole is what we need to do. And that's what we do on a daily basis. Like obviously if the virus is off even by 0.5 or a point like that's going to impact metabolism in this whole metabolic pathway.

And we need to look at that. We need to look at how is the person sleeping, right? Are they sleeping well and is it based on how they're eating or is it a function of something else?

Is their iron low? Is their vitamin D low, like all these nutrients that I think also play a huge impact on women with PCOS. How's your cholesterol? Like all these markers that we need to look at together? And I think, you know, just telling somebody took all those weight, that's great.

Like maybe they do. And we do see that it can help them. But I think another part of the puzzle is what is the first step that these people can do to actually see a change?

Because a lot of times it's you know, they get overwhelmed and there's so much to do. Like we could talk about, you need to eat this, do this, move your body, make sure you're not stressed, make sure you sleep well, make sure you, you know, meditate and do all these things in yoga.

And it's overwhelming. But I think if the person can really look get her get help where somebody can say, no, this is the actual first thing you need to do.

And it depends on the person. A lot of times it's, you know what, you actually need to be sleeping before 1 a.m. and once you get that down, then your mental in rhythm has improved.

Your energy is going to improve, your mood is going to improve, and now you're going to want to actually make the food to actually get through the day.

So I think yeah, I think we need to look at it as a whole. Yeah. And to that point, like sleep being one of the crucial elements of like there are studies that have shown if you didn't get adequate restful sleep, you're going to crave more sugar.

Yeah, right. So then you're like feeding that loop of insulin resistance, if you like, shot yourself in the foot essentially by not getting enough sleep.

Yeah, yeah. Really like creating. And I know I feel like we see this all the time, but really creating that foundation in a solid way in your sleep, probably being one of the biggest pillars of that is so, so, so important.

Sleep, Stress, and Lifestyle Priorities

Yeah, because I think that's one of the struggles with a lot of women with PCOS, they're not sleeping well and it could be related to how they're eating, but it also also could be related to their cortisol throughout the day.

Other factors, like we said, the thyroid, the iron, the vitamin D, B12 status, you know, so I think it is actually complex. But if you were to walk away today and you're like, what can I do?

I think one of the biggest things is look how much protein actually eating. Are you getting 20 grams in each meal? Just go and look at that for just try changing that one thing and you'll notice your mood gets better, your energy gets better, sleep better, you know, because that one little change.

Yeah I think and that's where, you know, someone like us can come in and say, like, this is what you need to change. But overall, from what I've seen, that's probably one of the number one things I'm coaching women on is how much protein I concrete get more in.

And that makes a world of difference. Amazing, right? Sometimes it's like simple, but it's hard. Yeah, exactly. Yeah. You mentioned a little while ago that progesterone because of this like testosterone, estrogen, you may be making enough progesterone, but sometimes you're not making enough progesterone compared to the amount of estrogen that you have.

So what is the role that bioidentical progesterone plays in supporting ovulation for women with PCOS? Yeah. So this is something that I've used many years now and I've seen such great success with identical micro nines, progesterone.

This comes from it's compounded in a pharmacy. We make it into suppositories or an oral form of progesterone and the source as well. So this is a herb that has a component in it called diastole and diastole.

And the chemical structure of it looks just as similar as progesterone, our natural progression in our body. So what's really unique about this type of progesterone is it's not synthetic.

It actually helps our own progesterone receptors turn on and tell the body, Hey, progesterone is actually here. And what's really cool about progesterone is it can help the brain bring testosterone down and our overall body bring that testosterone down.

What's really interesting, too, is women with PCOS, we have an increased, pulsating pulsating generates this is gonadotropin releasing hormone in our pituitary gland or in our brain, I should say.

And so what happens is the more this pulsating action happens, the more LH we're going to produce, the more LH that's present, the more testosterone we're going to produce.

