Hormone Therapy Myths Debunked (Part 1): Cancer Risk, Estrogen, and Testosterone Truths Transcript

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Hormone Myths and Cancer Fears

You don't, when you shut down the testosterone, what are you also shutting down? Estrogen. And so you're, what's going to happen is most of those drugs work for about a year or so.

And then all of a sudden you'll start seeing the cancer come, start coming back because you're dropping the estrogen, which is protective. Also, if you really want to know what a man, a woman goes through when she goes through menopause, gives another those drugs, because what's going to happen, you're going to drop that estrogen.

You get, man's going to go hot flashes, diet, he's going to go, oh, he's got heart disease and the gay weight. His sexual function is going to drop. Cause we know estrogen is integral sexual function.

I have several patients that come to me that have metastatic prostate cancer that they don't want to get all those droids because of the nasty side effects.

So I treat them with estrogen. This is Dr. Talks, real talk from real doctors on the issues that matter to you most. Hey, my name is Leif Onewell and I'm here with Dr.

Peter Fetinos and we are here to discuss an interesting topic, which is the misconceptions that are out there about hormone replacement therapy and I know for myself from my journey through this I had a ton at the beginning thinking they were only thing that women had or or you're gonna give me cancer or all these things that you hear from different people so thank you so much for being here and um I'm sure you've heard them all could can you give me some of the like the the most out there?

What have people told you is going to happen to them or, or misconceptions that people have had from hormone replacement therapy? So it depends on what hormone they're talking about.

Usually for men it's going to be, it's going to cause prostate cancer. If you take testosterone or blood clots, you're going to hear also from thyroid, you're going to get osteoporosis and you're going to get a fib and all these other heart conditions related to thyroid.

For women use is going to be breast cancer from taking estrogen getting it right. Yes. Yep. Yeah. Exactly. Exactly. Getting these diseases as while you're taking some of the, a lot of that stuff's been misproven.

Um, there's a lot of really good studies out there that shows that it's kind of the exact opposite. And a lot of these misconceptions have come from, and I like using this term a lot, conflating, meaning confusing and interchangeably using the two types of hormones.

We have synthetic hormones and we have bioidentical hormones. And what traditional medicine typically does is they think they equate the two. So they think estrogen is primary and progestins are progesterone and they cause the same problem.

But when you look at the research and they divide that So basically they sit and conflate the two. And that's the problem, that's where the issue occurs.

ALICE Let me ask you this, so is it true, then, that the cancer risk is synthetic hormones, or are they okay? Or is that just a… where does that come from?

Y'know. So interesting enough, well, Women was with Women's Health Initiative, and the problem with the Women's Health Initiative It was looking at synthetic hormones, but the study was really poorly done.

Actually, we used to think it was a well done studies, but there's information that's coming out now. Like for example, the women who are a part of the control group, meaning ones that were not supposed to have been on hormones or be on hormones were actually on hormones.

So it pretty much through the whole, the data is pretty much useless because of that. Interesting enough, they used to think that estrogen, even in the form of premarin, which is the synthetic oxygen, that's the one that they get from pregnant Mary urine.

And that's usually estradiol, which is a beneficial estrogen. And then you have multiple animal versions of the estrogens. And is that what makes it bioidentical then?

No, that was not bioidentical. Okay. That one they actually shown in a 28 year study by Chablowski that it actually reduces the incidence of breast cancer.

Synthetic vs Bioidentical Hormones

So this idea that estrogen causes breast cancer is even with synthetic estrogen as pretty much is falling out of favor because the studies are not showing that.

Okay. There are hormones that are synthetic that do increase the risk of cancers, like for example, the progestins, which are what you typically see in birth control.

Those are the synthetic progesterones. Those have been shown to increase the risk for breast cancer. We're now becoming laser focused on what is actually called enhancer.

We're finding estrogen, even synthetic estrogen is protected. I would never give synthetic estrogen because this increased risk for blood clots, but they decrease the incidence of breast cancer.

And then progesterone, which is the natural progesterone is protected against breast cancer. So now we're kind of getting laser focused on what may be the actual two things causing cancer.

So the lack of progesterone or adding a synthetic progesterone. You said something too early, which I want to ask you another question about. I think the fear of cancer for men with testosterone, like this is one of the things I hear all the time.

One of the most common misconceptions is that is going to cause cancer. Yeah. The idea here is prostate cancer. Yeah. And, um, that came from a study back in the 1940s by Dr.

