PCOS Relief: Learn About Cyclic Progesterone Therapy Transcript

(Transcripts are generated by AI and may contain errors)

Introduction and Lara Bridenu2019s background

Hi. Welcome to this episode of the PCOS Summit. I'm your host, Dr. Felice Gersh. I'm here today with renowned hormone expert and naturopathic doctor Lara Briden.

Thank you so much, Lara, for joining me. You have over 25 years of experience. You've written several bestsellers, the Hormone Repair Manual and the Period Repair Manual, which I have read and loved both of those books.

So I know that understanding menstrual cycles is such a key part of what you explain to your audience or your readers, and when you give lectures and all the different things that you're doing, I know you're involved in so many different advisory boards, and I hope you'll share that with us.

So I want to delve a lot into what is a menstrual period. You know, we talk about them all the time, and many people don't really understand their importance and what's really going on in a menstrual cycle.

But first, I'd like you to tell us about your journey in your involvement in women's reproductive health. Thanks, Dr. Felice. It's so nice to get a chance to chat with you again.

I really hope we can meet in person one day because we have so much in common. Our shared love of female hormones. So I came to this work. I was a biologist before I became a naturopathic doctor.

And I was it's funny because I was looking back at the scientific paper or a couple of scientific papers I wrote 30 years ago about sex differences in animal behavior.

And I realized way back then I was already very interested in female physiology and what that means. And so that has that was my journey. And then I became a naturopathic doctor and I worked with patients, as you did through the years.

That's how you really learn about female hormones, isn't it, seeing what happens on the ground with women. So, yes, I'm very passionate about female hormones and about the menstrual cycle because that's how we make female hormones.

I mean, I guess that would be my starting point is a menstrual cycle is not an add on. It's not a separate optional part of histology, I would say it's it's it's an integral part of how during our reproductive years we make both estrogen which is very important, a wonderful hormone and progesterone which we're going to be talking about today, which is like the Cinderella of hormones, is kind of the forgotten hormone sometimes.

And it plays a very important role in PCOS. Well, absolutely. And we both agree that the menstrual cycle is not an add on. It's like intrinsic to what a woman's body is doing and her overall health.

And as I have said, like, I guess a million times by now, whether we like it or not, this is what it is, fertility reproduction. These are intrinsic parts of what a female body is designed to, to have and to do, and that involves a healthy, functional set of ovaries and a menstrual cycle.

So I was hoping for people out there who, you know, we talk about with women with PCOS, one of the cardinal findings is irregular cycles. So what is, you know, just from, you know, the basics.

What a menstrual cycle is and why ovulation matters

What is a menstrual cycle? What hormones are being produced? How is this happening? And then we'll talk about why it's important and what's happening in women with PCOS.

Yeah, great question. And I'll just clarify and I'm sure you agree, the menstrual cycle and our reproductive system is important. Even if we never have a baby, even if we don't want to have a baby or never do have a baby.

So it's not I think the narrative has been, oh, you know, until you're ready for a baby, none of this matters. But, you know, my message would be it very much matters.

So an answer to your question, what are the basic mechanics of a menstrual cycle? It has to start with ovulation because that is the as you say, that's one of the key features of PCOS potentially is not ovulating regularly.

So ovulation, of course, people know it's the release of an egg, which is, you know, if you wanted to make a baby, that's important. But it's not only that, it's also the key event in a menstrual cycle.

It's the key hormonal event. It's actually what defines a menstrual cycle. It is possible to have bleeds, even somewhat regular bleeds without having ovulated and those are called and ovulatory cycles.

And I know that's kind of a technical sounding word, but I always encourage my followers to learn the word and ovulatory, which means without ovulation, because that's not just for PCOS, but for PCOS, that's an important part of what's going on.

So in a healthy ovulatory menstrual cycle where ovulation does occur, we have during the bleed, which is the first part of the menstrual cycle a day, one of the bleed is day one of the menstrual cycle.

That's like the big reset when everything starts over and we have very low hormone levels at that point, very low both estrogen and progesterone, that's entirely normal levels are as low as actually menopausal levels at that time, which I think sometimes if patients see a blood result when they see very low estrogen, that they can be quite scared by that.

But that's normal. If it's if you're early in the cycle and then the communication between the brain and the ovaries starts and these hormones from the essentially from the part of the brain called the hypothalamus and then through the pituitary.

