Podcast Introduction

Welcome to Doctor Talks, the podcast where every episode leads to a healthier you. Join us as we navigate the world of optimal health, uncovering groundbreaking strategies to conquer chronic disease.

In each episode, we'll bring you the latest insights from leading health experts, medical innovators, and wellness warriors. If you're seeking to transform your health journey, or if you're looking for answers to burning questions, you've come to the right place.

Get ready to unlock the secrets of lifelong health and vitality. This is Doctor Talks, real talk from real doctors on the issues that matter to you most.

Do you know that perimenopause can last ten years before the onset of menopause? I'm doctor Mary party. I'm joined today by Doctor Natalie Sheila from Modern Med.

We're going to discuss all things hormone replacement therapy, perimenopause and menopause. And we are very excited for this. Welcome, doctor Sheila. Thank you.

I'm excited to be here. I'm excited to have this conversation. Me too. Me too. I was actually doing some research right before, we jumped on this just around a women education, around the reproductive cycle and hormones and, you know, sex and reproduction in general.

And I was really interested in what I found.

Perimenopause and Menopause Overview

There was one observational study that showed that up to 67% of women do not know when ovulation occurs during a menstrual cycle. So surprising to you, I guess. Yes and no.

It's like it's a little disappointing, but I guess not a total surprise. Yeah. And we see it in practice, too. We have a couple of questions on our forums.

One of them is how long is your menstrual cycle? And then the other one is how long is your period? And often times like those get confused and people think their menstrual cycle entirely is five days.

And they're confusing that for for their period. Yeah, definitely that all the time. And so I want to kind of jump in to generally the menstrual cycle and what it looks like.

So our hormones fluctuate throughout the course of our life. But let's go through the stages of for perimenopause, perimenopause, menopause take us through kind of the overview.

And we're just talking about female reproductive cycle here. Yeah. So to start kind of big picture to to set the set the background as a women have kind of three main stages in our reproductive life cycle.

So we have that pre reproductive stage which is childhood pre puberty before we get our menstrual cycle. And then we move into our reproductive years.

And so that's kind of marked by our first period or menarche. And then after that we we we move into the post reproductive years. And that's marked by menopause which is that absence of period for one year.

And so I do have some visuals that we could jump into to kind of help set the scene a little bit of, okay, let's do it now. I think it's a really good place to put some visuals, because sometimes it's hard to understand.

Yeah, absolutely. So let's start here and we see that okay. Yep. Awesome. So this is what we call the hypothalamic pituitary gonadal axis. And so what that essentially means is we have our hypothalamus.

The hypothalamus is a structure inside the brain. And what that does is it releases hormones. One of those hormones being generated during age moves to our intuitive pituitary or sorry anterior pituitary gland, which is also up in our head here.

And that stimulates the release of two hormones, LH. And these two hormones travel down to our, sex organs. For females, it's the ovaries. And they stimulate the production of the sex hormones that we tend to be more familiar with.

Estrogen and progesterone or estradiol. That's the main form of estrogen. During our reproductive years. And so this is where people are most familiar with.

But there's quite the process that happens before before here. So it's helpful to see. So it starts up in the brain here goes to a pituitary gland. And then we get signals to our ovaries to then produce these hormones.

And that is helpful to know as we kind of look at what a cycle typically looks like in for a menstruating female. Share that image here. While you're sharing that, I think it's really important people might want to flip back to that image or Google at themselves when we're talking about menopause and FSH and LH and what happens there.

So keep a bookmark there to. Yeah, absolutely. And then so then here we see our kind of what the menstrual cycle is for a during our reproductive years.

And so we have kind of two parts to the the menstrual cycle, two halves that are separated by ovulation. In this first half of the cycle we call this the follicular phase.

This is as our bodies start to our ovaries start to produce, what we call follicles, which and are kind of the precursors to the egg that's released during ovulation.

So through this first half of the cycle, the follicular phase, those follicles are being produced.

Menstrual Cycle and Hormone Basics

Eventually a single follicle is chosen and then that gets released midway through the cycle. Here at ovulation. To helpful to point out is that cycle day one here, the first day of our cycle is that first day of our period.

This is when we start bleeding. And so usually that lasts around for seven days. And so start there. Then when once we get to ovulation, that egg is released and the egg starts to produce progesterone.