Huggins. Um, and basically what they, that study looked at, and this is how bad at the stud. When you look at it, you're like, why would they think that causes?

cancer, right? What they, they did is they saw what happens to people with prostate cancer. Okay. When they remove testosterone, meaning either they castrated the patient.

Yeah. Either chemically or with estrogen or with something of that nature. You're harsh. Yeah. Pretty harsh or physically castrated patient. It's all what happens with prostate cancer.

It got better. So they assumed that those people would get prostate cancer if you give testosterone. Well, that's not what the study was. The study was what happens to men with prostate cancer when you remove testosterone.

Okay. And they did get better. Interesting. But what happens when you give testosterone? And if you look at most recent studies, studies done way more recently, Dr.

Morgentaler is a big, he used to be the chief of urology at Harvard. He's a big guru on testosterone and prostate cancer. And a lot of these studies by Johns Hopkins, they're actually showing that when you give testosterone, you actually reduce prostate cancer.

And there's two school of thoughts. There's a school of thought of saturation model, which is what truly is what happens with the prostate when it comes to prostate cancer and testosterone versus the fuel of the fire model, which is what most doctors and traditional things.

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Within six months, 96% of our patients report life-changing results. And with our 90-day Excel Advantage Guarantee, you've got nothing to lose. Feel stronger, healthier, and more energized with MelXL.

Okay. What did you tell me? What is it? I'm didn't understand. So, so they saturation models. So the fuel to the IR model is really simple. Uh, the more testosterone you get, the more, the higher the risk for prostate.

Okay. But that's not what you see when you actually see that the models for prostate cancer, when you get testosterone, you see the saturation model. So if I gave you a sponge, right?

Yep. And you put water on it, would it continue to pull in water? No, eventually it's saturated. Once it's saturated, stop. You'll stop. You'll start seeing the water coming out.

Well, that's what happens with the prostate. Prostate does not have. infinite receptors on it for testosterone because it's not an infinite order. It's a finite order.

So up to the 200 level, you will get a stimulation of prostate cancer with testosterone. But once it gets above 200, those receptors are massively saturated and stimulated, and you don't get any more stimulation after that.

So it doesn't go like this, it starts going like this, but why does it start flattening out the prostate cancer risk? And then it starts dropping off.

Oh, that was what I was about to say. So if it stimulates it at all, why would you do it? So you're saying once it levels out, once it gets to 200, you don't stimulate anymore.

Testosterone, Prostate Cancer, and the Saturation Model

And then what you'll see is something funny with the graph. You'll start seeing it flatten out the risk of prostate cancer. and actually the risk drops.

And the reason for that is estrogen. The more testosterone you give, what do you make more of? That's estrogen. And estrogen is apoptotic, which means it causes cell suicide.

So it kills the prostate cancer cells because it forces them to commit suicide. And it also causes a reduction in blood flow to the prostate cancer cells.

And so that's what happens. The more estrogen you get, you start flattening that risk. And then eventually what happens, you get to a high enough estrogen, usually 75 and above, and you'll see a reduction in prostate cancer.

So let me ask you the question and so would it would it would seem logical to me therefore that the treatment would be to increase estrogen. So. Until we got these drugs called Casodex and Lupine, these are drugs that are actually, they're called gonadotropin-releasing agonists.

Obviously what they do is they drop production of testosterone and, uh, via, uh, basically dropping the signal to

these, to send it to your test to produce testosterone.

I mean, that's how they treat prostate cancer. Now that's metastatic. Well, before that, we used to choose a synthetic drug called DES, which is a synthetic estrogen.

So they did use estrogen. They use estradiol, but they used estrogen in the form of DES, which is not great because it does have some of the negative side effects you get with synthetics.

And that's why they try to go away from it. But the reason why we're in Casodexalupron now is because they made money off of it. So they were able to patent them stuff.

But DES is what we used to treat. And a lot of studies that we use when we say, hey, estrogen can kill prostate gathers is DES studies. But if they're now recent studies, now they're showing that estradiol is doing the same thing.

So let me ask you another question. So I know from personal experience, um, someone who's recently had this cancer and the first thing they did was shut down his testosterone was, see that was a mistake.

That is a big mistake. In the sense of you're going to make the man have some of the worst symptoms ever. You don't, when you shut down the testosterone, what are you also shutting down?

Estrogen. And so you're, what's going to happen is most of those drugs work for about a year or so. And then all of a sudden you'll start seeing the cancer come start coming back because you're dropping the estrogen, which is protective.