And you don't have to remember those terms at all. But there's a couple of hormones called FSH and LH and they start talking to the ovaries and that process takes a couple of weeks.

Depends on your age when you're young, that can take quite a long time. It can take three or four weeks to achieve ovulation. When you're older and typically in our forties, it is a lot quicker.

That's why our cycle shortened because the brain is a lot louder at that point talking to the ovaries. But yeah, the the conversation begins and if all is going well, ovulation will occur in response to that.

And in the build up to ovulation, we make lots of estrogen. That's really good for us as we get our peak estrogen just a few days before ovulation. That's all coming from the ovaries.

And then if all goes well and we do ovulate, then we make a huge amount of progesterone. Like it's actually we make 100 times more progesterone than estrogen in a healthy menstrual cycle, peak progesterone, which is quite astronomical.

And we don't you don't see that on the typical representations of the menstrual cycle because they always scale them to look roughly equivalent. But we make it just a giant amount of progesterone and we only make that for two weeks unless we're pregnant, of course.

And then the whole system is rescued and changed and carries on. We have then high progesterone throughout the pregnancy, but if you don't conceive, then that progesterone can only last two weeks because the little temporary gland in the ovary that makes progesterone has a what I call in my book The Lifespan of a Butterfly.

It's, it's only with you for a short time and then progesterone drops away and that is partly what signals the next bleed. But I do want to emphasize, because so many of my followers have said they know, they know, they've learned that the drop in progesterone triggers, the period.

So then they're confused about how you can have a period. Without that, you still can you can have a bleed without the up and down of progesterone. So that's important to know.

One of the things that you said that is very important, I think, to emphasize is that whether or not you want to become pregnant, the menstrual cycle is key to female health and wellbeing.

Humans make determinations about what they want to do, about when they want to have families, and that's what we're all about, you know, is making personal decisions.

But it is so important to understand that the menstrual cycle, whether or not you want to become pregnant, it's intrinsic to our wellbeing during these reproductive years because the menstrual cycle and these vital life hormones, I've actually changed their name from sex hormones to life hormones because they do so much more than just a reproductive function.

They have these hormones have reset, enters and functions all over the body and the rhythm of the menstrual cycle is key to so many different things happening in the body.

And one of the things that's so important that I'd like you to touch on is how these rhythms of hormones matter, you know, because so often women with PCOS are treated with oral contraceptives, which get rid of the rhythms and of course they're not human hormones.

And maybe you could just touch on like the interplay, like you mentioned, like high progesterone and then changes in estrogen. You know that these rhythms are important to how the whole body functions and key to having ovulation even occur, that you can't have a static level and then end up with an egg coming out.

Absolutely. Yeah. I couldn't agree more about the life hormones. It's a lovely phrase release. Yeah, that's really nice. Well, I guess one thing to consider is we are cyclic beings, as we've said.

So establishing regular ovulation and ovulatory cycles is an important part of the maturation of the hormonal system. So the problem was shutting it down with oral contraceptives, which is what it does essentially it temporarily and reversibly switches off that viability process that I've just described and flatlines both estrogen and progesterone.

Hormone rhythms, birth control, and testosterone balance

One of the problems with that is it doesn't allow that maturation of the communication between the brain and the ovaries, which according to some research and I have the citation for that in my book period of her manual, it takes 12 years to mature that.

So which is pretty interesting. So if you get your first, you start getting periods at say 13. I know often it's a little bit younger these days, but let's say 13 years old, then you won't have fully matured kind of robust ovulation or fertility or progesterone levels until you're 25, which kind of fits right.

Like that's about sort of peak fertility would be around early to mid twenties. But unfortunately if you if you switch it off, it can actually take some time to kind of get it all going.

So I've had I'm sure you've had the same I've had many patients who might have been on the pill since they were like since they were 13, possibly. It's not unusual to put young girls on the pill now and then if they stop the pill at 31 hoping everything's just going to like snap into place, that is often.

Yeah, not going to be the case. So that's that's one reason that's at least one of my main concerns with the pill is

the way it flatlines hormones and robs women's women of their own hormones.

But to acknowledge, just to give a nod to why the pill is prescribed, of course, is that it does pretty reliably suppress testosterone or androgens, which is one of our obsession with we're talking about PCOS.

That has to be one of the clinical goals is to suppress testosterone and the pill can do that. But one thing I want to mention at this point in our interview is that progesterone also does that.

So progesterone, it has both actually both estrogen and progesterone have natural anti testosterone affects. Progesterone does via several mechanisms.

