I Changed My Mind About GLP-1s: What You Need to Know About Ozempic, HRT, and Longevity Transcript

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Reconsidering GLP-1 Medications

Welcome back to Menopause Mastery. If you've been listening to this show for a while, you know that I pride myself on foundational pillars, bringing you unbiased evidence-based bioy.

And secondly, being willing to say the quiet parts out loud. Today, I'm actually making a confession that I've changed my mind about something big. If you go back to my original podcast episodes a couple years ago and read my commentary or listen to my commentary about Ozimpic, WGO, Zepbound, GLPS, GIPs when they first exploded onto the scene into mainstream culture, you probably heard me express some pretty deep skepticism. And let me be clear, I was not really skeptical of the underlying science about how these medications work. I was really worried more about and frankly what still sort of angers me is the wild west of prescribing and when it's being used inappropriately and the and the guidance that should go along with these medications isn't actually being given.

You know, we created a culture where women in pmenopause, you know, could log into and fasttrack a tele medicine company, fabricate height and weight, and get a high dose of GLP1 on a prescription sitting in her doorstep within 30 minutes with no blood work, with no actual verification of the data, without even a visit to confirm and have conversations about how to use these medications safely. and then also how to make sure that you're getting the right medication and the right guidance for you to have the actual outcome you deserve. And especially when we're not ne giving good dietary recommendations and things like resistance training and evaluation of your ovarian and hormone status, we now a couple years later have a lot more data about how these medications work, how to utilize them prop appropriately, and how to especially use them in midlife women because you know what, the most common uh people being prescribed these medications are midlife women. And so I was vocal and I called it out. But you know, science is not a static dogma.

It's always evolving and it's the conversation's always evolving. And over the last few years, some clinical trials have really expanded exponentially. And now we have more robust long-term data on cardiovascular protection, chronic kidney disease, systemic inflammation, hypertension, neuroinflammation, even addiction. And simultaneously, we have more forward-looking clinicians that have completely shifted how we really are using these medications as tools. So, today I want to set the record straight. I want to help vindicate these medications and where they're being used correctly.

Midlife Hormones and Metabolic Change

We're going to talk a little bit about uh why semigloid tepatide and the new to come to the market retreatide can be used and dosed and where are all the little sort of uh caveats coming in about dosing and what do we know and what do we not know and especially what does the most recent research say about using it with hormone replacement therapy in the midlife woman and how these instruments can be used for longevity. So grab your notework notebook. So grab your notebook. Let's dive in and let's dig in. All right. To understand why GLPS matter in midlife, first we have to talk about what's actually happening in your body in midlife between the ages of 40 and 60.

For decades, women have been told, "Hey, you're gaining weight in midlife. You're eating too much. You're moving too little." And I think we need to put a kaibos on that whole idea. It's patronizing, medically inaccurate, and ignores fundamental changes to the endocrine system. When you enter pmenopause, your ovarian production of estradiol begins to fluctuate wildly before ultimately dropping. And that dropping is even before you actually hit where your periods stop. You're actually still having cycles, but your overall estrogen level is either highly variable or actually lower than what it was. And when that happens, estradiol isn't just a reproductive protective hormone. It's a master metabolic regulator. And estrogen sensitizes your cells to insulin, protects your blood vessels, maintains

mitochondrial function, and also regulates how and where your body stores fat. And as estrogen declines, we know that it causes more insulin resistance. Even if your diet hasn't changed, your cells become less efficient at utilizing and clearing glucose from the bloodstream. fat distribution shifts. It's not only on your butt and thighs and abdomen. It actually shifts to visceral fat deposits where you get a widening of the of the actual waistline. But that visceral fat tissue, the deep fat surrounding your organs is more pro-inflammatory.

And because of this we get inflammatory systemic inflammation inflammaging a steady lowgrade elevation of inflammation and inflammation signaling with molecules like TNF alpha and interlucan 6 that increases our overall systemic inflammation and that's why we also see the increased risk for cardiovascular aging neuroinflammation and and and degeneration and even bone loss and that's why you can do everything right and run that extra mile, cut out carbs, fast for 16 hours, and it still feels like your metabolism has put on the parking brake. Mainstream medicine offered really two terrible solutions.

