Estrogen Isn’t The Enemy: The Truth About Hormone Replacement Therapy | Dr Betty Murray Transcript

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The Womenu2019s Health Research Gap

We make up 50% a little actually more We make up 50% a little actually more than 50% of the population but I think than 50% of the population but I think almost all of us are drawn to the thing almost all of us are drawn to the thing that we are passionate about because of that we are passionate about because of our own experience. For me it really our own experience. For me it really came from my diagnosis of colitis first came from my diagnosis of colitis first kind of going down that road and all of kind of going down that road and all of a sudden learning like oh out of 10 a sudden learning like oh out of 10 people nine are women. I'm like well people nine are women. I'm like well that's an interesting statistic for that's an interesting statistic for autoimmunity and then you start looking autoimmunity and then you start looking at other risk factors heart disease at other risk factors heart disease Alzheimer's and dementia three out of Alzheimer's and dementia three out of four. And so the reality is is we have four. And so the reality is is we have such an enormous gap in women's health such an enormous gap in women's health and particularly around research and and particularly around research and legitimate research. You know, women are legitimate research. You know, women are just little tiny longerhaired men. I just little tiny longerhaired men. I don't play that. We're not bikinis. We don't play that. We're not bikinis. We are a full human and we deserve our own are a full human and we deserve our own research. Agreed. What are we supposed research. Agreed. What are we supposed to do about hormone issues and to do about hormone issues and disregulated hormones in a world where disregulated hormones in a world where we're getting this onslaught of we're getting this onslaught of endocrine disruptors from the chemicals endocrine disruptors from the chemicals in our food and water? How are we in our food and water?

Estrogen And Cancer Myth

How are we supposed to navigate that with hormone supposed to navigate that with hormone issues today? So here's things like I issues today? So here's things like I I'm obviously really really logical you I'm obviously really really logical you know I've been in software before know I've been in software before engineering obviously biochemistry that engineering obviously biochemistry that was like my love language. The thing was like my love language. The thing that never meshed for me was okay if we that never meshed for me was okay if we look at women as a whole about 4 in 1000 look at women as a whole about 4 in 1000 will have the risk for breast cancer will have the risk for breast cancer over their lifetime. I'm going to use over their lifetime. I'm going to use this as an example but when you go this as an example but when you go through menopause that starts to through menopause that starts to accelerate at this extraordinary rate accelerate at this extraordinary rate right and then by the time you're about right and then by the time you're about 85 it's one in eight. And so you go, 85 it's one in eight. And so you go, okay, we've been told by conventional okay, we've been told by conventional medicine estrogen drives cancer, but yet medicine estrogen drives cancer, but yet none of the studies that ever looked at none of the studies that ever looked at hormone replacement in a woman ever hormone replacement in a woman ever showed that estrogen actually drove the showed that estrogen actually drove the increase of cancer. Not a single one has increase of cancer. Not a single one has ever showed an increase in mortality.

ever showed an increase in mortality. And so I looked at that and I go, okay, And so I looked at that and I go, okay, so let me do the logic thing. So if we so let me do the logic thing. So if we have our hormones and they're cycling have our hormones and they're cycling every month up and down, and when you every month up and down, and when you ovulate, your estrogen can go easily to ovulate, your estrogen can go easily to 500. When your second half of your 500. When your second half of your cycle, it's easily 4 450. So, we have a cycle, it's easily 4 450. So, we have a lot of estrogen and it's okay to give lot of estrogen and it's okay to give you a birth control pill, but something you a birth control pill, but something magical happens at 50 and your hormones magical happens at 50 and your hormones and any other hormones now going to kill and any other hormones now going to kill you. And I'm like, but our breast cancer you. And I'm like, but our breast cancer risk goes up, but we don't have any risk goes up, but we don't have any hormones. That doesn't make sense.

hormones. That doesn't make sense. That's not logical. So, 22 years ago, we That's not logical. So, 22 years ago, we had a failed, horrible, poorly done had a failed, horrible, poorly done study that keeps getting propagated out study that keeps getting propagated out into the media. We took women off into the media. We took women off hormones. Did breast cancer rates go hormones. Did breast cancer rates go down? Not a bit actually went up. And we down? Not a bit actually went up. And we have greater incidences of heart have greater incidences of heart disease, dementia, and osteoporosis from disease, dementia, and osteoporosis from it. It defies logic to say that your it. It defies logic to say that your hormone that your body makes suddenly hormone that your body makes suddenly becomes evil, villainous, and deadly at becomes evil, villainous, and deadly at a magical number of 50-ish. It's the a magical number of 50-ish. It's the environmental chemicals. And here's my environmental chemicals. And here's my current hypothesis. It's the reason why current hypothesis. It's the reason why I'm building what I'm building. My I'm building what I'm building. My current hypothesis is when you don't current hypothesis is when you don't have your own estrogen to attach that have your own estrogen to attach that keyhole and turn it on, what do you keyhole and turn it on, what do you think will do it? Your pesticides, your think will do it? Your pesticides, your herbicides, your phalates, your herbicides, your phalates, your fragrances, all of that stuff. And if fragrances, all of that stuff. And if you look at it from a logical you look at it from a logical standpoint, it's also logical science.

standpoint, it's also logical science.