And it's even been proposed. It's quite interesting actually, because I'm an evolutionary biologist, so I do always see things through the lens of, you know, how the systems develop.

But teenage years, most teenagers. Would you agree, Dr. Felice, that like in our teenage years, most girls are kind of in a sort of temporary state of the US anyway.

There's an androgen or testosterone sort of dominance happening before ovulation kicks in. They might have mild insulin resistance around those early puberty years.

That's pretty common. And then the maturation of the menstrual cycle and arrival of progesterone is what helps to push down on testosterone and essentially mature the menstrual cycle.

So if you don't allow progesterone to come on, come online, come on board, then you know that's going to contribute. And to be fair, there's lots of, as you know, lots of factors in the reason women develop androgen excess or PCOS or testosterone.

There's lots of prenatal, genetic and epigenetic reasons that happens. But in the natural system, progesterone is part of our natural anti-androgen maturation process.

Well, absolutely. And some of the really key things that you touched on is what would be called like a feedback system. Right. Which a lot of people don't really know about that hormones have receptors and that these receptors are not like a lock in a door.

They're not fixed. You know, that sometimes people use the analogy, the hormone is like the key and then the receptor is like a lock. But that's not really the way it works because receptors are very dynamic and they're, they're like shapeshifters, right?

So they can change their receptivity and they can change how well they work, you know, how well they work kind of like a mouse, which is a receptor of food.

It could be open. It could be open a lot. It could be closed. Right. So the receptor for hormones can have different capabilities of receiving the hormone, which is what ultimately then leads to the effect of the hormone going into the receptor.

And these different hormones like progesterone, testosterone, estradiol, the form of estrogen made by the ovaries, they have different effects at different amounts and different parts of the cycle on how the receptors actually receive them and how they work.

And there's this incredible dynamic of up and down regulation is the words that we use of the receptors. So when you talk about like, well, progesterone can like downregulate, testosterone production and receptor function and all of that, it's like fascinating.

These are some of the really like cutting edge ways that, you know, we're evolving in our understanding of PCOS and the basic fundamentals of how hormones work and the menstrual cycle.

And, you know, you touched on testosterone excess, you know, and of course, that is one of the key reasons why they try to do with birth control pills and excessively just shut down the ovaries.

Of course, we always prefer, if we can, to fix it rather than just turn it off. You know, just shut it down because it's not working. But maybe you could explain because a lot of people may not know, like where is testosterone coming from, you know?

Yeah. And like, what is going on that there is excessive testosterone production. Like where's it coming from and why do women have testosterone? I thought that was a man's hormone.

Well, great question. Yeah, so well, of course, in PCOS, a lot of it's coming from the ovaries. Not all of it's of course, we make testosterone in the adrenal glands as well.

And testosterone is actually really important for health. So we there's a sweet spot like with every hormone, there is a sweet spot with testosterone.

And certainly we need some testosterone for lots of things, bone health and mood. And we have more testosterone typically when we're younger. That's partly why, as I referenced earlier, like teenagers at around the time of puberty, testosterone is relatively high for women, still way lower than for men.

Obviously, men have ten times more testosterone. That's a different topic. But and then also we get this lovely little it's quite interesting, this little testosterone surge just before ovulation, which a lot of us will remember in the day when I was having menstrual cycles.

I'm menopausal now, but like that little pre ovulatory testosterone surge can feel amazing. So testosterone can actually have quite a number of benefits.

But of course, in the problem with PCOS, almost by definition I would say is that testosterone is upregulated in primarily the ovaries, but also depending on the woman, some of it, a lot of it might be coming from the adrenal glands.

As you know, in some of my work, I, I kind of differentiate I categorize PCOS into different types, kind of depending on what's driving the androgen excess, kind of where that's coming from.

And there is a, for what it's worth and you see that in the scientific literature, there is an adrenal gland essentially type of PCOS, which is quite different than the ovarian PCOS, which has a lot to do with testosterone from the ovaries, though not exclusively from the ovaries.

These are things you want to add about testosterone. Well, when we're talking about PCOS, we're usually talking about like the ovarian variety, which involves high testosterone, predominantly from the ovaries.

But you're absolutely right. And it's important for people to understand when we talk about PCOS, the stands for syndrome, which just means it's a constellation of physical symptoms, presentation and findings like with an ultrasound.