They either tell you to accept aging and hand you a max dose GLP um and they might titrate you, but they might just hand you that medication, say go um and in many cases that medication makes you so nauseated that you live on bone broth and crackers. I know because I hear it all the time in our clinic um as people come in on these medications and they're struggling and it also can destroy your remaining amount of muscle mass if you're taking these medications without being able to maintain enough protein and exercise in the diet. And so neither of those options are really acceptable and it's where precision really is required. So, let's talk about what these drugs actually do. Because calling GLP a weight loss drug is like calling a smartphone a pocket calculator. It severely understates what these actual peptide hormones do. So, GLP-1 is glucagon like peptide 1. It is a naturally incurring hormone called an incretin produced in your gut and your brain. And we've known about these hormones since the late 1800s. And we have receptors for GLP-1 that exist throughout your entire body. Your hypothalammus in your brain, your mioardium around your heart, your renal tubules, which are in your kidneys, your liver, your blood vessels, and your immune cells. And here's what the research shows beyond the scale.

Systemic inflammatory actions are actually part of the mechanism of this drug. In major clinical trials including outcome studies looking at semaglutide and proceepide researchers notice that something remarkable happens. Markers of systemic inflammation specifically highly sensitive C reactive protein drop significantly.

And here's the critical detail. The inflammation drop occurs independent of weight loss. So that's really important. It is not a side effect of weight loss which a lot of people were proposing early on. It is independent to weight loss. So the GLP-1 receptor activates directly the down reggulation of inflammatory cytoines NFCappa B which is the central switchbox for chronic cellular inflammation. It cools down the vascular walls. So it actually slows vascular inflammation and aging and reduces neuroinflammation in the brain and reduces inflammatory signals in your fat tissues which makes you more insulin sensitive. So when we look at the cardiovascular and kidney renal protection, the data confirm that GLP-1 agonists reduce major adverse cardiovascular events, heart attacks, strokes, cardiovascular death while slowing the progression of chronic kidney disease. for midlife women whose risk of cardiovascular disease rises sharply like an uphill you know hike after menopause due to the loss of estrogen and estrogen's vascular uh protection this organ protective benefit is a gamecher right so GLP1s act independent and reduce these other chronic uh cardiovascular risks that coincide with the loss of estrogen in midlife women Now, here's what I think is even more important.

How GLP-1s Work Beyond Weight Loss

The powerful combination of GLP1s plus hormone replacement therapy for pmenopause and menopause. This is where the magic can really happen. Estrogen and GLP1s work synergistically in the central nervous system to regulate satiety, regulate energy expenditure and glucose handling. And retrospective and clinical data, including recent observational data from institutions like Mayo Clinic, demonstrate that post-menopausal women taking both hormone replacement therapy and a GLP-1 receptor agonist like Ozepic or Wagobi, Semaglutide throughpatide show a higher loss of body fat mass and maintained better metabolic stability than women taking a GLP1 alone. Why?

Because bioididentical hormone replacement, specifically estrogen, helps preserve muscle protein synthesis, supports bone mineral metabolism and bone mineral density and keeps baseline metabolic rate intact while the

GLP1 addresses insulin resistance, visceral atyposity, and central food noise. And I'm going to tell you estrogen also when used appropriately in a pmenopause par and menopausal woman helps with insulin resistance too because it increases insulin sensitivity and it reduces visceral adiposity because it also reduces the inflammatory response of atapost tissue and can be so very helpful. So when you combine these together you're not starving the body you're actually restoring youthful cellular signaling. So here's some things too that are very very interesting.

In many clinical practices, a lot of doctors and prescribers have been using these GLP and GIP1s off label at different doses. Right? So we know from the research data from the actual clinical trials that for many people there are GI distress symptoms everything from nausea vomiting to gastroparesis to a host of different symptoms and for some people taking these medications even at the lower approved doses prove to be symptomatic and and unattainable.