So the way to bring this LH down is to use mechanized progesterone. And what we do is we use it in a cyclical pattern. And so we're using it in like 14 days on, 14 days off, or we're using it, you know, every cycle, 18 for 14 nights just to give the body a chance to emulate by itself.

But if it doesn't, typically when patients are using progesterone in about an actual micron sized form, we see they actually are reading one or two days after starting the progesterone and they're naturally operating because what happens is they'll come back and they'll say, Did I actually ovulate or was it just a withdrawal bleed?

Because they're so used to taking synthetic form of progesterone Depo-Provera medroxyprogesterone where they are getting a lead, but this is a withdrawal lead from progesterone, so we're just artificially putting some progesterone in, taking it out and in the body because of that level is dropping.

Our body just naturally shows the triggers, right? Yeah. But if we're using microRNAs for production, we actually see and we've seen this in charts where a patient takes progesterone, we see that rise in LH and estrogen and then progesterone comes after that too.

And which is really cool. We're actually seeing progesterone helping patients isolate on their own. And when you operate on your own, you're going to get your natural period, your own period.

This is not a withdrawal bleed. So a lot of this information I've learned from drilling prior reproductive endocrinologist and DC shows a research center called STEM Core.

So lots of good information coming from there in terms of how can we get patients to ovulate and use progesterone to help them. I think the the confusion around progesterone is really intriguing for me because because it's called progesterone.

I really like it's all been equal. Yeah. So can you just highlight again a little bit of the like why does this help your body while something like medroxyprogesterone in birth control pills or supplemented progesterone is not going to have the same effect?

I think based on how I understand it, is the progesterone in microRNAs identical progesterone because it's microRNAs. So the the actual molecules are small enough to get into the bloodstream.

That's the first thing. Second of all is the biochemical. So it's just a similar as the progesterone you would put you would have naturally in your body that you would naturally create.

So because it's biochemical, it can actually sit on your own progesterone receptors. And this is something I don't think that, you know, synthetic from progesterone can do.

It does not able to get onto those receptors. If we can help to stimulate our natural progesterone receptors by ourselves, I think that's where the magic comes in because they also say too, like sometimes with women with PCOS, when they get pregnant, they build so much progesterone.

This massive amounts of progesterone actually helps bring the testosterone down naturally in their body. And after pregnancy, we actually see their cycles get better because they got that exposure to progesterone that they didn't get in their or when they first got their period ever because we have we have this wall of LH right and when men are when we're just about to and we are getting our first period ever and then women of PCOS go commonly saying yeah, I got that first period.

But then it just went away. And I mean the reason why is because that LH luteinizing wall is optimizing hormone tells the ovaries to make they're so strong and this while they can't get it down because they're not ovulating enough and the way we get it down is we are really when we offer that we build progesterone.

So women with without PCOS, they're, you know, they're ovulating, they're building progesterone. This wall comes down at this age. All beautiful advice.

But with women, as we just struggle a little bit with getting that wall down and I think that's how that mechanized progesterone works.

Bioidentical Progesterone and Ovulation Support

It's sort of like it's training the body to see the progesterone and react to the progesterone more effectively than women who just don't have that exposure to the progesterone.

And there's nothing to like reset it. Exactly. Yeah, exactly. Yeah. That's really cool. So yeah, I know. So PCOS of course is like a kind of variety of things can be happening under the surface and it can vary a lot between one woman and the next woman.

Like there's so many different hormone patterns that could be going on. So in terms of like health care providers that need to tailor an approach to supporting someone with PCOS to navigate their affiliation better and support their fertility, what are some tools or methods that practitioners could use to help women with PCOS?

Yeah, so first things first is that intake right? Because even if someone has a history of cystic acne, they grew up having this excess of hair growth they thought was normal or they just thought, you know, Oh, this is probably just because of my ethnic ethnical ethnic background, you know, because that's what I thought.

I was like, Oh, I think I'm just building all this hair because of my background. And, you know, this is not true because my sister was not like that.