So we see this darker blue line, the progesterone start to rise here. And what happens is so the body's go through this process is for sexual reproduction.

It is to become pregnant and have a offspring not always the person's desire. But that's what's kind of what this is happening in our bodies. And so at this point the egg here is either fertilized by sperm.

And if that happens, then, progesterone will continue to get produce. The pregnancy will ensue. If that doesn't happen, that egg starts to break down and we see that fall and progesterone that you see here.

And with that fall and the pressure on that, the estrogen also falls. And we have, we restart the cycle, come back to day one. And that's where we have that menstrual bleed here.

So that's kind of general overview of what a, this kind of 28 to 35 day cycle looks like. During those reproductive years. Great. Now I'm just gonna summarize to you in terms of day one, first day of bleeding.

And so oftentimes we'll have women draw blood around day 3 to 5, which means 3 to 5 days after the first day of bleeding. Day 14 ish, of course, like every woman is different.

So we're just basing this off the 28 day cycle that's around our population occurs. That's the number that 67% of women do not know when it happens for them.

And then the luteal phase is where we see progesterone being the highest. And if you get pregnant, that progesterone will continue to get produced. Otherwise both estrogen and progesterone fall.

And we've talked about on other videos, what happens when that decrease in estrogen and progesterone and symptoms that can occur premenstrual as well.

Exactly. Okay. And so keeping that in mind I share my screen of how that changes with, as we get into perimenopause and let's hear, okay, so on this left side of the screen is what we just looked at.

These are the kind of pre menopause during our cycling years. And this looks a little bit different because this is looking at six cycles together. So this is one of the cycles we just looked at.

The predictable rise and fall of just red and estrogen. And then this is this another cycle here, another cycle here, another cycle here etc.. So this is over six months that we're looking at the 180 days as we move into that perimenopausal period, the ovary stop, responding to the, hormone messengers as they once did.

And so progesterone and estrogen production becomes a little bit wonky. And so remember back to that first image that we looked at. We saw that FSH and LH are those messengers that, that target the ovary to produce those hormones.

And so when we see here, if they stop paying attention or they stop responding as well, we get this kind of wonkiness craziness. And I feel like this is a really helpful image for people to see as they enter that perimenopause, time.

There can be a lot of kind of crazy symptoms that feel unpredictable and confusing and sometimes chaotic. And I feel this this picture can kind of validate what people are experiencing because this is essentially chaos here.

These are kind of hopping all over the place. And then as we move through, we eventually get into that post menopause after, the when the ovaries stop responding, and so actually reproduction are both very low.

We see them stable here. We still see those FSH and LH messengers from the pituitary gland. Gland. Higher up here. Yeah. And I like I love this visual.

I actually think we need to show it to patients more often because it does so well. Visualize what people are feeling. I would say this is probably like late perimenopause too, because perimenopause can be so long.

And the initial, you know, starting in menopause, we can talk about what that or perimenopause. We can talk about what that can look and feel like too.

And then you can see and post menopause. I like that image because you can see how high FSH is. And that's really what we use to to tell kind of about where women are in that transition.

Yeah yeah yeah. Absolutely. Okay. And so let's go into kind of the next phase in terms of just describing a little bit more in depth what this transition can look like.

Yeah. And so, so as far as symptoms go. Yeah. Exactly. What are women feeling. You know, maybe even like an example of a woman coming in to see you, like what she may report.

Yeah. So are you going to have perimenopause is when we start to see changes to the cycle. So. So a woman

might start to see irregular cycles, maybe a missed period or a longer time in between cycles.

You can start to see changes in their mood and their energy levels. We can also start to see things like hot flashes and night sweats, with time and changes.

So libido is another a big one that, can occur. And then over time too, we can start to see, some other symptoms, maybe, vaginal dryness, thinning of some of that, vaginal tissue, the vulva tissue or pain during sex, all common symptoms of that perimenopause to transition menopausal time period.

Yeah. And you might have this one. But changes in sleep is a really common one, especially early Perimenopausal years. Like even women in like their mid to late 30s can start to experience that.

Have you heard that for your patients too? Yeah, absolutely. And as you mentioned, the perimenopause can start as ten years prior to menopause. And so the average age of menopause is around 51 right now.