Right? So there's a distinct group of people where women are actually using these in a different dose escalation therapy off label through compoundingies.

Now this is not what the FDA approved them for. This is not how the drugs were actually delivered through the brand names. However, what do we know anecdotally from the data of people that are doing a different dosing? Okay, so the commercial dose escalation world, right, where these medications from the approved studies, they usually start on a standard pharmaceutical titration schedule where they scale up every four weeks to a maximal dose of like a 2.5 milligrams of semiglutide or 15 milligrams of um so what we see is depending on the study and depending on the feedback a lot of times this is where we start to see exhaustion, chronic nausea, or it's really hard to choke down 800 calories a day because you've lost every bit of hunger and this is where we start to see a loss of significant muscle tone when we sometimes hit these higher doses. Um, but this is where the weight loss really occurs. And so for a lot of women, we start to see hair loss. And long term, we see metabolic rate that can be changed, right? And so for many women, this is when we get into the caveat of, hey, I can't handle these medications, but I want these medications because it's killing the food noise for the first time. And I was seeing really weight loss, but the ever escalation of dosing causes too many symptoms, right? So this is where a lot of practitioners have started micro doing or lowd dose targeted therapy instead of pushing the dose to cause this severe appetite suppression or or you know all the symptoms many are actually doing sub therapeutic minimum effective dose. So what does a micro dose do?

A micro dose is a dose significantly below those starting doses of turseptide saglutide and what it is intended to do in most cases I don't prescribe I'm just talking about the either the anecdotal data and what has been reported is what they're doing is getting a therapeutic level to turn off the intrusive food noise. This is probably one of the most significant things that we see in the research on these drugs is the turning off of the addictive patterns that happen in our brain. We know that they are there.

GLP-1s, Hormone Therapy, and Microdosing

This is hypothalamic control that have to do with satiety and hunger signals. Well, what's really interesting is when we look at these drugs, they also do that with alcohol and other addictive substances. So, one of the most powerful effects of these medications is this food noise and craving, right? So for the people that get that effect, but the medication at the standard doses cause nausea and vomiting when when a micro dose is used, it can be used to shut off the food noise but maybe not induce that appetite activity entirely. Um, so what ends up happening is we get a suppression of that food noise, a better appetite control, an improved post-eing blood sugar spikes and enhanced insulin sensitivity without the nausea, vomiting, and fatigue. And it can deliver [clears throat] an anti-inflammatory benefit that might help with vascular tone and things like overall inflammation, and even joint pain. We don't have clinical data that's proved by the FDA to say that, but we're hearing that anecdotally from the individuals that are prescribing in these lowd dose arena. And what it does is also allow women to eat a little bit more food, but still see the positive effects of these medications and especially getting to that 120 gram minimum of protein a day because this is the part that even two years ago I was very concerned about. It was the um just overall loss of hunger. And even I did it. I mean, I did an entire podcast saying, "Okay, I'm going to try these medications and see how it feels." Cuz Dr. Amy Hornman, a good friend of mine, was like, "Betty, you haven't taken these meds, but you're lambasting them." So, I did. And the first dose, I didn't really feel anything, right? That first level dose. But as soon as I titrated to that next kind of therapeutic dose at the pharmaceutical level, I was so nauseated. And I could