She didn't have to get her eyebrows threaded or like every two weeks. Right. And so I think, you know, asking those questions about the testosterone, how much hair do grow, how often do you have to deal with it?

How have you had to do laser in the past? Did it work? You know, what was your skin like as a teenager? Did you have this really fantastic jawline acne, even if it's gotten better now, like just that history before is a sign because, you know, as we age or testosterone comes down. So which is really interesting as well.

So you might have these high testosterone symptoms more prevalent, you know, when you were younger and now you're trying to conceive in your thirties, mid thirties, even later than that.

And maybe the testosterone does look a little bit better. Right. And then, you know, really figuring out like what's going on with their hair, is it just because of low iron or pirate or is it because it looks like male pattern, hair loss? You know, are we seeing that bald come out when the hair is coming out of the follicle?

And it's not just breaking like it's not brittle, like where it would be in like a hypothyroid case. So really like delving into that testosterone I think is really important.

What is their history of their cycles growing up? Did they ever miss like a month on end? What does it look like now? Those are questions that are really important, but then also using lab or gray hair can be really helpful for us, even just cycle day three testing for the third day of your period testing efficacy elite estradiol.

Are we seeing that early time right then? Like at a 2 to 1 or 3 to 1 ratio to assess age and then what's happening after that are really being if they are ovulating because we want to know, even if you are ovulating, what's your progesterone doing because if it is low, that could also be a contributing factor as to why a pregnancy isn't happening.

And a lot of times even just using a little bit of progesterone in that second half of the cycle can help women with PCOS. So really important to assess for that.

And then we have at home devices like Mirror as medical director of Mirror really looking at home and seeing, you know, what's going on with my hormones.

If you're not a secretary yet or you're just curious, you want to know like, what is my fertility like when I want to start trying it a few months? Or maybe you're already trying and you've been trying for a while.

You have no idea you're eating right because the strips don't really work or you just haven't seen a good pattern or basal body temperature isn't really working for you at home.

Maybe something like now, which is testing your actual urinary metabolites of hormones, can be helpful in actually determining what's going on. Yeah. So maybe I can show you a few examples too of your own charts.

Yeah, I would love that. So this is a patient with PCOS. Now, what's interesting about this patient is actually let me back it up a little bit. This pill line is LH or this is luteinizing hormone.

Again, this tells the ovaries to make testosterone. We have progesterone in purple and then we have estrogen and gray. What's interesting about this case is sometimes, you know, if you're using an app and an app might just be telling you, oh, you're probably operating on cycles eight, 14, 15 because they're just taking an average or they're just taking, you know, on average where women actually ovulate, you might be missing ovulation.

So what's interesting about your. Like so it's true more often than not that women are using these random apps that are like our special algorithm, which is basically like what's the halfway point between your cycle of.

Exactly. Until your bed. Yeah. In the halfway point through your cycle could be helpful, but every cycle is different sometimes when it comes to us, right?

Like sometimes you might have a 32 day cycle, you might have a 42, then you might have a 28 days cycle. Right? It's all over the map a lot of times when it comes to PCOS.

And then also what's interesting is, you know, everyone when I worked at a fertility clinic, everyone was getting tested on cycle day 21 for progesterone, which I thought was really interesting.

You know, like I was like, Oh, every single person was going to get tested. May 21. They're like, Yeah, because that's when people that's seven days post-operation on a single day, 14 of their 14 questions.

And I was like, this doesn't make sense because you know, especially with this patient they're operating on cycle the 1770s post-operation is going to be way past the cycle day 21.

Right. And what's cool about this is like you can actually figure out, okay, I'm actually I'm doing a little bit later than I thought it was. And it kind of just gives you an idea to like what signs and symptoms are coming up because what Murad will do to say, okay, you know, you're probably about five days to ambulation based on what you're Ali. Ali.