And so 45 to 55 is all kind of within that normal range. So that can be as early as late 30s or late 40s and people start to experience this. Yeah. Changes to what estrogen, progesterone actually do in the body because I think that makes the symptoms make sense as well.

Yeah. So I should do progesterone. Both do a lot of things of this. Not exhaustive but kind of what we mainly think about with estrogen.

Hormone Changes in Perimenopause

So we talked about producing those follicles that eventually, get chosen as a single follicle and release as the egg, responsible for libido, responsible for the building of our uterine lining that gets shut as the period, estrogen also important for kind of our secondary sex characteristics, things like breast tissue development.

Also really important for our bone health. And so a major driver of our, our bone density there, and then progesterone, I think I covered the importance on there.

Anything you would add with estrogen? No, I think you got it, too. Yeah. And so then progesterone, mainly we think about it's really important for the process of, fertilization of the, the egg into the uterus, implementation of that egg into the uterus after it's fertilized.

It is also helpful for bone support. Lesser degree to a lesser degree than estrogen. But it's also for to is a calming hormone. It can be relaxing for some.

Yeah. Yeah. Awesome. And when we talk about perimenopause, some of the things that we talk about with our patients is whether or not hormone replacement therapy is appropriate and when we want to start it in that whole discussion.

So first off, what is hormone replacement therapy. Yeah. So hormone replacement therapy is essentially using exogenous hormone hormones from outside the body.

As a therapy we're typically referring to estrogen. And then we can use progesterone depending if a woman has a uterus or not. And then testosterone could also be included in that.

But we're mainly referring to that estrogen plus or minus progesterone plus or minus testosterone. And so HRT or hormone replacement therapy, it's kind of what we, is most commonly talked about or called the official name for that is actually menopausal hormone therapy.

But that really hasn't caught on as much as HRT is still kind of more commonly used to talk about. Yeah. The lingo is starting to shift whether it catches on.

But, and then let's talk about the difference between, hormone replacement therapy and bioidentical hormone replacement therapy and how there's kind of like this mismatch that's happening there.

Yeah. So first, in what bioidentical hormone therapy is, is, is the hormones that we're using. The hormones outside hormones that we're using look identical in structure to the hormones that are found in our body.

So estradiol progesterone all those different types of and but they look like the hormones that are found in our body. And so in some there are, there are both synthetic forms of hormones that you can get, depending on where you're located and also the bioidentical.

A lot of the research, which I think we'll talk about, we'll get to two, has been done with the synthetic hormones, and there's definitely some safety concerns there.

And that has, definitely a discussion. We can, we can talk about. But those are the kind of major differences. Bioidentical look like the hormones are during use that are in our bodies.

And then this, non bioidentical are synthetic hormones that can look different. Yeah. Yeah. And technically are they all synthetic, would you say just because I mean we're not taking them from your own tissue.

Right. So they're not your own hormones. We are manufacturing them. But the big difference being that some will look exactly like like they're exact replicas of the estrogen and progesterone that are circulating versus we have the conjugated equine estrogens and progestin that look differently to your body.

I wanted to talk about I think I worded it incorrectly. Mismatch is not the best term, but I think that there, you know, a lot of the times I'll still get patients saying, I want to make sure the estradiol you're putting me on is bioidentical.

Like it's it's a real sticking point because I think it got a lot of media attention. And for, for, I would say for the better in a lot of senses. However, there's a lot of overdo and using bioidentical hormones.

So it's not just something that you see in the functional medicine or integrative space anymore at all. But I'm trying to think of like what my actual question is here.

I think that, I think my question is the difference between compounding versus commercial pharmacy with these. And so when we talk about bioidentical, it's often associated with those that are manufactured in a compounding pharmacy.

So the creams the things that are made individualized to the person, versus if you go to CVS and Walgreens and people think that you can't get bio identical hormones here, can you just speak on that point a little bit.

Yeah. Yeah. So kind of continuing on what you said is there's that misconception that if, if you're getting this compounded cream that it's made for you, that's the only bioidentical hormone that's been used.

And then if you go to these, kind of conventional pharmacies like CVS and Walgreens, that you're getting this again, word synthetic, even though as we we said, they all are synthetic in a way, that you're getting these, kind of negative or hormones, that have the higher risk profiles, but that's generally not true.