Also, if you really want to know what a man, a woman goes through, when she goes through menopause, give them those drugs, because what's just going to happen, you're going to drop that estrogen.

You get, man's going to go hot flashes, diet, he's going to get heart disease in the gay weight. His sexual function is going to drop because we know estrogen is integral sexual function.

I have several patients that come to me, uh, they have metastatic prostate cancer that are, they don't want to get all those drugs because of the nasty side effects.

So I treat them with estrogen. those estrogen and they do great and it suppresses their PSA, it suppresses those metastases and it also improves their quality of life because you're not getting rid of the estrogen.

Makes sense. You're just holding the testosterone. What I also do is once I get their PSA suppressed, I add a little bit of testosterone and see what happens because that's going to help them build muscle.

It's going to help them and you just watch their PSA. If their PSA goes up, they may never be able to get all testosterone. If their PSA doesn't get all testosterone, then you could pop it and keep them on testosterone because their quality of life is going to be better.

So why couldn't you put them on testosterone anyway then? You want to suppress their PSA first, and then you want to add in the testosterone. Because most of these men are going to come to you, especially if they're metastatic, they're going to come with a very low testosterone.

Remember, and I told you up until 200, you will stimulate. Understood. You want to give them that estrogen to just suppress the hell out of that prostate cancer that's metastatic.

They're not going to get rid of the metastatic prostate cancer. If it's in their lungs and their bones, it's always going to be there, but you can give them…

They do this with thyroid cancer. They'll give high dose thyroid. medicine to suppress the thyroid cancer because

the high dose thyroid can suppress those cancer cells.

So it's the same idea. You give estrogen to suppress the cancer cells and then you can maybe add a little bit of testosterone and you see how they respond.

If they respond favorably, then you can keep them on and their quality of life is going to get better. But anyways, they already have metastatic prostate cancer.

You're not going to make the disease worse. You're actually going to make it better by giving them the estrogen and the testosterone because their quality of life is going to get better.

They're going to be able to do the things they want to, right? Yeah. I have a guy that's been metastatic for years and they're taking estrogen and they're going to be great and they've added testosterone and they're doing great.

I have one guy. No matter how many times I try to give him testosterone, as I give him, try to keep their estrogen up and their PSA keeps on going up.

And that's my trigger point. If I make your PSA go up with testosterone, you can't get on it. That makes total sense. Yeah. That then to least now, so that under the base of that common myth, that makes sense.

Yeah.

Using Estrogen in Advanced Prostate Cancer

So, so what would you, if, you know, you're a, if you're a male Excel patient, which, you know, there's thousands of you guys out there and you're sitting at the bar and someone goes, Oh my goodness.

Oh, I'm not taking that stuff. That fuels cancer. What, what should they, what, what ammo can you give them? What can you tell them short, sweet in layman's terms that, you know, they're doing the right thing.

So that's the difficult thing that I have to deal with every day. You have to balance with them. And here at MelXL, we only treat with capsular prostate cancer if it's been treated for a year and you've been cured.

Those are more complicated cases and I usually treat them at my other clinic and stuff. But if somebody comes to me and says, oh, testosterone causes prostate cancer, I'll look at them.

I said, no. And I say, this is the research of what it shows. Just because you remove prostate testosterone with somebody with prostate cancer and they get better doesn't mean what happens when you give testosterone.

If you look at all the studies where they give, you don't see an increase in prostate cancer. In fact, you see a reduction because you're increasing that estrogen.

In fact, in men who have prostate cancer, you can reliably treat them. I mean, you can see a lot of urologists now. I have urologists that I send my face to.

They're like, yeah, you can start testosterone on these guys. It's because they understand the science. They understand that testosterone, up until 200 does it level, does not cause an increase in prostate…

up until 200, it does, but after that, you get that saturation model. It's like total sense. I think another misconception is that if you're a man, and you're wanting to get your energy back, just give him testosterone.

And my understanding is testosterone is one of the hormones in a male's body. And like, for instance, since I've been involved with this, I had no idea vitamin D was a hormone.

It's not that simple, is it? It's got to be done in cohorts as a cohesive effort. Could you tell us a bit more about that?

Yeah, you're correct. You know what's funny?

You know, the hormones, they don't work alone. Like if you look at the studies, you'll see men with low testosterone typically had low thyroid. And vice versa, men with low thyroid typically have low testosterone.