So it's not talking about etiologies at all, it's just talking about presentation. And yes, the adrenal gland is a major producer of Androgens and the big producer of DHEA. Yes.

Which is one of the lab tests that we measure when we're trying to figure out, well, where is this excess of androgen coming from? Is it from the ovaries?

Is it from predominantly the adrenal gland? But they're really different entities, you know, and we, you know, we have to that's why PCOS it's important to emphasize that it is always a diagnosis of exclu.

Jean In other words, you need to do testing to make sure that it's not something else. Like there's a whole array of

things we're not going to deal with, like acquired adrenal hyperplasia.

Yeah. Is, you know, so we have to really make sure, like anyone out there who thinks they have PCOS, they have to see a healthcare professional who makes sure what really is going on, you know, what's causing their symptoms, not just accept the symptoms as well.

You have PCOS and therefore, you know, we're just going to put you on birth control pills, end of story, because it could be an adrenal issue. That's correct. So I'm glad that you brought that up.

I think it's important for everyone to know. And then I want you to we're going to talk about progesterone. Is that all estradiol that's produced in the ovary is derived from one hormone and that's testosterone.

So it's not. Like half of that comes from testosterone and half of it comes from something else. No 100% of the estrogen produced in the ovary, which is a type of estrogen which is estradiol, comes from testosterone.

Progesteroneu2019s role in PCOS and cyclic therapy

And the ovary has specialized cells that make testosterone. And they're made by these special cells when they're stimulated and told to do so by the pituitary, you know, which you talk about.

And then the pituitary is then told what to do by the portion of the brain called the hypothalamus limits. And the pituitary puts out that little hormone that you mentioned, luteinizing hormone.

LH And then the there's an enzyme in the ovary aromatase that is in a different set of cells that then converts the testosterone into the estradiol under a different pituitary hormones direction, the FSA follicle stimulating hormone.

So I'd like you to talk about, you know, I always defend what I call the defenseless poor estrogen. So because it's been so long, but you're 100% right, progesterone is super important to me.

You can have a functioning, healthy female with just one and not the other. And progesterone is so often forgotten. And the role that it plays in so many aspects of female health and in the menstrual cycle and so on.

And of course, women who don't ovulate cannot make progesterone in their ovaries. That's just absolute. You can make some estrogen, but you can't make progesterone without having that ovulation.

So I'd love you to introduce this audience to that amazing forgotten under appreciated hormone progesterone. Absolutely. I want to pick up on a couple of things you said there.

So I'm a huge fan of estradiol as well. And the other thing that if you don't ovulate, not only do not make progesterone, you also don't make peak estradiol.

So the ovaries, it's pretty easy for the ovaries to make a little bit of style. But that's not enough for this whole sequence of events that has to happen.

There actually has to be a spike and essentially a peak estradiol to be able to ovulate. So SNL is also very important that estrogen and not to get too technical for everyone, don't worry, it's not going to be technical. But two things.

You said that there's two parts that are kind of going wrong with PCOS, if you will. This I mean, there's many parts, but two parts of what you said. So there's the LH signaling from the brain, which is stimulating testosterone essentially.

And then there's the aromatase which is converting testosterone to estrogen. And both of those systems are not functioning perfect like, well, with PCOS, I think that's safe to say.

There's research into both of those systems. So you want we need to be trying to support both of those systems and that's where progesterone comes in because it's super power is it feeds back as it feeds back to the brain as progesterone receptors in the brain, as you say, there's receptors everywhere.

And when the hypothalamus part of the brain receives that huge, like I said, like just enormous amount of progesterone that's made after ovulation, it downregulate LH Progesterone pushes down on LH after ovulation and that is, as we can imagine, that's very important for PCOS because we just said LH is part of what stimulates testosterone production and the LH is a very dynamic hormone in that it's supposed to be kind of relatively low and then undergo this like huge spike just before ovulation and then go back down and with PCOS it tends to be just generally elevated like kind of baseline elevated and that is not a good situation.

So anything that kind of can push down on LH can really help the hormonal system find its rhythm again. And that's what progesterone does. And I might introduce the topic, if that's okay, Dr.

Felice, of cyclic progesterone therapy, which is a new it really sort of a new treatment approach that was developed by my colleague. She's a endocrinology professor, Jacqueline Prior in Vancouver, Canada.

They've just done I think have completed it. They haven't published it yet. So we're all excited to see the results. But they've done a clinical trial of cyclic progesterone for PCOS, and this is going to be quite a different approach.