The, the, estrogen forms that are approved by the FDA. So they're available at CVS and Walgreens are typically estradiol, which is and which is bioidentical.

So commonly, if you are going to an Oregon and getting prescribed something from a pharmacy, you are getting bioidentical hormones and the same is true for the, oral progesterone that's commonly prescribed.

That is bioidentical as well. It is. It looks like the one that we find in our body. Yeah. And that's not to say that Ob-Gyn aren't prescribing non bioidentical.

They definitely are, especially when they're using oral contraceptive pills. And SAP is to treat perimenopause, which is quite common. And so that would be a case where that would not be bioidentical or body identical.

But I think it's a really important point to distinguish.

HRT Basics and Bioidentical Hormones

And you and I were talking the other day in terms of when we were in school, a lot of the education was around using compounding pharmacies to get these bioidentical hormones, and there wasn't even a huge knowledge base that was instilled upon us that there were these other forms of bioidentical hormones that are available and commercially, you know, produced by pharmacies that are much cheaper for the person as well as, much more, regulated in terms of like the dosing being the same for each product.

And so we both have, you know, discussed kind of switching away from the creams and the things from the compounding pharmacies to go more commercial for that reason.

I'm so into ten data of kind of at least what I was taught, it was mostly surrounding those creams as kind of the best option. But with the kind of more commercial products, there are things like patches that can be put to better absorption, and there's other options there that creams out are not always and sometimes aren't at all the best option for, patient.

Yeah, yeah. Great point. What are the benefits? Why would somebody consider hormone replacement therapy. How do you kind of view it and talk to patients when they come in in terms of these benefits.

And we can go through rest as well. Yeah totally. So as far as when somebody is in that perimenopause menopause time period, HRT is the most effective therapy we have for those vasomotor symptoms, which is the hot flashes in the night sweats.

And then the genital urinary syndrome of menopause, which is mentioned earlier, the, thinning of that tissue, either the vaginal tissue, vulvar tissue, that external gentile tissue, vaginal dryness, pain during sex irritation.

And so HRT is the best treatment that we do have for those. It's very effective. So that's commonly what brings up the discussion of, whether to somebody wants to start HRT.

The other really important thing that it does that I think we both kind of agree, doesn't get as much attention as it should, is the fact as bone health and, estrogen therapy and bone health is very supportive, of our bone density and, preventative for fractures.

And so, and low potency bone fractures are a big deal. And, can be but can be really serious. I think there's a few studies I can pull these numbers if I get them right.

But yeah, this is like one point where, I think I did this when I was younger, too, and like, osteoporosis. Not something I have to worry about. Like bones.

No big deal. Like, I'll be fine. I'm not going to break a hip kind of thing. And I feel like it's really dismissed. Well, it was dismissed by me, I should say.

I don't know if you know, at. But when you look at this stat, it's like, oh my gosh, we need to be paying really close attention to this. Especially because not especially because but women, number one, but also women of lower body weight or BMI that are really healthy who are thinking like, I'm on top of the world, I've got it.

You know, I'm, I've figured that this health thing there had a higher risk than somebody who is obese. And so it is this thing that happens, paradoxically, in terms of, you know, having a lower BMI actually increases your risk here, where in most chronic diseases, if you're in a healthy BMI range, it will reduce that.

Yeah, definitely. And just to clarify to for us just that jump there for osteoporosis. That just means reduction in bone density. And that puts you at increased risk for a fracture.

And then osteopenia which is another one that's the first stages of osteoporosis. But there is a study. And so they've found that older adults have a 5 to 8 fold increase for all cause mortality or death after that first three months after hip fracture.

And then more specifically, white women who have a hip fracture at 80 years old will have an excess annual mortality rate compared to the, white women who have not had a fracture at the same age.

An increase by 8% at one year, 11% at two years, 2,018% at five years, and 22% at ten years after the injury, which is a little insignificant. Yeah, it's really significant.

If you look at the rates for men two, they're very, very high. So this is not just women, but we're talking about HRT for women here. But 5 to 8 fold increased risk for all cause mortality during the first three months after a hip fracture.

