Should You Use HRT for Your Bones? | Dr. Felice Gersh Transcript

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Introduction

Hey, Margie here. Are you ready to delve Hey, Margie here. Are you ready to delve into hormones? Because they can be so into hormones? Because they can be so important for our bones and overall important for our bones and overall health, but we need to know what are the health, but we need to know what are the myths, where did they come from, and myths, where did they come from, and what does the research really show us?

what does the research really show us? Well, today that's what we're going to Well, today that's what we're going to discuss with our very special guest, Dr.

discuss with our very special guest, Dr. Feliz Gersh. And Dr. Gersh is a double Feliz Gersh. And Dr. Gersh is a double boardcertified OBGYn and integrative boardcertified OBGYn and integrative medicine physician. She's a best-selling medicine physician. She's a best-selling author and someone I've known and author and someone I've known and admired for years. She's done so much admired for years. She's done so much for women's bone health and I just can't for women's bone health and I just can't wait for you to hear from her. She This wait for you to hear from her. She This interview is full of so much great interview is full of so much great Welcome, Feliss, where you've [music] Welcome, Feliss, where you've [music] been friends for such a long time and been friends for such a long time and it's always such an amazing pleasure to it's always such an amazing pleasure to be with you because the truth is you are be with you because the truth is you are a women woman ahead of your time. I a women woman ahead of your time. I mean, I have known you probably for mean, I have known you probably for around 10 years and you were talking around 10 years and you were talking about things that now only are getting about things that now only are getting out into the public such a long time ago out into the public such a long time ago and you're just always on top of and you're just always on top of everything and always researchbased. So, everything and always researchbased. So, I just so appreciate the work you do and I just so appreciate the work you do and thank you so much for being here today.

thank you so much for being here today. Well, it's always such a fun experience Well, it's always such a fun experience and yes, what you said is true. I have and yes, what you said is true. I have lived a lot of what to some of the lived a lot of what to some of the younger doctors is history. So I was younger doctors is history. So I was there upfront center when the women's there upfront center when the women's health initiative came out about 25 health initiative came out about 25 years ago and I was screaming in the years ago and I was screaming in the wind for decades about the importance of wind for decades about the importance of hormones but now they've been like hormones but now they've been like discovered you know so but I'm really discovered you know so but I'm really thrilled that finally menopause is thrilled that finally menopause is seeing the light of day but you know a seeing the light of day but you know a lot of things still need a lot of work.

lot of things still need a lot of work. >> Absolutely. But it is true cuz my >> Absolutely. But it is true cuz my generation was the generation that generation was the generation that really missed out when we're talking really missed out when we're talking about bones and so many things. You about bones and so many things. You know, this that this was the generation know, this that this was the generation with the women's health initiative that with the women's health initiative that estrogen hormones were stopped estrogen hormones were stopped completely. And so only now is there completely. And so only now is there resurgence and there's a lot of resurgence and there's a lot of confusion. So, we're going to go go confusion. So, we're going to go go through that because I really through that because I really want to through that because I really want to clear up the picture and there's just clear up the picture and there's just nobody better who's done with worked nobody better who's done with worked with us for so long and that can with us for so long and that can do that than you. Let's get started. Let's start than you. Let's get started.

History of hormone replacement therapy (HRT)

Let's start out. Do you want to just start out with out. Do you want to just start out with what the problem was and why now all of what the problem was and why now all of a sudden there's this resurgence and a sudden there's this

resurgence and it's coming back into the picture where it's coming back into the picture where people were told no, no, no, that's not people were told no, no, no, that's not an option for you. You want to just go an option for you. You want to just go back just a little bit of history to back just a little bit of history to make sure everybody make sure everybody >> Yeah. You know, that's a good idea >> Yeah. You know, that's a good idea because what is so like like ingrained because what is so like like ingrained into me and you is is really not for into me and you is is really not for many women it's still what happened you many women it's still what happened you know what's going on. So back if we go know what's going on. So back if we go back in history in the 1970s back in history in the 1970s estradile estradile estradile was not yet available.

was not yet available. So in which is the estrogen that the So in which is the estrogen that the human ovaries make. So what was human ovaries make. So what was available because you know you can only available because you know you can only use what's actually on the market use what's actually on the market [clears throat] [clears throat] [clears throat] was conjugated equin estrogens. And what was conjugated equin estrogens. And what are they? That was the brand name is are they? That was the brand name is Premaran for pregnant mayor urine. Okay.