promise you whenever I put a piece of animal protein in my mouth, it was everything I had to actually choke down a couple ounces. It for me it was very very difficult. And I was like, this is unattainable. I can't I can't take these medications and also fight through a piece of chicken breast, right? And so my concern always back then was how do you get in that protein amount that you need when that's the one food you absolutely don't want? And so for a lot of practitioners that have been micro doing over the last two years, what they're finding is they can get that sort of benefit without actually moving the dose so high that it starts to impair the intake of protein, right? And it also allows women to still hit the gym and hit the weights. Because the other thing is is if we're undereating calories so bad that we're losing weight rapidly, which is a lot of what's driving the significant kind of skinny talk and the other things that we're seeing, we're also losing muscle mass if we're not hitting the gym, right? And that's already an uphill battle in midlife. And so, you know, we had a a woman that I talked to last week, which is really what prompted me to talk about this medications and kind of how I feel about it today. And she was 52 years old, permenopausal, and she had all the things, all the inflammatory things, elevated, highly sensitive C reactive protein. You know, her in fasting insulin was getting higher. Her ceptide, which is the precursor that kind of holds on to insulin before it hits the bloodstream, was elevated. and she picked up a steady 20 pound gain around her waist mostly and was experiencing joint pain which is part of that musculark eeletal syndrome of menopause. when we looked at her lab work at the clinic, what we noticed um is that you know there's a lot going on and medically our medical team here put her on a lower dose of GLP and we optimized her her estradile and oral progesterone and used a lower dose of tzepatide and then adjusted a protein target to 1.2 g per pound of lean body mass. Right? So in that case where we're looking at, you know, 100 to 120 grams along with 3 days of heavy heavy ins uh resistance training, you know, so here's the thing that was a great plan for her, right? And we're going to see 6 months from now to, you know, what her relative joint pain was. We know that joint pain actually improves with hormone replacement therapy. It improves actually with weight training. Oddly enough, the thing that you're most worried about, weight training, increasing uh joint pain actually reverses joint pain. And we also have arthritic studies that show that more physical activity and especially more weight and resistance training makes the pain better. And then you add the anti-inflammatory effects of turepide and what we're going to probably see is that her fasting insulin is going to get better. She's going to have weight loss and we're going to see especially visceral fat loss because we've seen it before, right? This is part of metabolic engineering, right? Metabolic engineering looks at not just adding to weight loss because everybody's worried about what's on the scale. It's actually turning back and turning on the things that are changing in midlife like the hormones and improving glucodon type one peptide and the receptor activity so we can kind of engineer the metabolism to work as if it did several decades ago, you know. So if what's the PLA practical translation of this? What's the advocacy you could do? So and and if you're thinking about it and you're like, "Okay, maybe I'm not on hormones and maybe I should be on hormones or maybe I'm not on a GLP1 or one of those medications or maybe I tried them and they made me feel that crap and I couldn't do them, but I I also am envious or andor sad that I can't take them." So here's some of your framework for your own self- advocacy. So how to think about that? So, first I always I you know even yes like if you're permenopausal and you're symptomatic that enough warrants getting treatment, right? You don't you don't have to have labs. However, I really like knowing where I'm starting, right? It's kind of like a map. You can't get to where you're going if you don't know the first left or right that you have to take. So, I do like getting data. So, what data would be helpful for you if you're if you're thinking about sort of re-engineering your metabolism? First and foremost, it's I recommend getting a DEXA. So, a DEXA does your body composition and your bone mineral density. Now, some places may only do bone mineral density. Some places can do both. And what I recommend is if you can get to one that does both, that would be advantageous. That's what we do is we look at both because DEX is going to have a much more accurate assessment of your body fat, visceral fat, and lean muscle mass and where it's distributed.

Labs, Protein, and Resistance Training

And then obviously the DEXA scan, if you've never had one done, you should have one done because that tells you your lumbar and and femur level of bone mineral density, which is extremely important. we lose bone mineral density through pmenopause and menopause and we don't want to do that. But it's a very important part of establishing particularly your lean muscle mass and fat mass so you can pay attention to where you're losing it from. I also think it's really important to get a full metabolic panel on your blood work.

That also includes things like your fasting glucose, your fasting insulin, your hemoglobin A1C, your lipids, and your lipoprotein, apo lipoprotein B, and apol lipoprotein A1. That tells us along with your triglycerides kind of what your

cardiovascular risks are too. And are you brewing insulin resistance? Are you having glucose management problems?

What's going on there? because a fasting glucose is not enough to understand that. And I think it's really valuable to get inflammatory markers, things like HSCP to understand what's your general level of inflammation, particularly from a cardiovascular risk. And even if you're in pmenopause, I also like to see an estradiol, a progesterone, a total and free testosterone, and a full thyroid panel.