That's like a very staggering number. Yeah. And and one of the issues too, that you kind of pointed out earlier is that it can be silent until generally the first symptom of osteoporosis is the fracture itself.

So there's no symptoms beforehand. That kind of alert anybody that this is could be an issue for them. And so we do use screening methods. The Dexa scan Dexa is typically what we use.

It typically doesn't start till 65 unless there's concern to start it earlier. But yeah no symptoms. Before that fracture usually. Yeah. And I don't know about you, but this is where I do drift off the guidelines here.

I think the guidelines are really helpful for a lot of things, but I feel like this one, we're going to be missing too many cases if we're waiting that late to test women, especially women, of lower BMI is.

And so I will test women, younger if I'm suspecting that they're at a higher risk for, osteopenia or osteoporosis. And I've found in a bunch when I do that.

So I think it's worth it. Yeah. And at a minimum just at least being discussed earlier with women of prevention strategies, HRT being one of those things that should be part of the discussion.

Yeah. Okay. Let's talk about the controversy with hormone replacement therapy. This is actually really, nuanced. It's confusing to there's a lot of misinformation that's out there.

And I'll be the first to admit that I'm still sifting through things because there's so much data out there. And some of it is really poorly done research, and then some of it is actually, you know, very helpful.

It's all helpful, I should say. However, we need we need to make sure that we're reading into it the right way. So give us like a little like overview of the history and we can dive in.

Benefits of HRT and Bone Health

Yeah. So definitely a lot of history as you said. But as far as it kind of start us off in the 1940s, early 1940s, conjugated equine estrogen or C was first approved for the treatment of menopausal symptoms.

So that's when we first started, having that FDA approval and using them. And then about 30 years later, three years after that, we started to see an increase in endometrial cancer in women who were using HRT.

And so that started to raise safety concerns. And so at that point, we started using and prescribing, progestin. So a specific one called proxy progesterone acetate, it is a static progestin.

So a to progesterone that binds to the progesterone receptor and that was used to to balance the effects of estrogen. Estrogen can as we kind of mentioned earlier, is one of its job, promote growth in that uterine lining.

And so increased uterine lining thickness raises our risk for enemy trail cancer. So progesterone can offset that. So that's when that was brought in.

And then that was 70s. And so then in 80s and 90s, we started to have quite a few observational studies that showed that women who were on HRT had better outcomes as far as, reduce cognitive decline, better, better cardiovascular outcomes and reduced all cause mortality.

And so people, started to use HRT as for preventative of, of those things, cardiovascular health, cognitive health, all cause mortality. Chronic disease started using it a lot more frequently there.

And that because there was more, prescriptions and more use of those hormones, there's obviously a need for, more studies, observational studies we can't see cause we want those randomized controlled trials.

And so in comes a large study called the Women's Health Initiative. And so this is one that some people may be familiar familiar with because it is often talked about, when talking about the risks and benefits of HRT.

But so this was that kind of first major randomized control trial looking at HRT. And it was about, I would say 27,000 women. And they were, yeah, separated into either, got C, the conjugated equine estrogen or, the estrogen plus the MPA image, oxy progesterone acetate, if they had a uterus or a placebo group.

And so the outcomes that they were looking at for this study was, incidence of breast cancer and then cardiovascular disease. And so what ended up happening is the group, the arm of the study that received both the estrogen and the progestin, was stopped or really stopped about after about five years because there seemed to be an increase in breast cancer without, any benefit on that cardiovascular side or overall, improvement in risk for mortality.

And so that ended up being stopped. And so then at that point, a lot of concern was raised for the safety of HRT, and there was a lot of, providers pulling back on kind of how much they were grabbing what they were prescribing it for.

But I'm sure we'll talk about there's quite a lot of, I want to say, issues or kind of factors in that study that, we, that we should be discussed to as far as interpretation of whether breast cancer and the in HRT in general is as of, of high concern.

Yeah. And let's do that. Because I don't want people pausing here and taking that on as the take away. I think this trial was really important because there was a lot of off label prescribing and kind of things based on some information that now we know probably isn't, the truth in terms of all the benefits of HRT.

But let's go into the Women's Health Initiative in terms of who were the people that they were doing this study and so I think that's a big part to distinguish is who were the subjects that were actually in this study.