Premaran for pregnant mayor urine. Okay. What they did was they took the urine of What they did was they took the urine of a pregnant horse and then they dried it, a pregnant horse and then they dried it, turned it into like a powder and then turned it into like a powder and then put it into a tablet and they gave it to put it into a tablet and they gave it to human women and it the horse estrogens human women and it the horse estrogens which they call ecoin and it came which they call ecoin and it came through the liver first from the horse through the liver first from the horse so that it could be converted from a fat so that it could be converted from a fat to a water soluble product so it could to a water soluble product so it could go out in the water which is what urine go out in the water which is what urine is like water. So they called it is like water. So they called it conjugated. That's the process in the conjugated. That's the process in the liver. Equin for horse estrogens because liver. Equin for horse estrogens because there was a variety of different equal there was a variety of different equal or horse estrogens plus other stuff that or horse estrogens plus other stuff that just got in there. Those estrogens were just got in there. Those estrogens were unique to a pregnant horse. Never found unique to a pregnant horse. Never found in human females. Well, but that's all in human females. Well, but that's all that was available and it did that was available and it did significantly reduce night sweats and significantly reduce night sweats and hot flashes. Okay. So that was available hot flashes. Okay. So that was available and it became quite popular but then it and it became quite popular but then it was recognized that some women would was recognized that some women would develop uterine cancer endometrial develop uterine cancer endometrial adnocarcinoma at a higher risk like adnocarcinoma at a higher risk like seven times the higher higher incidence seven times the higher higher incidence than women who were not on prem. That than women who were not on prem. That didn't make it a high incidence. It just didn't make it a high incidence. It just still made it seven times higher. So still made it seven times higher. So then estrogen use dropped and then they then estrogen use dropped and then they discovered if they added a fake I'll discovered if they added a fake I'll call it a fake mimic of progesterone call it a fake mimic of progesterone because at that time there was no human because at that time there was no human available progesterone on the market available progesterone on the market either. And that particular molecule is either. And that particular molecule is called a progesterine. So it's a called a progesterine. So it's a man-made product and the name of that man-made product and the name of that product is madroxy progesterone acetate.

product is madroxy progesterone acetate. Now, it has the word progesterone in it, Now, it has the word progesterone in it, but there's no progesterone in it, okay?

but there's no progesterone in it, okay? It's just in the word. So, it does bind It's just in the word. So, it does bind like supercharged binding to the like supercharged binding to the progesterone receptors in the uterine progesterone receptors in the uterine lining, which it turned out would be lining, which it turned out would be protective against the proliferative or protective against the proliferative or growth factor effects of the the primer, growth factor effects of the the primer, the conjugated ecoin estrogens. So, by the conjugated ecoin estrogens. So, by giving that in a cyclic, and that's what giving that in a cyclic, and that's what they did. So you'd have a cycle. You they did. So you'd have a cycle. You would use the progesterone mimic for 14 would use the progesterone mimic for 14 days or 12 days and then you'd have a a days or 12 days and then you'd have a a bleed, like a fake period, and you would bleed, like a fake period, and you would do like a pretend cycle. And that do like a pretend cycle. And that reduced