So estrogen and progesterone look like on cycle 13 or something, you know, so that's pretty cool. They can kind of estimate based on like previous numbers, but also just in general, we're sitting on like a a curve.

So this patient like yeah, we're looking at cycle 17 here and so really cool to test that home to see and then you know even if you are in the clinic or maybe you're at a fertility clinic where they don't they can't actually test often or look at ultrasounds often for you, something like a mirror at home could be helpful.

For. This patient is an inability cycle. So, you know, sometimes when you're starting out, you're like, I have no idea if I'm leaning like I get a period.

I don't really know if it is an actual obligatory period, you know, because you can get discharge or like a flow happening, but you can have an inability to cycle, meaning you didn't ovulate.

So even using something like me, I can tell you like, no, actually there is no ovulation happening here based on like what we're seeing, even though you are getting a withdrawal, like a brief of leave is coming.

So yeah. Which is interesting here. And it's, it's a sign like a bleed can happen without ovulation when like it's sort of like your body realizes, well, this uterine lining is just getting thicker and thicker and thicker and nothing's happening.

So we're just going to we need to, like, let it go. And let it go. Shed the lining. But that's really like population has happened. Exactly. If you're not getting like a full flow nice period like cycle day one, two, three, using, you know, 3 to 4 pads or tampons.

And these are coming out like 90 or like 70 to 75%, like 100% full. Like that's a nice period. And if you're getting that, then yeah, there's most likely there's an observation going on that right like it's very clear.

But if you're getting like a, you know, maybe a three day period or even less than that, maybe is like what you could use one pad the whole day. And you know, by the time the day is done, it's not even full.

But it really sounds like it doesn't sound like an uncommon type. Yeah, exactly. It's not you didn't obviously. But, you know, using something like your at home can confirm that for you if you're stuck in your I'm sure you've tried for many, many, many months and you're like, I have no idea what's going on.

Something like a miracle, like kind of help you to figure out like, well, actually, I'm trying, but I'm doing really. I'm not trying, right. I'm not trying around in ovulation.

So what we need to do is help get you to ovulate and then then starts trying. Right? And this looks like they never had a LH surge. And. No progesterone rise really.

No real progesterone rise like that. We saw the progression come up here, but it's coming back down and it can do that sometimes. But we want like a nice rise in the production stays up and you'll see this in the next chart actually.

Tracking Ovulation with At-Home Hormone Charts

So this one's really cool too, because this patient you can think about like if you're testing with LH ovulation strips at home, the cutoff is about 20.

So if you're obviously eating and your LH, your LH can actually go up below a 20 and you can actually still ovulate. And this is a prime example of this because this LH probably reached about a ten and the patient still did ovulate and so on an LH test.

This would basically tell you you didn't obviously, but on your your actually it's actually showing you did. And the reason why is because we do see this nice rise in progesterone and it's pretty stable and it's high.

It's staying high. So we know the patient did ovulate here, which is really cool because they would have missed it on the ovulation test strip at home and they would have missed that opportunity to try to conceive on the cycle.

Yeah, because you're like, oh well the strips are telling me nothing's happening, right? Yeah. So I didn't try, I didn't try it. So I think using something like that is pretty accurate.

Really great. I like really determining that pattern for you and learning about where where's that LH and that estrogen and progesterone sitting and how and providers can use this to help guide their treatment plans too, especially in a case like this.

Okay, so what can we do to get that a little bit more stable in addition to. Yeah. And it almost seems like this person, that last person was a little bit more balanced than some of the other people that are obvious dating or they're just super high.

It's like this person almost had a closer to a regular. Yeah I call that not. Yeah exactly. They're building as acid did in the first time. Maybe it's a little wonky, not perfect, but they're still building it.

They're getting that leads even though it's a little bit low, you know, from the beginning, we do get a little bit. Enough to trigger an ovulation and.