Understanding Perimenopause

It's amazing. What are the cries for It's amazing. What are the cries for help in each stage of life for a female? help in each stage of life for a female?

>> You know, if you look at very young >> You know, if you look at very young girls, you know, as we go into puberty, girls, you know, as we go into puberty, right, your ovaries are kind of figuring right, your ovaries are kind of figuring it out. And so, you're getting kind of it out. And so, you're getting kind of abnormal expulsion of hormones. So, abnormal expulsion of hormones. So, they're high, they're low, they're all they're high, they're low, they're all over the place. You usually have crampy over the place. You usually have crampy periods. Like, everything's bad. I periods. Like, everything's bad. I remember when I was a kid and I was remember when I was a kid and I was like, being a woman sucks.

like, being a woman sucks. >> I know. I was like, I don't like this. >> I know. I was like, I don't like this. The world is ending. The world is ending.

>> Yeah. I was like, this is terrible. What >> Yeah. I was like, this is terrible. What am I looking forward to? So, you're in am I looking forward to? So, you're in kind of hormonal chaos at that time. And kind of hormonal chaos at that time. And then usually for most of us it starts to then usually for most of us it starts to normalize. We get our own cycle which normalize. We get our own cycle which could be you know 24 days to 32 days on could be you know 24 days to 32 days on average. And then you know depending on average. And then you know depending on your fertility some women might have your fertility some women might have lower progesterone levels or higher lower progesterone levels or higher androgens fall into those categories of androgens fall into those categories of like PCOS endometriosis. Those are all like PCOS endometriosis. Those are all signs that the hormones are not balanced signs that the hormones are not balanced right some of it genetic but that right some of it genetic but that doesn't mean you have to accept the doesn't mean you have to accept the genetics. It just means that there's you genetics. It just means that there's you know there's some imbalances there. But know there's some imbalances there. But I think the thing that most people get I think the thing that most people get really confused by is the pmenopausal really confused by is the pmenopausal journey. We've told women that menopause journey. We've told women that menopause is when it all happens. And that's a is when it all happens. And that's a single day in your life. That's one year single day in your life. That's one year from the last time you had a menstrual from the last time you had a menstrual cycle. That's the end of the cycle. That's the end of the permenopausal season. But the average permenopausal season. But the average woman spends at least eight years woman spends at least eight years symptomatic. Remember, it's a bell symptomatic. Remember, it's a bell curve, everybody. So that means some of curve, everybody. So that means some of us are outliers for 16 and some of us us are outliers for 16 and some of us ski through with very few symptoms. And ski through with very few symptoms. And the lack of

symptoms doesn't mean the lack of symptoms doesn't mean something's not going on. uh just means something's not going on. uh just means that you're not presenting those that you're not presenting those symptoms. If you look at it, you have symptoms. If you look at it, you have kind of three stages. Early pmenopause, kind of three stages. Early pmenopause, right? Which usually means that your right? Which usually means that your progesterone levels are starting to progesterone levels are starting to decline. Testosterone has already been decline. Testosterone has already been sliding downhill from 20. It doesn't sliding downhill from 20. It doesn't vary that much. It just keeps going vary that much. It just keeps going downhill. But progesterone starts to downhill. But progesterone starts to decline. So, usually you get crime scene decline. So, usually you get crime scene periods, fibroids, heavy periods, more periods, fibroids, heavy periods, more frequent periods. Like that was what was frequent periods. Like that was what was it for me. I was like, "Oh, awesome. I it for me. I was like, "Oh, awesome. I get to have a period every 21 days." And get to have a period every 21 days." And it's like a crime scene, you know? So, it's like a crime scene, you know? So, you're like, "Okay, never wear white." you're like, "Okay, never wear white." you know, all the things you think about you know, all the things you think about how you address that time period how you address that time period relative to the midline where relative to the midline where everything's starting to get crazy. So everything's starting to get crazy. So now progesterone is declining and now now progesterone is declining and now estrogen has attached itself to a bunchy estrogen has attached itself to a bunchy gourd and so it's going up and down and gourd and so it's going up and down and up and down, up and down. So then you up and down, up and down.