It basically mimics the the luteal phase production of progesterone for a while with with the understanding that it might not need to be permanent because once progesterone comes on board and exerts its negative feedback, its regulatory effect on the brain and pushes down on LH, then that can allow the ovulatory cycle or regular ovulation to establish essentially for the cycle to mature and for women to start to make their own progesterone, which is what is so great about it as a treatment that it's not you don't have to go on it and stay on it like you would the pill.

And also it's you can take it when you're trying for pregnancy because it's safe during pregnancy and it permits ovulation, which is obviously a big plus.

So the progesterone, the cyclic progesterone therapy is real progesterone, what's called body identical or bioidentical or natural progesterone, depending on how you want to phrase it.

It's not the progestins in the pill. We haven't really talked about that yet, but I'll just say as a simple statement, there is no progesterone in any type of hormonal birth control, which is very confusing because it's often called progesterone, but it's not.

And the the progestins, the various synthetic versions of progesterone that they use in hormonal birth control do not have that same effect on the brain, just flat out they don't do that.

So they can't be used in the same way that progesterone can be used. So well. Have you. Yeah. So we have never discussed this but yeah I so I've been doing that as well with the theory that you can't heal without the hormones, but until you have the hormones, you can't really heal, you know?

So it's like a temporary thing to try to get back the rhythms of the body, the beautiful spike of estradiol, the progesterone. And so I'm just so excited to hear what you've been doing and, you know, in a different part of the world and that we're kind of, you know, like to say great minds think alike, right?

That we recognize that the hormones that the human body makes, which are not the same as the, you know, chemically made mimics, which are not the same, like progestins versus progesterone or ethanol, estradiol versus 17 beta estradiol, the estrogen made by the ovaries.

So, you know, I just want to hear I'm so excited to hear about this new research using the human body animal progesterone, because I've been doing that, but we haven't talked about it.

So let me hear all about what I've been learning. Well, it's it's fun. I mean, I think you've intuitively kind of come to

the same conclusion. This the cyclic progesterone therapy was not my invention.

It was endocrinology professor Jocelyn Prior. And she was using it clinically for a lot of years and has because she's a scientist, she's finally been able to bring it to a clinical trial.

I wrote a paper, a review paper with her about it a couple of years ago, kind of more of a mechanistic sort of looking at all the nuts and bolts of how that works, including a lot of what you just talked about.

Like all the interesting things that happen in the brain at different times of the cycle and in terms of exposure to progesterone. So is what you said. It is sort of imposing, if you will, or, you know, hooding the structured like cycling, putting the hormonal cycling in it, giving a woman that with external doses of natural hormones, with the expectation and often the result, that that will essentially train the brain in a way like it sort of establishes that cycle.

Often what I say to my patients when they're trying to get ovulation going and I'm sure maybe you found the same thing, it's once you get it going, it's kind of like getting a big boulder rolling.

Like it can take a bit to kind of get it moving. But then once it's going, it will keep going. Often like there's a momentum to that. So I think that has been the idea.

And also just what I said earlier that both yesterday and progesterone have anti androgen, anti testosterone effect. So that can be that can just push down on the level of testosterone that's interfering with the system, essentially.

And yeah, I mean, I think using it for a year is reasonable. Sometimes my patients are doing cyclic progesterone for six months and then, you know, be able to come off it.

It really depends. Honestly, it just depends on how severe that testosterone excess was. I think, you know, there's different degrees of it. Some women just have a quite a mild amount that they're potentially even just going to outgrow.

For some women, it's a lot stronger amount. And so that will tend to determine, you know, for how long they'll need to continue using natural hormones this way.

And this can always be done in conjunction with other things. I just want to say as well, it doesn't have to be the only treatment people use because I'm also a huge, huge fan of Inositol, which we can sure.

You talk to other guests about and that supplement. But yeah, this natural hormone approach can work quite well and you wouldn't want to combine it with the pill though, because that would just defeat the purpose, because the pill, as we've said, like shuts down the system and this is a treatment that's trying to get the system going and functioning normally.

So I don't know what version of progesterone you use like in the US that's available as permission or you could get a compounded capsule. What do you tend to use with your.

Well, I use depending on the situation, I use the oral version like you mentioned. But and occasionally some people can't tolerate that. And so I will occasionally use the creams which have less data and you have to use large quantities to get it absorbed.