Yeah. So they did women and they did it based on age versus relation to their menopausal status. So as between 50 women who are 50 to 79 years old. And the average age I want to say is about 63. So theoretically, well, after menopause, if that average age of menopause being 51, and so and with many had cardiovascular history, so there's no exclusion based on that.

And so these were older women who could be well after menopause, who potentially had chronic health disease, weren't at the, best health at the start of the study.

And the other thing to is, is with not screening for, by time in relation to menopause, there's also women who were included who may have had, surgical and use at a pause earlier, meaning they had both their, uterus and their ovaries removed at a younger age, potentially.

And so theoretically could have gone through menopause if that happened at age 40. And so then they're starting these, HRT well, after 20 some years after they went through menopause.

Yeah. And usually when we're talking about initiating HRT, it's within ten years. The menopausal transition is the general guideline because of the potential increased risk.

It's not to say that has to be for every single person, but we're really looking at that is the ideal candidate and somebody who is within that ten year span or in perimenopause even.

Yeah. Exactly. What are some of the other drawbacks of this study that we have to look at. Yeah. So one of the major things that we look at is kind of the products that they were using.

WHI Study and HRT Controversy

So they were using the conjugated equine estrogens. And that's an oral estrogen. At that time. And currently we do know that if you take estrogen orally through a pill that does increase, clotting factors in our blood, makes it increases the risk for clots.

The reason we didn't know this at that time, the reason they use this type of estrogen is because it was the most commonly prescribed estrogen at the time.

That's what most of the observed studies was looking at, where we did see that benefit. So they expected that the benefit that we saw with the estrogen therapy would outweigh those risks.

Now and we'll certainly kind of circle back to this in the future. But there are other options. And so typically oral estrogen at least, in our practice is not what we use because of that risk.

There are transdermal. It's usually how we're using that. And the other one is the type of progesterone that was used. So it was a progestin and not a progesterone.

And so if anything this study, it was the group that had the, estrogen plus the progestin that had the increased risk of, breast cancer versus the we didn't see that in the, group that had estrogen alone.

So points to more of the progesterone being problematic than the, estrogen itself. And kind of further looking at those numbers. So when we see the study was stopped because there was a relative risk, about 25, 26% for the group that was getting both estrogen and progesterone to develop breast cancer compared to the placebo group.

Which is which sounds very scary. A 25, 26% risk. We don't like to hear that. But that was the relatively risk. If you look at what the actual absolute risk, it only equates to about 1% increase in likelihood.

And what that means is so in the group that was the placebo group, there was about four women out of every thousand who went to develop breast cancer.

And in that group who had both the, estrogen and the progestin, they was about five out of every 1000 women that went on to develop breast cancer. So that's only one person between the two there.

And that is also looking at development of breast cancer. It wasn't looking not talking about mortality. There's no change in mortality, no change in deaths with that.

And so that's something to also kind of think about when you're talking about risks. If there's no change in deaths, do we do at what at what risk do we kind of wipe out all of these positive findings for one increased case per thousand.

Yeah. And that's also a given. And we have to keep reminding ourselves that they were using conjugated equine estrogen, which I don't think that's the, the thing we're talking about, the progestin as being the main thing here for

breast cancer risk.

Not in the ideal set of women either. So there's so many other factors. And yet we were still getting that 0.1% absolute risk increase in that group. So and that that's what halted the entire study to say, hey, it might not be safe anymore.

So I think that, you know, and I know a lot of other people are talking about this as well, but, we really need to we were using conjugated equine estrogens.

Then we're not using them anymore. We need, like, the same mass study at the same level of participants. Now, using what we are currently using. Absolutely.

And there are some further studies to later studies that looked at the progesterone versus the progestin. And so that and relative risks of developing that breast cancer.

And for this one study it found that the relative risk using a progression was 1.4. So a 40% increase of the development of breast cancer, for the progestin, but a 0.9, relative risk for using the progesterone microRNAs, progesterone identical British roan, which is a a 10% reduction in risk of that development.

So there are some studies not to go to the, timeline and, extent of the Women's Health Initiative. That points to kind of feeling more comfortable with that safety, but definitely would love more research.

Yeah, yeah. And if you're listening to this on YouTube and you want the citations for these studies we're talking about, head over to our website. We'll have all of them listed at the bottom of the blog there as well.