TSH, T4, T3, free T3, free T4. your thyroid antibodies and reverse T3 if you can get it because thyroid is often along for the ride on this situation and we want to understand it and if you can get a DHEA sulfate and cortisol now we have a much fuller picture of your metabolic hormones that have a lot to do with what's going on along with your sex hormones and your thyroid. All [snorts] right so when you have that that gives you your first stop sign what's going on with your body. Now we have to really look at a muscle centric protocol, right? You know, Gabrielle Lion talks about muscle centric medicine. Um, you know, everybody under the sun is talking about it, Stacy Sims. But when you're looking at putting in a GLP-1, we have to anchor that GLP-1 therapy with protein minimums, right? And protein minimums are 1 to two grams per pound of targeted lean body mass, right? So that puts most women squarely in that 100 to 120 grams is the low end of the scale, right? We had a study that came out last year that looked at protein intake and showing just having more protein intake in a woman in midlife improves muscle protein synthesis. However, that can be lost when there's not resistance training. So we got to make sure we get enough. If you're going to the gym, you got to make sure you get the protein to actually make the muscle, right? So, your protein minimums are that one to two one to 1.2 grams per pound of targeted lean body mass. And our target lean body mass is at least 100. And we need to do progressive resistance training. You know, lifting three to four times a week. And you can you can create harder lift mechanics by either raising the weight and reducing the number of repetitions you do or by increasing the number of repetitions and keeping the weight lighter. Here's how you know which one to do. Number one, don't lift heavy weights if you don't have people spotting you. You don't want to be doing this on your own where you might cause injury because that sets you back. Now, you can increase the number of repetitions, add a lower weight, and make it harder. How do you know whether those weights are at the right amount?

The last two reps should be really difficult because that's where all the growth grows, right? And if you can add, you know, once a week or once every 10 days, a weight training session that is lower repetitions, heavier weight, big compound movements, squats, deadlifts, you're going to get more muscle growth that comes from that. Both will increase strength gains, but muscle growth actually is slightly improved with those lower repetitions and heavier weight.

But what you want is that mechanical signal for muscle protein synthesis and muscle tissue growth along with your osteoblasts that tell your bones to grow. Right? So, we have to make sure that we're playing paying attention to that before we put in GLP ones, right?

That that's part of the picture. And if you're looking at can I do these right so first and foremost hormones have to be part of the picture GOP ones GIPS absolutely can help with food noise reduce inflammation and help with the weight loss picture. However, hormone replacement therapy not only gets rid of hot flashes and night sweats and might help with your mood, depression, anxiety, brain fog, palpitations.

Menopause has a stiff arc of aging and we know that there is this kind of increase that we see that's exponential when we hit 40 and a lot of that is the hormone chaos and probably the most powerful longevity thing we can do is replace the hormones that are missing because of loss of ovarian function and so when we put those hormones in and we stack a GLP and especially for somebody that might need a GLP that is um micro do so we get the anti-inflammatory effects, but we don't induce some of the digestive and nausea related symptoms.

You want to make sure you're working with somebody that can see both. So, you want to ask your do your provider if you've tried the medications before and they're too much. Ask if you can start a low dose. Ask if we can evaluate my inflammatory glucose levels, my appetite response before escalating the dose.

Because what you may find is that you're getting metabolic improvement without having starvation.

Self-Advocacy and Longevity in Midlife

And like I said, this is this is not the FDA cleared doses, but lots and lots of functional medicine practitioners are using these lower doses to help out. But I what I would say is that the GLP1s help when we have all of that other stuff dialed in. And they are exponentially better when we have the hormones on board to actually improve all of those other activities of aging.

And you know this entire conversation is kind of how I came full circle to creating the Manurva project because the Manurva project is not only Manurva Tele medicine which is providing hormone replacement therapy and thyroid support in all 50 states but it's also my research and my own experience navigating perry menopause. If you've heard my story before, I gained like 30 pounds as I went into pmenopause from a tubal. And it was kind of this acceleration that happened. And it wasn't until I went back and started digging through the research and understanding the impact of these hormones on our actual metabolism that I was able to sort of reverse gears. And it was really as I embarked on actual menopause that I was able to kind of get this under control, lose the 30 lbs, and I been able to keep it off for over eight years. But the reality is is for many many women and generations, women's health has been plagued by this binary thinking. We either given no options or told that our symptoms are just part of aging and we are handed either quick fix pharmaceut pharmaceutical band-aids that are stacks of medications that completely ignore female biology or we've been under under reppresented even in the brosphere longevity research and metabolic research for far too long.