the risk of uterine cancer back reduced the risk of uterine cancer back to square one. And that's what then to square one. And that's what then caused a very big resurgence in the caused a very big resurgence in the popularity of hormones because the risk popularity of hormones because the risk of uterine cancer was gone. So that of uterine cancer was gone. So that became the popular product. And then became the popular product. And then over time they found that they could over time they found that they could combine both the estrogen product the combine both the estrogen product the conjugated ecoin estrogens premorrin conjugated ecoin estrogens premorrin with the madroxy progesterone acetate with the madroxy progesterone acetate provera and they called that product provera and they called that product prem pro. So it was a combination of the prem pro. So it was a combination of the two molecules. They're hormones if you two molecules. They're hormones if you can call them hormones not human can call them hormones not human hormones. Never either one of them would hormones. Never either one of them would ever be naturally in a human ever. And ever be naturally in a human ever. And they marketed that and then it became they marketed that and then it became super popular like close to half of super popular like close to half of women were on this product and they felt women were on this product and they felt better and they started doing better and they started doing observational studies like the women's observational studies like the women's health study. There were other health study. There were other observational studies and what did they observational studies and what did they find that women who were on this product find that women who were on this product either prein and cycling with pre either prein and cycling with pre provera or the combination that they provera or the combination that they seemed to do better particularly in the seemed to do better particularly in the area they noticed of cardiovascular area they noticed of cardiovascular health and also bone health. So they had health and also bone health. So they had fewer fractures and they seem to have fewer fractures and they seem to have fewer heart attacks and strokes. So they fewer heart attacks and strokes. So they started promoting it like into the whole started promoting it like into the whole population for those purposes and they population for those purposes and they said you know you should use it to said you know you should use it to prevent heart attacks to prevent aging prevent heart attacks to prevent aging to be you know and then even way back to be you know and then even way back there was a book written in the late there was a book written in the late 1960s. It was either forever feminine or 1960s. It was either forever feminine or feminine forever. I keep forgetting the feminine forever. I keep forgetting the the you know because it was the idea the you know because it was the idea that hormones were really a healthy that hormones were really a healthy longevity tool and it became so popular.

longevity tool and it became so popular. So the FDA said, "Wait a minute." Okay, So the FDA said, "Wait a minute." Okay, you're now saying that this hormone you're now saying that this hormone product can help prevent heart attacks product can help prevent heart attacks and strokes. Meanwhile, they actually and strokes. Meanwhile, they actually gave it FDA approval for prevention of gave it FDA approval for prevention of osteoporosis.

osteoporosis. osteoporosis. So it actually got the FDA approval for So it actually got the FDA approval for two uses for systemic use, total body two uses for systemic use, total body use. One was reduction of night sweats use. One was reduction of night sweats and hot flashes. The other was and hot flashes. The other was prevention of osteoporosis.

prevention of osteoporosis. Well, the FDA said you can't keep Well, the FDA said you can't keep promoting it for cardiovascular health promoting it for cardiovascular health unless you prove that it's going to unless you prove that it's going to reduce heart attacks and strokes. not reduce heart attacks and strokes. not all this observational stuff where they all this observational stuff where they would look at a group of women and they would look at a group of women and they would say, "Oh, the women on the hormone would say, "Oh, the women on the hormone products had fewer heart attacks and products had fewer heart attacks and strokes than the women not, but it strokes than the women not, but it wasn't placebo control, double blinded, wasn't placebo control, double blinded, all that kind of stuff." You know, it all that kind of stuff." You know, it was just observational. So, they said, was just observational. So, they said, "Well, you because if observational, "Well, you because if observational, there could be a bunch of variables.

there could be a bunch of variables. Maybe the women who used hormones had Maybe the women who used hormones had ate a better diet. They were more ate a better diet. They were more educated. They were from an upper strata educated. They were from an upper strata of the economy and that kind of thing.

of the economy and that kind of thing. So maybe there are other confounders So maybe there are other confounders that would make them have a better that would make them have a better outcome. So they said, "You need a outcome.