But as an alternative for people who don't tolerate it, small percentage just don't tolerate the oral progesterone. But I usually start with oral progesterone.

And the thing that's so interesting, I read your paper. That's why I feel it's good. I did and I enjoyed it very much, you know. So even though you didn't invent it, you're definitely promoting it and you're part of this is because many doctors and other health care professionals use progesterone to do what they call inducing a bleed, right?

Yeah. They say a period is not really a period. It's bleeding like you said. It's not because you there's no ovulation

in that case. They're just giving progesterone to convert the uterine lining to a cold like a secretory state.

So you're changing it so that it's somewhat similar to what it would be prior to having a real menstrual period, because it changes how the lining is sort of like looking and how it's behaving.

And then you withdraw, you stop the progesterone and then the lining sheds out. It just comes out. But it's not really period bleeding, but it's blood, you know.

So we call it withdrawal bleeding and that is important. So you don't have what's called unopposed used estrogen that's made by the ovaries, a low but chronic amount of estrogen that causes growth or proliferation of the uterine lining that in a process inflammatory state which women unfortunately with PCOS are in a pro-inflammatory they're kind of like systemic total body wide inflammation and so that kind of can increase the risk for uterine or endometrial cancer.

So that's why, you know, they give progesterone just to get rid of the lining and change it into that secretory format. But you're using progesterone.

It also is like retraining the brain and looking at brain receptors and affecting testosterone levels and so on. So it's really a totally different approach, you know.

So for people who hear that, well, my doctor gave me some progesterone to bring on a bleed, you know, but that's and that's important, okay. Because we don't want uterine cancer, but it's a different thought process.

And it's so it's a different use of it, which has more will say greater sort of scope of benefits when you're using it in the way that you're discussing it.

That's a great way. That's a really good point to bring in. So that that getting a semi-regular withdrawal bleed, as you say, is important for protecting the uterine lining.

And a lot of women are aware of that. Their doctor might have mentioned something about preventing cancer. This is what they're talking about, like, you know, preventing the cancer of the inner lining, which to be fair, is a long term.

Practical use of progesterone and closing resources

A lot women get really scared by that, but that would just mean that would be a risk after many, many years of not having bleeds. And so most women are not going to end up in that situation.

But yes, so progesterone has that benefit, which is a kind of level one, if you will. Like, that's great to be able to use a natural hormone to induce the bleed.

But then, as you say, there's there's more like if you do it this in a cyclic manner, which is two weeks on, two weeks off, essentially, then you can also have this brain retraining.

And I'll just reemphasize again how you and I right now are talking about natural progesterone, her body, identical progesterone, which you can get other types of progestins, which are sometimes called progesterone, which makes it very confusing.

Progestins can induce a withdrawal, but they can't retract. They cannot retrain the brain. So that's where the distinction comes in. And the other distinction is, of course, natural progesterone is safe when you're trying for pregnancy or is compatible with achieving pregnancy can actually help to hold the pregnancy.

One thing I don't know if you agree, but I would just say like one pretty one kind of listening and hoping to maybe go down this strategy if you are using progesterone, progesterone when you're trying for pregnancy and then if you do become pregnant, I usually say stay on it for the first few months.

What do you say with that, Dr. Felice? Just because you want to keep that natural progesterone in place and not, you know, withdraw it early in the pregnancy?

Yeah. Often, you know, depending on each individual situation. But I wouldn't be uncommon that I would say take it for the first 12 weeks. Yes. For the first trimester.

Until your then the placenta kicks in and starts to make a even huger amount of progesterone. And at that point, you just, you know, you don't need it anymore.

I want to follow up I want to ask you a question, if that's okay, because you just you did mention the women who cannot tolerate progesterone. So I do want to just touch on that because, again, for anyone who's going to go out and try to try this treatment, there's a couple of things to know about oral progesterone.

One, you should at least I think you should really take it at bedtime because it's quite normally it's quite tranquilizing. It can make you feel very sleepy if it's bedtime, which is a good thing, or very groggy if you try to take it during the day.

That's what most women experience from it. And that's how Professor Pryor doses it as well as a bedtime dose. But about I think it's about one in 20 women.

You can tell me what you find from your clinical practice. As you say, don't tolerate it. They actually get a paradoxical kind of anxiety reaction from progesterone, which is that's usually when you have to switch to either a cream or maybe vaginal progesterone to avoid that brain effect.

Would you say it's about one in 20 or maybe more frequent? What do you find? Yeah, I would say that one in 20 is about right. It's not like super common and.