And so either we're applying men's doses or doses that don't really work in a combined therapy sort of way or we're just driving without instructions. And that's really where Manurva, the data and technology and research side is coming. It's coming. It's coming ladies.

I promise you because the reality is is we have decades of gap in women's research from the women's health initiative. But we have over a hundred years of ignoring women's health to begin with. And it really requires us understanding not only what's happening in imperry menopause and menopause, but capturing data and applying more research directly to women today and not waiting decades for double blind placebo control trials of every single thing.

Because if that's the case, I'm sorry, the boomers and the Gen Xers will be dead long before we ever get there. And so we don't have to apologize for wanting to feel great and energetic and also lean in midlife. And you don't have to choose between having all natural solutions. Yeah, I said that too that I was just going to handle my pmenopause and menopause with nutrition and good lifestyle, which is complete and utter because you can't replace the hormones that are missing when your ovaries stop making them. And so we can be natural and there's nothing more natural than replacing the hormone that your body is no longer making because our body hasn't caught up to our longevity yet. And we can use modern biochemistry to do that. True Healthspan architecture uses every validated validated evidence-based informed tool available. Even if that evidence isn't double blind placebo control trials, when they're done intelligently, safely with a care team that is listening to you and also capturing data, utilizing data, and utilizing emerging research, we can do that respectfully and we can also do that while we actually make a difference in the science of longevity for women. So, as we wrap up today's episode, I want to leave you with three questions to reflect on this week. Number one, are you measuring your health progress by arbitrary numbers on a bathroom scale?

Are you trying to get back to the woman you used to be? What we need to do is get to the woman you're supposed to be right now. Right? If we're having that conversation about who you used to be, we're still playing in an arena where we're not recognizing that the game has changed. Right? or are we looking at our muscle strength and our strength overall and our cellular inflammation and our overall longevity health? That's that's where we want to put our focus on. Is our medical provider working with us as an intelligent partner or handing you cook cookie cutter solutions or being dismissive of what you need, right? and being willing to maybe go into the gray sometimes to help you navigate your health. And I'm not talking gray market, right? I'm not talking gray market. What I am talking about is that they're willing to sit in the emerging science because we cannot, in my estimations, this is my opinion, we cannot let the boomers and the Xanaxers of which I'm a part struggle because we want pharma and NIH to fund a study. We get less than 1% of all fundable research dollars in midlife. If we wait for that, we'll all be dead. And what would happen if you stopped viewing metabolic support of a failure of willpower and started viewing it as an

opportunity of proactive longevity care? Because it isn't a loss of willpower. It isn't your lack of willpower. It is a biological, biochemical, physiological change to your body of which you're trying to navigate. And in most cases, your medical providers are navigating with old technology or crap that was made for men. So if this episode has changed the way you think about metabolic health in midlife, I know I have created a lot more opportunity for these weight loss drugs in a broader scope because I've been watching the emerging research and watching patients within our clinic and within tele medicine navigate this experience.

You know, think about this. If this has really changed how you think about metabolic health in midlife, please share it with a friend, share it with a sister, share it with somebody who needs to hear it because you don't want to navigate this alone and you don't want to let your good friends navigate it without help. And I want to thank you for listening to Menopause Mastery. You know, it's literally why I do what I do.

I want to make sure that we're all having the most amazing midlife possible. And you know what? If you're listening to us on your favorite podcast platform, don't forget to leave us a review.

That's how we get found. And if you happen to be watching this on YouTube, don't forget to subscribe and leave a comment. And until next time, keep asking better questions, demand better data, and own your midlife mastery.

See you next week. >> [music]