Why Hormones Fluctuate

So then you get hot flashes, night sweats and brain get hot flashes, night sweats and brain fog and you know mood swings and rage fog and you know mood swings and rage and all the other sort of symptoms that and all the other sort of symptoms that can go with it, heart palpitations. You can go with it, heart palpitations. You know what we do to address that will be know what we do to address that will be different. So sometimes it's maybe different. So sometimes it's maybe putting progesterone in, other times it putting progesterone in, other times it might be putting progesterone and might be putting progesterone and testosterone in. You know, as you enter testosterone in. You know, as you enter that sort of last phase, the sort of that sort of last phase, the sort of last part of the chaotic period. What I last part of the chaotic period. What I always was afraid of, and it's I would always was afraid of, and it's I would say this is a disservice functional say this is a disservice functional medicine does to the community. And some medicine does to the community. And some of it's because we're lacking the of it's because we're lacking the research, is I knew I was estrogen research, is I knew I was estrogen dominant. Anybody watching this can tell dominant. Anybody watching this can tell I got a badon dunk butt. I'm chesty. You I got a badon dunk butt. I'm chesty. You know, if you're curvy, you had estrogen know, if you're curvy, you had estrogen quite a bit. So I had been told and I quite a bit. So I had been told and I had had labs, you know, previously and had had labs, you know, previously and all this time that said you are estrogen all this time that said you are estrogen dominant. So, I'm like, "Okay, I'm dominant. So, I'm like, "Okay, I'm terrified by estrogen. I couldn't terrified by estrogen. I couldn't possibly have it until the end." But possibly have it until the end." But when you get into that last chaotic when you get into that last chaotic period where it's all over the place, period where it's all over the place, you can still have a period and it be you can still have a period and it be very, very low. And nobody knows that.

very, very low. And nobody knows that. You think, "Oh, if I'm still having a You think, "Oh, if I'm still having a period, I must still be estrogen period, I must still be estrogen dominant. I'm not there yet, so I can't dominant. I'm not there yet, so I can't start estrogen." And what I can tell you start estrogen." And what I can tell you from my clinical experience and my own from my clinical experience and my own experience, I didn't do this with experience, I didn't do this with myself. if I waited until it was all myself. if I waited until it was all done right before I added estrogen cuz I done right before I added estrogen cuz I was afraid I was going to get too much was afraid I was going to get too much is that you can often stabilize that is that you can often stabilize that bungee cord experience by stabilizing bungee cord experience by stabilizing the estrogen with a little bit of the estrogen with a little bit of replacement depending on the person cuz replacement depending on the person cuz the other thing again thinking logically the other thing again thinking logically if you were a estrogen dominant woman if you were a estrogen dominant woman what do you think you have a lot of what do you think you have a lot of receptors for estrogen yeah absorb who's receptors for estrogen yeah absorb who's going to feel it more profoundly when it going to feel it more profoundly when it starts to nose dive somebody who has a starts to nose dive somebody who has a lot of receptors and so we shouldn't lot of receptors and so we shouldn't take it away or be frightened of it when take it

away or be frightened of it when your body is actually crying for it you your body is actually crying for it you have those different stages ages that have those different stages ages that you have to kind of look at, you know, you have to kind of look at, you know, and then you have to add the thyroid and then you have to add the thyroid issues and the adrenal issues and all issues and the adrenal issues and all those other things. You can't ignore those other things. You can't ignore that.

that. that. >> I have so much discomfort around the >> I have so much discomfort around the whole hormone replacement industry. whole hormone replacement industry.

Concerns About HRT

>> Oh, yeah. Anywhere where there's just a >> Oh, yeah. Anywhere where there's just a ton of money being made, I want people ton of money being made, I want people to have great discernment about what are to have great discernment about what are the right decisions for them. What are the right decisions for them. What are the factors when you're considering the factors when you're considering different hormone replacement therapies, different hormone replacement therapies, which ones are more toxic? Which ones which ones are more toxic?

Synthetic Vs Bioidentical Hormones

Which ones are more compatible with your body's own are more compatible with your body's own strategies and rhythms? So the rule is strategies and rhythms? So the rule is if it's synthetic like hydroxyp if it's synthetic like hydroxyp progesterine, birth control pills, IUDs progesterine, birth control pills, IUDs and things like that, you don't want and things like that, you don't want those. Those are not long-term those. Those are not long-term strategies for menopause, you know, strategies for menopause, you know, pmenopause and menopause and beyond. Why pmenopause and menopause and beyond. Why not? Why does that matter? Oral not? Why does that matter? Oral estrogen. So the most commonly used oral estrogen. So the most commonly used oral estrogen for decades was primarin. And estrogen for decades was primarin. And primarin is made from pregnant horses primarin is made from pregnant horses pee. And it's got 13 estrogens in it. We pee. And it's got 13 estrogens in it. We only make three. So all 13 of those only make three. So all 13 of those estrogens when you take them orally go estrogens when you take them orally go straight to the liver. They pass through straight to the liver. They pass through those detox pathways where you got to be those detox pathways where you got to be able to wrap the right wrapper in the able to wrap the right wrapper in the right order. All of those have to go right order. All of those have to go through that. Then you have to actually through that. Then you have to actually take it and then it goes out into the take it and then it goes out into the bloodstream and then starts to work. But bloodstream and then starts to work. But it's not just those 13 estrogens. Now we it's not just those 13 estrogens. Now we have the other byproducts your liver have the other byproducts your liver made, some of which are really made, some of which are really pro-inflammatory. And so in much older pro-inflammatory. And so in much older women, oral estrogen is associated with women, oral estrogen is associated with stroke and heart attack risk because of stroke and heart attack risk because of the metabolites, because it's given the metabolites, because it's given orally. So today, estrogen is generally orally. So today, estrogen is generally given topically. There is a bio given topically. There is a bio identical form of estradiol in a pill.