How the Women's Health Initiative changed HRT

So they said, "You need a double blind placebo control trial if double blind placebo control trial if you're going to make claims that this is you're going to make claims that this is good for women's hearts and prevents good for women's hearts and prevents heart attacks and strokes." So the first heart attacks and strokes." So the first thing they did was the HERS study. And thing they did was the HERS study. And the HERS study looked at women who the HERS study looked at women who already had a heart attack or a stroke already had a heart attack or a stroke and they had known cardiovascular and they had known cardiovascular disease. And then they gave them disease. And then they gave them Prempro. These were on average Prempro. These were on average significantly, you know, women older significantly, you know, women older like in their late 60s and 70s who like in their late 60s and 70s who already had known cardiovascular events.

already had known cardiovascular events. They already had a heart attack or They already had a heart attack or stroke. And what they found in that stroke. And what they found in that study when they gave them Prem was that study when they gave them Prem was that in the first year of use there was a in the first year of use there was a higher incidence of bad things happening higher incidence of bad things happening with the cardiovascular system like with the cardiovascular system like heart attacks in the women who were put heart attacks in the women who were put on this hormone product. It seemed the on this hormone product. It seemed the study went for about four years and as study went for about four years and as time went by it seemed like the women on time went by it seemed like the women on the hormones did better and better but the hormones did better and better but the first year more died. So they then the first year more died. So they then said no this is bad. So don't use it for said no this is bad. So don't use it for secondary prevention. That's what secondary prevention. That's what secondary prevention means. Women secondary prevention means. Women already have known heart disease and already have known heart disease and cardiovascular badness. Don't give this cardiovascular badness. Don't give this to prevent a second stroke or heart to prevent a second stroke or heart attack. Don't do that. That's secondary attack. Don't do that. That's secondary prevention. So then they said, okay, prevention. So then they said, okay, well maybe that's not the right group.

well maybe that's not the right group. Let's look at it for primary prevention. Let's look at it for primary prevention. Women who who don't have known Women who who don't have known cardiovascular disease. So they needed cardiovascular disease. So they needed to do the study and it couldn't last for to do the study and it couldn't last for 30 years. So that would be too 30 years. So that would be too expensive, too hard to do. So they expensive, too hard to do. So they created the same exact study, the same created the same exact study, the same study with the same product. Only now study with the same product. Only now the study subjects did not yet have a the study subjects did not yet have a heart attack or a stroke. But they heart attack or a stroke. But they weren't like what they talked about weren't like what they talked about healthy women. No, they they couldn't healthy women. No, they they couldn't find thousands of women who were all find thousands of women who were all healthy who were in a high higher risk healthy who were in a high higher risk age group for having something like a age group for having something like a heart attack or stroke because they heart attack or stroke because they couldn't take women who were a bunch of couldn't take women who were a bunch of women who were just entering menopause women who were just entering menopause who were 50. Number one, many of those who were 50. Number one, many of those women like 80% would have heart attacks women like 80% would have heart attacks would rather many of those women would would rather many of those women would have night sweats and hot flashes. So, have night sweats and hot flashes. So, as soon as you gave them the Prem Pro, as soon as you gave them the Prem Pro, which is what they used, the combination which is what they used, the combination product Prem Pro, they would all know product Prem Pro, they would all know that they were on the real product that they were on the real product because their hotter their hot flashes because their hotter their hot flashes and their, you know, night sweats would and their, you know, night sweats would dissipate and the ones who had them and dissipate and the ones who had them and they didn't get better would know they they didn't get better would know they weren't on it. So, then they wouldn't weren't on it. So, then they wouldn't really be very blinded, would it?