And then let's talk about there. I think there's one additional study. Do you want to mention that one, the for near to 2007. Yeah. So and another study that looked on E2 so estradiol and progesterone and so there was no increased risk on the group who received the estradiol plus progesterone.

But in the group that received extra diol and the MPA, the progestin that was in the Women's Health Initiative, they had an increased, relative risk of 1.69, which was a 60, 69% increase in that risk of breast cancer.

So again, pointing towards that progesterone, or progestin specifically being more concerning. Yeah. So we don't use MPA in our practice at all for this reason.

And most other practitioners are obviously using the same advice to, let's talk about other kind of safety contraindications around hormone replacement therapy.

Yeah. So as far as, kind of when we want to use it, we've hinted at this already, but we generally recommend starting it within ten years of the perimenopause menopause time period before 60 years old.

And we want to be cautious with, with people who have established cardiovascular disease. As far as, safety wise there, the other things that we think about is, is, is route with safety.

And so if somebody typically I am not using oral estrogens in most cases, but it is something that is prescribed, you want to be super cautious with if they have cardiovascular history, if they have gallbladder disease, risk for clotting, all of those things really want to be cautious with because as we mentioned earlier, the increase increasing clotting factors.

Yeah. Okay. And then let's talk. We've already covered it a little bit, but let's talk about forms in terms of what does it actually look like if you're using hormone replacement therapy.

What are you doing on a daily or weekly basis. Yeah. So it depends on the form that you're using. So the first for estrogen, there's six FDA approved estrogen only medications.

And they come in different forms. So it can be the oral pill I can be gels, creams, patches.

Who Should Consider HRT and How It Is Used

Sometimes sprays. The most common one that we use are our patches. And so that looks like, using a patch either weekly or every biweekly or for two weeks.

And then, switching that as depending on the timeline there. And then if you are using a cream, it's typically daily. Use but sometimes you can people will do two, three days a week depending on symptoms and what the absorption looks like for them.

Yeah. Yeah. And then I guess progesterone wise. So if somebody has the intact uterus you want to use progesterone. And so there's two options there. So the more common one is oral progesterone.

The benefit a theoretical benefit of or a pedestrian is there are some systemic benefits. It can be, as we mentioned, helpful for that kind of relaxation.

So it can be helpful if somebody takes it before sleep. So you get some of the systemic benefits there. The other option is that if somebody doesn't tolerate the systemic, progesterone, they can use a progesterone coated IUD.

And so that is placed in the uterus that has those local effects of preventing the, endometrium thickening, which is what we're hoping from. Yeah. Okay.

And I want to just pose a case to you. So a woman comes in, she is 51. Maybe she just like, had she hasn't had her period and, you know, 14 months or whatever.

She's having hot flashes. She's having trouble sleeping at night. I'm going to throw them all in their shoes. Lower BMI, so maybe potential increased risk for osteoporosis or osteopenia.

What does that conversation look like with her? And, and then also, if she decides to go on hormone replacement therapy, let's say she comes back in three months after you redo her labs.

What is she typically reporting and then analysis. Fictitious. Yeah. So to start for further question, where that conversation starts is, if she's bringing up HRT, you talking about it from there?

She hasn't been kind of suggesting it. And a lot of it surrounds education. There is a lot of misconception and oftentimes I find I wonder if you do too, kind of in the patient population, we see there is a lot of concern about quote unquote natural or, synthetic and in the safety there.

So kind of talking through a lot of what we talked about today, and some kind of clarification there. And then, do we talk about her health? So we want to make sure that it works for her.

And so we talk about those things like the cardiovascular health risk factors. If there's any history of hormonal cancers that she has had where, family members close, family members have had would want to know about that.

Has she had the screening things like a mammogram screened for breast cancer. She up to date on her? Cervical cancer screening, all of those kind of things that we like to do, to make sure, that we are doing it safely.

And then, typically where I start personally is, with if she's not cycling anymore, starting with and she has an assembly, has a uterus, then typically start with the oral progesterone.

Started that lower dose 100mg. And then with the estrogen typically recommend starting with the lowest dose estradiol patch, because they tend to be the easiest and best tolerated.

And so those are the recommendations. And again, as far as pricing, these are these are things that you pick up

from Walgreens CVS, your conventional pharmacy.