They work like a web. And like a web, you're going to make an adjustment on one, you have to make an adjustment on the other. They're going to affect each other.

When one drops, you're going to drop the other. So a lot of people, they talk about TRT replacement. They think testosterone, testosterone is not a male hormone.

It's a male and a female hormone. Okay. Also, testosterone is not the only hormone in a man. Okay. Thyroids in you, estrogen's in you, DHT is in you. Yep.

DHEA is in you. There's other hormones in the male that you have to optimize too. You know, you can't sit there and be sure sighted and think, Oh, testosterone is the only hormone in the person and that's the only one we need to replace.

Yeah. You can do a lot of bad things by doing that. You know, that makes sense. especially if you start blocking estrogen because I was about to say that's where I was going to go next that's a amount of times I've heard well yeah I'm on it but I I take a estrogen blocker yeah which is completely contrary to what you just told me that you've got to optimize your hormones across the board yeah so so tell me tell me where that came from and and in your you know what's your opinion on estrogen blockers So, well, I hate estrogen blockers.

You know that one. I think they have their place in certain things, but not in hormone replacement. Got it. Estrogen blockers. basically block one of the most essential hormones we really don't have naturally occurring estrogen blockers that our body wants to make like fat is an estrogen blocker right okay um because it produces estrogen which fakes your brain out into thinking you have too much testosterone which drops your testosterone which blocks your estrogen from your deshock so but they think because of that they think that that's the problem is that you got got to get rid of estrogen so you can get your testosterone up they've done studies where they've given ai aromatase inhibitors which is an estrogen blocker okay to men to see if it raises their testosterone and it does, but it blocks their estrogen and the outcomes are still the same as somebody being on low testosterone because the active form of testosterone is not testosterone.

It's estrogen and DHT. You want both of those. So where did this come from? weightlifters, bodybuilders. There's a book called an underground book of steroids.

I think David Deschenes was the name of the, or Daniel Deschenes was the name of the gentleman who wrote it back in the eighties. And it was written to kind of teach men how to trick their doctors into giving them hormones and also how to block estrogen to boost the production of DHT because they thought DHT was the most important hormone for building muscle.

Got it. That's not correct.

Why Hormones Work as a System

In fact, their own book contradicts itself by saying the most effective testosterone are the ones that aromatize the most, meaning the ones that change to estrogen the most.

So why the hell would you want to block it? Because they're done. They think that if you block the estrogen, you're going to force everything to DHT. which makes them think that's the most important for building muscle.

But if you look at the Finkelstein study from 2013, that was published in the New England Journal of Medicine, it was a randomized control trial where they showed when you block estrogen, You don't build muscle.

Makes sense. You get fatter and their penis stops working. That's what I've heard too. Cause like one of the most common misconceptions is like you covered earlier, testosterone for men, estrogen for women, which is completely not true.

But I don't think people really understand the role that estrogen has in a man. They're like, I, I've, I'm on your protocol. I'm one of your patients, fortunately for me.

And I take estrogen. I do too. And it was a game changer. Holy cow. Yeah. Yeah. I mean, people don't realize how important it is and all you're not going to grow breasts and you're not going to cry kitten commercials.

That's all bullcrap. I may do it. Yeah. That was before, man. But that's all bull crap because it's all lies propagated by one of this book and by the bodybuilding community to make men or try to get men to get all these drugs to block it towards DHT because they think DHT is the beneficial.

DHT has activity, but you can't build muscle efficiently if you don't have estrogen. The channels that push sugar from outside of your muscle cell to inside your muscle cell require estrogen to function properly.

So what happened with a lot of these guys, and this is why you can see, oh, it's going to cause cancer. Well, if you block estrogen, you're going to get cancer because you're going to get prostate cancer.

If you block estrogen, what's going to happen? You're going to get a penile issues. You're going to have the rectal issues. Why? Well, your estrogen helps blood flow.

It's the main hormone that increases that blood flow to the penis. And this is why these weightlifters cycle. Because they would be taking the testosterone with the estrogen blocker and their penis would not be working.

And all of a sudden, well, they stop it and they start doing HCG. But what HCG does, it mimics a hormone called LH, which causes your testosterone to go up, which at that time they're not taking that shot.

Which makes you, it makes your essence of, which then their penis stops working. So this is why they went into these stupid cycles. You don't need to do any of that stuff.

Just take testosterone, don't block estrogen, add your thyroid in, and you're good to go. You just hit on another one. I hear all the time from people who I know or on the org or HGH, whatever, they cycle.