really be very blinded, would it? Because they would all figure it out. So Because they would all figure it out. So they had to take women who had no they had to take women who had no symptoms and also were in an age group symptoms and also were in an age group where if you gave it you could actually where if you gave it you could actually see a difference in heart attacks or see a difference in heart attacks or strokes because very few women happily I strokes because very few women happily I call it the halo effect of hormones for call it the halo effect of hormones for the first decade after they go into the first decade after they go into menopause they usually don't have any menopause they usually don't have any overt bad things like they don't usually overt bad things like they don't usually break their hips break their spel their break their hips break their spel their pelvis have you know vertebral fractures pelvis have you know vertebral fractures they don't usually have heart attacks or they don't usually have heart attacks or strokes in their 50s I because they're strokes in their 50s I because they're still riding the wave of the hormones still riding the wave of the hormones that they used to have because they, you that they used to have because they, you know, they're sort of things can be know, they're sort of things can be happening that they don't know, covert, happening that they don't know, covert, but not overt. So, they couldn't use a but not overt. So, they couldn't use a whole bunch of women who were 50. That whole bunch of women who were 50. That wouldn't make sense for their study wouldn't make sense for their study purposes. So, they had to take older purposes. So, they had to take older women who were more likely to have a women who were more likely to have a heart attack or stroke. So, they could heart attack or stroke. So, they could see the difference between the placebo see the difference between the placebo group and the study group on the group and the study group on the hormones. and they wouldn't know hormones. and they wouldn't know presumably if they were on the real presumably if they were on the real hormones or the placebo because they hormones or the placebo because they wouldn't have night sweats or hot wouldn't have night sweats or hot flashes as a clue when they all got flashes as a clue when they all got better on when they were on the better on when they were on the hormones. So, but B, by the way, many of hormones. So, but B, by the way, many of them figured it out because they had a them figured it out because they had a lot of breast tenderness. They had lot of breast tenderness. They had bleeding. I mean, it wasn't so double bleeding. I mean, it wasn't so double blinded like you might think because blinded like you might think because most of the women on the hormone product most of the women on the hormone product really figured it out that I'm on the really figured it out that I'm on the hormone product. So, there you go. And hormone product. So, there you go. And there were a lot of dropouts, huge there were a lot of dropouts, huge dropouts because they had so much dropouts because they had so much irregular bleeding and breast irregular bleeding and breast tenderness. They a lot because these tenderness. They a lot because these were women who hadn't seen a hormone were women who hadn't seen a hormone like this. And and these are not human like this. And and these are not human hormones either for like 15 years. You hormones either for like 15 years. You know, they were so far out in menopause.

know, they were so far out in menopause. The average age was 63. They took women The average age was 63. They took women all the way up to 79 to start this all the way up to 79 to start this study. And remember, they didn't have a study. And remember, they didn't have a heart attack or a stroke, but many of heart attack or a stroke, but many of them were on drugs for for high lipids.

them were on drugs for for high lipids. They were on blood pressure drugs. They They were on blood pressure drugs. They were, you know, they had like insulin were, you know, they had like insulin resistance. This was like, where are you resistance. This was like, where are you going to find thousands and thousands of going to find thousands and thousands of American women in their mid and late 60s American women in their mid and late 60s and 70s who have perfect cardiovascular and 70s who have perfect cardiovascular health? I mean, let's be real. So, they health? I mean, let's be real. So, they didn't have a heart attack or stroke, didn't have a heart attack or stroke, but in many ways, they weren't terribly but in many ways, they weren't terribly different from the group of the previous different from the group of the previous study, the HERS study. And like so why study, the HERS study. And like so why would you think there'd be a hugely would you think there'd be a hugely different outcome when this study was different outcome when this study was designed already at that point we designed already at that point we already had bioididentical human already had bioididentical human identical estradile and progesterone and identical estradile and progesterone and they were gaining momentum but they did they were gaining momentum but they did the study with all this you know the the study with all this you know the prempro because they said well still prempro because they said well still that's what most women are still using that's what most women are still using but we already knew that that was not a but we already knew that that was not a good choice. I knew if I knew I was just good choice. I knew if I knew I was just a regular OBGYn in private practice. If a regular

OBGYn in private practice. If I knew that that wasn't a good choice, I I knew that that wasn't a good choice, I knew the result of the previous HERS knew the result of the previous HERS study and I knew that this would show study and I knew that this would show the same thing. I mean, so like what the the same thing. I mean, so like what the heck are you doing spending bazillion heck are you doing spending bazillion dollars of taxpayer dollars doing all dollars of taxpayer dollars doing all this stuff and the outcome is already this stuff and the outcome is already shown from the previous study and we shown from the previous study and we don't want this product, but they went don't want this product, but they went ahead and forged forward with it anyway.