So really general ease of access is, is good. And then yes. And so then send her on her way, think about everything. And then coming back in in three months or however longer, hoping to see improvements in those, more immediate symptoms that she was mentioning was the hot flashes.

Sleep. I'm trying to remember everything changes. She never changes. Yeah, well, we can keep that one out because we're not going to go into it. But yeah.

And so I'll hopefully seen improvements there. And if not, then we can consider increasing that, dose of the patch and then and then with time it's kind of how we monitor bone density that is over a longer period of time.

More. Yeah. Yeah, yeah. So she comes in and sees you, order labs and she'll redo the labs about three months before or three months after starting the therapy, just to get like a full exposure to the hormones and make sure that she's in a safe range.

Progesterone. I dose of depending on bloodwork and symptoms, of course, too. But we're really looking for a adequate blood level of progesterone to protect that endometrial lining.

So that's a big factor. But let's just say that one more time actually in terms of who gets progesterone and and who doesn't necessarily need progesterone.

Yeah. So if you have an intact uterus meaning your uterus is in your body, it hasn't been removed. And it, it is removed through surgery. So it's not something that you like could have missed.

You would have that surgically removed. Then you will receive progesterone. That's because that estrogen supports the growth of that, the lining of our, uterus, which can, increase risk for any major cancer.

Progesterone will balance that estrogen back to to to prevent that thickening. Yeah. Yeah. Okay. So she comes back in three months. Majority of people at three months are going to say my hot flashes night sweats are better. Maybe they're still there.

And that's where you're talking about changing dosing. But usually people report they feel a lot better. With that sleep can definitely improve as well.

Progesterone can help with that. Mood can sometimes be a factor that they'll say that they just feel better. In general. I'm missing any big ones that people discuss skin as well.

Just like dry. Yeah. Sex drive frequent. Yeah I mean sleep I think you did say that's the other. Yeah. And then we didn't talk about testosterone replacement therapy.

We're going to do that in a separate video. But that is part of hormone replacement therapy for women. Women actually have more circulating testosterone than they do estrogen.

So that's a huge part of how our body functions. And we're just going to save it for another day. But that's part of the discussion when we do have it with women.

What are the other things that we maybe skipped over? We didn't talk. Anything else come to mind for you? Yeah, I think I just think it's important to kind of talk about what the change in prescriptions for women with HRT after the W. H. O.

Patient Case and Closing Remarks

because of that, concern with cancer. And so I think, there is a huge reduction. I have the numbers here. So after, the WDI was published, the HRT decreased about 80% since then.

And so now estrogens only prescribe to about 3 to 4% of postmenopausal women, compared to 25 to 30% before the W. H. O.. And in some ways, that's good, because we're not using it at well after menopause for the prevention of chronic diseases that wasn't effective for but in in some many ways, that's not a good thing because women are who are in their 40s and 50s, aren't getting the benefits with the vasomotor symptoms, the menopausal symptoms, and then quality of life, bone health, missing out on all of that.

And so super important there. I feel like there's a lot of, misconceptions. And that's hurting women and their ability to access. Yeah, I think that was really clearly and yeah, it's it's it's so and that's a huge shift.

So previous is a post Women's Health Initiative study, that drastic reduction that's there. Really fascinating and so important that we like, keep talking about it to make sure that women get the treatment that they need.

Not to say that every woman needs to go on hormone replacement therapy. Would you agree with that 100%? Correct. Yeah, yeah, not for everybody. But if that's a decision for patient and provider.

Yeah. Awesome. Any other and I get that you have. That was a good one. Yeah. That was a big one that I, that I have I think it just highlights the importance of kind of everything we discussed today.

And making sure that everybody knows, all of the information so they can make the decision that works best for them. Yeah. All of the information, all of their options there, are other ways, obviously, to treat and the vasomotor symptoms.

So estrogen is one of the ways and it is the most, successful way, I would say, right. In terms of has that true? My. Yeah, it is the most effective, most effective way, but there are tons of other options or lifestyle factors too that can be really effective.

And so we, you know, it's not for everybody. Thank you so much for going through all of this. I learned things on today's call, which I always do. And, we'll be back for another episode at some point.

So thanks for having me. Thanks. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health.

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