identical form of estradiol in a pill. I'm still not a fan because again it's I'm still not a fan because again it's going to go to liver first because you going to go to liver first because you swallowed it and it's given as a patch swallowed it and it's given as a patch or a cream or an oil or a pellet. Here's or a cream or an oil or a pellet. Here's the reality. Pellets go underneath the the reality. Pellets go underneath the muscle. They're tiny and they are bio muscle. They're tiny and they are bio identical but they have other non you identical but they have other non you know ingredients in them that are going know ingredients in them that are going into your body. Your body creates a into your body. Your body creates a little capsule around it. It's a small little capsule around it. It's a small surgical experience. Then your body's surgical experience. Then your body's going to slowly absorb it. But that going to slowly absorb it. But that absorbability is just dependent on you absorbability is just dependent on you individually how much you exercise your individually how much you exercise your own unique biochemistry. And I have seen own unique biochemistry. And I have seen we do pellets in our clinic, but it's we do pellets in our clinic, but it's begrudgingly we make sure that it's begrudgingly we make sure that it's moving in the right direction and it's moving in the right direction and it's not getting too high cuz over time it not getting too high cuz over time it starts building.

And then you have the starts building. And then you have the patches. Well, the patches are great.

patches. Well, the patches are great. They're bio identical, but you've got an They're bio identical, but you've got an adhesive. So if you're a chemically adhesive.

Choosing Safer Hormone Therapy

So if you're a chemically sensitive person, do you want to stick sensitive person, do you want to stick an adhesive on you? Cuz they've got a an adhesive on you? Cuz they've got a bunch of polymers and other things in it bunch of polymers and other things in it that are endocrine disrupting. And then that are endocrine disrupting. And then the compounded creams in order for them the compounded creams in order for them not to separate. So it's kind of like if not to separate. So it's kind of like if you put like mayonnaise out and let it you put like mayonnaise out and let it sit, it would separate and be like oily sit, it would separate and be like oily and then chunky stuff on top. Well, they and then chunky stuff on top. Well, they put all of these solvents in it so it'll put all of these solvents in it so it'll stay in solution. Well, those solvents stay in solution. Well, those solvents are endocrine disrupting. A lot of women are endocrine disrupting. A lot of women will say, "Well, I was taking this cream will say, "Well, I was taking this cream and it seemed to work, but this one and it seemed to work, but this one doesn't." I'm like, "It's the base, doesn't." I'm like, "It's the base, right? It's probably not the hormone.

right? It's probably not the hormone. It's the base." We use a bio identical It's the base." We use a bio identical hormone and hoba oil. Two ingredients, hormone and hoba oil. Two ingredients, that's it. Hoba oil is a waxy like oil.

that's it. Hoba oil is a waxy like oil. It absorbs rapidly to the skin and It absorbs rapidly to the skin and delivers without having any exipients in delivers without having any exipients in it. That took a long time to get to. We it. That took a long time to get to. We have to think about where we're taking have to think about where we're taking it and how we're taking it. And same it and how we're taking it. And same thing with testosterone. Testosterone is thing with testosterone. Testosterone is not actually FDA approved for women and not actually FDA approved for women and female doses. So if you go to a female doses. So if you go to a conventional or menopause society conventional or menopause society trained doctor, they're going to give trained doctor, they're going to give you androgel which is dosed for men and you androgel which is dosed for men and are going to go guess and put a little are going to go guess and put a little bit on and then they poo poo compounded bit on and then they poo poo compounded but again if it's compounded in cream but again if it's compounded in cream you are putting on a cream that's got you are putting on a cream that's got solvents in it. Um we obviously do the solvents in it. Um we obviously do the hoba oil. We have to look at it and say hoba oil. We have to look at it and say I don't want to take hormones that are I don't want to take hormones that are adding additional endocrine disrupting adding additional endocrine disrupting things.