Exactly what you're going to. In terms of what PCOS women are facing with ovulation, I think like trying to restore ovulation in PCOS women is probably one of the bigger challenges.

What what kind of expectations or timeline should they look forward to when they're using dietary and lifestyle modification and hormonal interventions in trying to restore their ovulation?

Yeah. So say they're using it's a challenge. I can attest to that for sure. I mean so but I think, you know, give everybody some grace, you know, it does take time.

Think about it this way. We are trying to get your body to naturally ovulate on its own and maybe it hasn't done this ever. Or it has, but it just needs to be reminded how to do that.

And one of the biggest things I can say to this is the body needs time to do these processes. It's not as fast as maybe, you know, some other interventions that we have, you know, like medical interventions where we're using medications to get you to on the way.

But it's possible. And so if you are wondering and you're like, how long do I have to take these supplements? How long do I have to keep eating this way to actually get my cycle regularly, then give it at least 3 to 6 months, you know, give it time.

And even with progesterone like giving your self, if you're using biotin for micro nice progesterone, I would say give it at least 3 to 6 months. A lot of my patients, I'll tell them even we need to stay on it for at least like 9 to 12 months.

And then maybe if they wanted to come off, we would check their blood and see what's going on there and then we can decide, okay, yeah, they're ready to come off and maybe their cycles will be better after that.

But I mean, there's times where they do have to stay on it for a longer period of time. But in in that case, it's more about regulating the cycle. But even just using production, we can get the patients are ready and they can try to conceive on those cycles too.

I agree. I don't I don't feel like 3 to 6 months is a long period of time. I actually learned I don't know if you guys learn this, but in medical school, our motto is like the number of years that you've been strong with something, expect that that number of months to restore.

And. A lot of times if we're thinking about PCOS women, it's like 10 to 20 years that they've been struggling with this. So 3 to 6 months is a really short period of time.

I know that. Your body to reset. It's true. And you might feel like you're on a time crunch because that's how it always feels when you're trying to conceive.

I feel especially in this day and age, because we are naturally, you know, trying to get pregnant at an older age than we were before because and I think, like you said, it's only 3 to 6 months, but in those 3 to 6 months, massive changes can happen in your body to get you to even learn about what your body needs for the rest of your life.

Right? Right, yeah, yeah. In life. It's so insane to me that like we because we're in such a culture of like, the quick fix and I want everything today.

Why did you get delivered to me yesterday? Right. Like that, that mentality. And when we get that mentality, that health, we really forget that, yes, you want to get pregnant yesterday.

But like doing this now actually doesn't just help you right now. It helps you for your next baby. And your hormones after or through perimenopause. Like there's so many that that really like addressing some of these things early on and spending early on can ease the game after the fact.

Exactly. Yeah. You know, it's funny while we're talking about this, I'm thinking of this is going to age me as well. But

I wasn't thinking like a long time ago when we used to like start up our computers and like get on the Internet like modem and whatever.

Like it would be like so long, like kind of, you know, but it wasn't like 3 minutes, like get your computer onto the internet and now it's just like it's really in your hand every cycle, every day, you know?

Right. So we can have something that patience with our body and, you know, give it time, I think. Yeah, we will. It's going to be slow. It's definitely going to be slow. Not going to lie.

But now you're going to learn when your body's actually overheating, get it to activate and then try at the appropriate time. Because again, like I think one of the things we said too was patient psych patients will come in and say, Oh, I've been trying for like two years.

I'm like, Well, have you been trying around isolation? Or like, yeah, I've been trying around psychiatry 1415 because that's what my app is telling me that I'm I'm leaving.

But that doesn't mean that they're trying at the time when you're actually online. So I haven't actually even tried to just like think about it that way, like really look back at like what's actually going on.

And again, just give everybody some time and some grace. And I think with more information, more changes, you will get to that place. And I want to ask you one more question before we close out, which is, do you see, like in this in the context of what we're talking about here, that the the allure of the quick fix, like if you if you just give me Clomid like this will happen instantly, right?