I'm on now, then I'm off, then I'm on now. Or people do a weekly injection or they do something, they take it and burst. Tell me how you feel about that.

Is that the correct way to do it? No, because you don't make testosterone once a week. You don't make mine on Sunday afternoon. You want to keep your testosterone up.

There is some cyclical to it, but you don't want it to drop below a certain level because it's going to cause you to have symptoms and actually can't put you at risk for a lot of these diseases.

We want to keep these levels sustained. And this is the problem that occurs. The cyclical stuff came, A, from side effects that occurred when you're blocking this stuff.

Yeah. When they make it, you're trying to manage the side effects. The side effects. Exactly. And they think that getting off of it, get on of it, get off of it, get off of it and stuff like, also remember they're bodybuilders.

Their singular focus is building muscle. Yeah. At the detriment of everything else. Makes sense. Okay. Now I just made all this stuff about bodybuilding.

We wouldn't know a lot of stuff if it wasn't for bodybuilders, right? So there is some benefit to that, but I just feel like you got people that are, I call it bro medicine, that are doing these experiments on their bodies and they're not

understanding the studies.

Look at the studies. Quick reading a book that was written by somebody that's just purely thinking about muscle and not thinking about your health. That's what's sad about it.

It makes total sense. I think another one there, what about the role of, you've mentioned a couple of times of women take testosterone.

Estrogen Blockers and Bodybuilding Misconceptions

Yes. What does it do? What does it do for women? Why, you know, I've heard of women's supplement. They're going to grow beards. They're going to end up with, you know, giant muscles.

Is there any truth to that? So do women have testosterone? No, naturally. Well, I of course know the answer is yes, but I bet you vast majority of people would say no.

Yeah. The only difference between men and women on testosterone levels, women typically have 10% of what men have in. Got it. Okay. And so. testosterone is very vital for women.

You know, we know from research recently that it's protective against breast cancer. There's actually a receptor in your breast tissue and when it's breast tissue and men's tissue that protects them against breast cancer.

It causes apoptosis of breast cancer. This is why when you see the triple negative studies where this is where you don't have estrogen receptors, okay, progesterone receptors or HER2 receptors.

Those are kind of the worst cancers to have from breast cancer. That's why when Dr. Glosser, who's a doctor from Wright State, Wright University, Wright State, yeah.

who published the studies on testosterone replacement in women with breast cancer under surgery and stuff. She got benefits even in women with triple negative cancers because they don't check that receptor.

So it's getting testosterone to breast cancer women is good. Now, what you're going to get the argument back is women who have baseline elevated testosterone, meaning high testosterone, but we're not given testosterone, tend to get breast cancer because they have a completely different disorder called PCOS.

Okay. And that disorder, you have a six and a half fold increased risk of breast. This is why this is so complicated and even doctors don't understand it right.

There's a difference between giving testosterone and having high testosterone because you have a disorder. Okay. And so they, again, the term conflate, they conflate the two.

They think, oh, if you have high children, it included all in one group. And they say, high testosterone is high testosterone. No, if you replace testosterone in a woman and you give it to them, it's a protective against breast cancer.

But if they're naturally high, meaning they have this disorder, they're going to have an increased risk of breast cancer because it's a completely different metabolic That reminds me of another common myth.

I hear it all the time is, we treat the symptom, not the level. And, you know, I know everybody, like, it's almost like, I'm a, I have an 800, I have a 900. That doesn't really necessarily mean that much.

No, am I correct? Yes. If you look at the research, the studies have been showing that the blood work doesn't really give us all the information. Because, and I like to simplify for a lot of my patients, There's many factors that can adjust how much your testosterone is in your, in your bloodstream.

Yeah. How much you produce from day to day, how much you reduce in the day. Okay. How your body respond to how your cells respond to the, uh, to the, cause you have receptors that can respond differently, but ultimately that hormone has to get inside of the cell.

Does blood level show you what's going on inside of the cells? No. What's going to tell you what's going on inside of the cells? How you feel. Yeah, that's the ultimate number one thing that we use to main guide.

Blood work we do use, but it's not the end all be all. We've seen that that's been flipped over time where blood work is the main tool we use and hell or high water, no matter what that patient says, patient give you every symptom of having low thyroid.

If that thyroid is normal, there is not the thyroid and that's it. Well, we're finding that's not true. Makes total sense. That actually there's things called subclinical thyroidism.

hyperthyroidism, and that disorder, your numbers do look a little bit normal, like your T3 and T4, but you have symptoms of low thyroid. So what do you do with those people?