Yes, and it's it's always annoying when this happens because it makes it harder for everybody. But yeah. We just have to recognize it. And 100% I only dose oral progesterone at bedtime.

Since I love it they say I'd never sleep. You know, there's a relationship between progesterone and GABA, but we could just talk forever. All right, you know, because, you know, we we think along.

So many of the same lines because we're looking at the key role that the menstrual cycle and these vital hormones that are produced by the ovary and what they mean for the total body and, you know, the different things that go awry in women with PCOS.

And we're like constantly searching for ways to not just cover up symptoms, which I'm not going to belittle. Covering up symptoms is very valuable, but we're doing and want to do more than that.

We want to actually like repair, like you, like love in your books, like repair, want to repair the problem, fix it so that I don't want to use the word cure.

That's like a little too powerful. Perhaps, but like, really repair so that the body can function in a much more normal fashion rather than just cover up symptoms and then, like, unfortunately, I agree with you, with birth control pills, often I call it kicking the can down the road because they may do fine while they're on it.

But eventually if they go off and eventually you have to eventually go off, you know, they find that things are maybe worse than what they seemed to be when they started, you know, so definitely, you and I are on the same page.

We're looking for a deep understanding of how hormones really work in the female body, how the ovary functions, the relationship chip between these different other parts, you know, the pituitary, the brain, the hypothalamus of the brain, all these different signaling agents.

I mean, we could talk both. So in-depth we didn't even touch on, you know, all the different, you know, intricacies of

the hypothalamic pituitary adrenal ovarian axis, how all of this works.

It's amazing. And so for people who want to learn more about, you know, what you have written about, can maybe you can give them some resources, like where can they go?

Because we've barely just weathered their appetite about this. Absolutely. Well, I have a couple of blog posts about progesterone. I actually have a blog post called Cyclic Progesterone Therapy for PCOS.

So and that links to the paper I wrote with Professor Prior. But also watch this space like I would encourage everyone if they're not already obviously follow you, maybe follow me, get on my newsletter list because I will as soon as Professor Durland Clinical trial.

As soon as that's published, peer reviewed and published, then I will share that. And of course it remains to be seen what they found. So, you know, I'm expecting they found good results.

So we'll we'll find out when the research is published. But then that will be a resource to take to your doctor. Because just to be clear, the progesterone we've been talking about is a prescription medication.

So you will need to have a conversation with your doctor that this is something you'd like to try. And my experience actually, the feedback I've had from a lot of my readers and followers is a lot of doctors are open to it for the main reason.

I'll just say that the main selling point on trying cyclic progesterone therapy is the safety. Because big picture, I would actually say progesterone, natural progesterone is safer than progestins in terms of things like breast cancer risk.

I mean, to be fair, the breast cancer risk with progesterone is quite low, but it does exist. And progesterone even safer, I would say, at this point, given the the reading of the research.

So that's often quite important for doctors is not just to know they don't have to be convinced that it's going to work. They just have to be convinced that it's safe to try, because that's I think that's probably fair to say.

That's, you know, the most important thing for most doctors. They don't want to they might be a little nervous about it but then you could just say look here's the research can I'll just leave that with you and come back next week for another appointment and we can talk about maybe getting started on it.

Well, I hope everyone will will follow. You read your blogs. We're all awaiting the publication of that of that article, the research and I agree that most doctors are already familiar with using progesterone, like we talked about, for creating that withdrawal bleed.

And so the idea of using it on a routine basis every month is probably not going to be that big of a stretch for them to adapt. And then and then we'll see where it goes from there, you know, and all the different researchers that finally we're getting more interest in PCOS, which excites me when I go to PubMed and Google Search and I find more and more articles published.

It warms my heart and I'm so happy. That you're. Out in this, that you're in this space with us and. You know, after all, it's only the most common endocrine disorder of reproductive age women.

Why should we be caring? Right. It's like, so amazing. And I appreciate all that you're doing. And, you know, the education, the books you're writing and you know that that you are so active and and growing stronger, you know, as the years go by in terms of your involvement in all of the basic science research as well as the clinical, you know, which is I love it when we get to join these two together, right?

The clinical science and the clinical practice is so important. So thank you so much. I look forward to staying connected and I hope all of you will follow my wonderful friendhere, Dr. Lara Briden.

And thank you so much. Thanks, Dr. Felice. It was such a delight to chat with you today.