Like, is there a distinct advantage that we have if they spend that 3 to 6 months supporting their body to ovulate naturally? Like what is the. I don't, I don't even know the way to ask this question, but like what is the distinct trade off when you go, oh, law is just so intense.

Like, I can get it, you know, like that person that's like I ordered me. Why isn't it here? You know, like, I want everything right now. I know I have the same.

I feel like I feel like your brains have been programed to be like that. But I think the allure of really working on your, you know, metabolism, the relationship with all the hormones is you're going to inevitably make the best quality egg by doing that.

Again, it takes 2 to 6 months to make an egg right upfront and CommInsure.

Timeline, Patience, and Planning for Conception

So if you can get the best quality and the chances of you getting pregnant are going to be higher than if you, you know, don't do that and still go and do it right.

You could do it. You could do it. It might not work. Are you like sometimes it takes a few cycles or it takes time. And a lot of times it actually takes time.

A lot of times it takes more time. Exactly right. Yeah. Like, yeah, yeah. The number of women that I talk to that are like, Oh, I've been doing IVF for four years.

And you're like, well, there's, there goes that quick fix. Well, that was. Supposed to be a lot of like. I know, right? You get ready. But it doesn't it's not I feel like it's not actually as quick as we think it is.

And it's really like that. It's the allure that's driving us. It's not that. It's like, Oh, the natural, holistic approach takes longer. That's exactly a misnomer that.

It's true. That it's been created that way, right? Like, Well, I'll do this once and you'll be done. And you do this like.

You're going to do this for six months and you still may not it?

Yeah. I feel like it's, it's doing women such a disservice to be in that mindset. And yeah, it's easy. Like I totally get it. Like if you get it tomorrow versus wait two weeks, I know.

And I'm like, I like it. Exactly. Yeah, I know, I know. But yeah, it's not, it might not be the answer. And also, you know, we do I think what would be great I was thinking about this when you were talking.

What would be great is like once someone's like, okay, I want to try to conceive. What would be great is like every woman goes through like an intensive of like, okay, I'm going to, I want to conceive.

So what I need to do as a woman is learn about my body. I need to learn about how these hormones are impacting me and just lead a healthier lifestyle so that I can have the best possible pregnancy and the best possible childbirth and the best possible baby, you know.

And then teach the baby. I know about what I learned, right? Because we don't get to learn any of this ever. Right. You never really learn this. So I think, you know, if you're out there and you're like, I don't know what to do or I want to try and I don't know where to start.

This is where I would start. Yeah. Mm hmm. Yeah. And and I see this a lot, like plan your conception for at least as long as you plan your wedding. I love that.

Right? Like, so much time and energy for that. Like, one wedding day, you can at least spend that much time for your baby. That will be 18 years. Yeah, I'm going to.

You put. Yeah, because planning a wedding is hard. Hard. So, yeah, it's it's hard. But like, we like there are wedding planners that you go to invite you get engaged.

It's like. Oh, I better get a wedding planner. Right? So like, why don't you have a fertility planner? Why don't you have one? It's like, okay, looks like look at what you have and let's see what.

All you're like. So people yeah, yeah. Like we don't. Well, planning for I love that. Yeah. Honestly, I think the more we women as women we are planners.

So I think the more and more we can plan and just support our bodies. Again, not only it's going to help us in this, ah, this phase of life, it's going to keep continuing to help us throughout the other phases that come later too.

Oh gosh. Yeah, absolutely. Absolutely. Well, thank you so much for joining me today. Dr. Mitha. This was great. Thank you for sharing all of your wisdom and and sharing that amazing mirror chart, which I'm a huge fan of, like being able to have this information and like access it at our fingertips.

Yeah. You know, our home is such a game changer, so. Yeah. It's great. Thank you so much for having me. Yeah, you're welcome.