Well, if you look at the research, you should treat it because they're at increased risk for having heart attacks and heart disease.

Testosterone in Women and Breast Cancer

So it's safe to say it's not one size fits all then. It depends on your genetics, your lifestyle. I'm assuming also, you know, your activity levels. And I assume also if you tested somebody where you wake up in the morning and you test them that same day, the level's going to be different.

It's going to be different. Do you know why they tell you to test testosterone in the morning? No idea. Because it's the highest and that way you can design more people to.

That's the reason why they do it. I mean, why don't you test it when it's the lowest? Cause that's what you really want to see. But no, they want to do it two times in a seven day period in the morning.

Because a lot of the negative torus hormones is to prevent you from taking hormones. Of course. That's what they want to do. Yeah. Because they think it's harmful for you, but it's not really cause they think it's harmful because they'd rather you be on a diabetic medicine or I was trying to say obviously they'd rather you have, get the disease and then you have to be treated for it.

It's really, that's the The agitation, I'm assuming, is sponsored by drug companies that make nothing from hormones. Yeah. No, hormones, you can't, because the valid interval hormones typically are, you can't patent them, they're naturally occurring.

Yeah. So you can't make money off of them. All right. So let me ask you, I said, this has been fascinating. I've learned a lot. If you could, if you could give one last thing on, you know, a, the truth of why hormones are essential to people and what the average person in the street should know about them, what, what would it be?

What's a, you know, the most common myth that you think people should learn about hormones? Uh, I think more so that it's the missing link. Everybody tell me, so what that mean by that is everybody, like a lot of my patients that come to me, they're already dieting and exercise.

They're, ah, they're gone. And they're like, why, why, why all of a sudden I'm gotten older and I'm not seeing any difference. Like I'm now, I'm now eating less food, exercising more, but I'm gaining weight.

I'm starting to get to all these, these issues occur. And that issue is, is that these hormones that naturally are in your body are starting to drop off for various reasons.

And that's why you're breaking down. Makes sense. But you're going to, this is starting at 50 years of age. How long do you got to live for? 80, 90, right?

100 foot. So we're on our way to God. Yeah. And then there is no answer from traditional medicine. They say, this is normal. You're supposed to have to go through this.

And also, the more and more research is showing that muscle is like, when you get older, it's one of them, it's the thing that stops you from aging, right?

It's not even that. It doesn't stop you from aging. They've shown that lean muscle mass, they've shown the amount of lean muscle mass is correlated to longevity.

So more lean muscle mass you have on your body, the longer you're smoking, you will live. Yeah. I know we're supposed to wrap up, we're out of time, but I couldn't help but notice that a FDA warning for heart disease.

No, no, it's not heart disease. Blood pressure, blood pressure, they remove heart disease.

Symptoms, Lab Values, and the Real Meaning of Hormone Therapy

There's a rare study. Yeah. But when you look at the study, I know it was significant, it just makes me laugh. You know how much is, based on the study, how much increased blood pressure by on average?

0.3 millimeters, not mercury. What that means is your blood pressure is 125 over 80. It on average will increase you 125.3, how do you call it? This is what we have to put up with.

So now that is put on as a black box warning that increases the abutory blood pressure at walls. So yeah, no, no, it does increase it with a blood pressure based on this study.

They want splat block warning on testosterone because they want people on it. They took testosterone causing heart disease and blood clots off because the studies have not shown that.

In fact, they haven't shown the exact opposite. But because of that study, the Traverse study, they actually put on there that increases ambulatory blood pressure.

Now, I've looked at the study. That's the only thing I see on it. It's 0.3 millimeters of mercury. And actually it's funny because it kind of sounds like a rounding error.

Yeah. And you're looking at like, really? But we have to say it. And every time I say to my patients, yes, it has a black box warning that's going to increase your risk for ambulatory blood pressure, but the risk is 0.3 millimeters of mercury.

I'm going to tell them that I'm not going to tell them, Oh, it's going to be 15 or 20. Cause I'm going to tell them the truth is 0.3 millimeter mercury.

Let's go with 125 over 80 to 125.3 over 80.3. Well, doc, you've really uncovered a lot of the common myths today. I know I learned a lot and I'm hoping everybody out there did too.

Thank you so much for being here. Thank you. Very appreciative. Thank you. Yes, sir. 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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