ahead and forged forward with it anyway. So duh, exactly what I believed would So duh, exactly what I believed would happen happened. So in the outcome, they happen happened. So in the outcome, they found that women who were on the found that women who were on the prempro, they didn't do as well. Now, prempro, they didn't do as well. Now, originally, they said they had more originally, they said they had more heart attacks. Turned out when they did heart attacks. Turned out when they did a reanalysis, they didn't. They a reanalysis, they didn't. They definitely had more strokes and blood definitely had more strokes and blood clots because it's been found that that clots because it's been found that that combination prem will increase the risk combination prem will increase the risk of blood clots. Oh, like about 400% over of blood clots. Oh, like about 400% over baseline. like so duh that's we know you baseline. like so duh that's we know you get a a a blood clot in your brain get a a a blood clot in your brain that's a stroke and they also they said that's a stroke and they also they said had more breast cancer a small amount had more breast cancer a small amount but it turned out that was only from the but it turned out that was only from the hydroxy progesterone acetate and not hydroxy progesterone acetate and not actually from the premer but it took actually from the premer but it took years and years before that all came out years and years before that all came out real and never really came out very real and never really came out very loudly. So in the end, oh by the way, loudly. So in the end, oh by the way, they did find a statistically they did find a statistically significant reduction in fractures. So significant reduction in fractures. So that was sort of nice thing. They also that was sort of nice thing. They also found a statistically significant found a statistically significant reduction in colon cancer, but none of reduction in colon cancer, but none of that seemed to matter to too many that seemed to matter to too many people, you know, like bones and cancer people, you know, like bones and cancer didn't the the colon, which is huge in didn't the the colon, which is huge in terms of deaths of women, that sort of terms of deaths of women, that sort of got brushed under the rug, too. and the got brushed under the rug, too. and the so and then they did the spin-off study so and then they did the spin-off study which was the whim study which looked at which was the whim study which looked at brain and because you get more blood brain and because you get more blood clots you're going to have more strokes clots you're going to have more strokes you're going to have more vascular you're going to have more vascular dementia so they found that women on dementia so they found that women on prempro the older women had more prempro the older women had more dementia so they put this all together dementia so they put this all together and the headlines were if you use and the headlines were if you use hormones they didn't say what hormones hormones they didn't say what hormones if you use hormones you're going to have if you use hormones you're going to have more breast cancer heart attacks, more breast cancer heart attacks, strokes, blood clots, and dementia. So, strokes, blood clots, and dementia. So, what woman would want to get it, take what woman would want to get it, take it, right? And what doctor would want to it, right? And what doctor would want to prescribe it? So, it was crazy. So, prescribe it? So, it was crazy. So, there the the it went from like close to there the the it went from like close to half of women being on hormones in their half of women being on hormones in their say their 50s to two to maybe at most say their 50s to two to maybe at most 4%. It just plummeted. It was wildly 4%. It just plummeted. It was wildly unpopular and women felt horrible. And I unpopular and women felt horrible. And I begged my patients because I was in begged my patients because I was in practice 25 years ago and I begged them practice 25 years ago and I begged them to stay on the hormones. I said, "I'm to stay on the hormones. I said, "I'm not even prescribing this for you. The not even prescribing this for you. The results of this study only apply to what results of this study only apply to what was studied, which actually is what it was studied, which actually is what it says in the study itself." But that says in the study itself." But that didn't happen. They applied it to every didn't happen. They applied it to every hormone combination, every dose, every hormone combination, every dose, every everything. Like it was all the same. It everything. Like it was all the same. It would be like you do a study with trans would be like you do a study with trans fat and then you say fat from a walnut fat and then you say fat from a walnut is evil. It will kill you. fat from an is evil. It will kill you. fat from an avocado is evil will kill you. It's like avocado is evil will kill you. It's like no trans fat can kill you, but it's not no trans fat can kill you, but it's not all fats. But it was and this these are all fats. But it was and this these are people coming out of Harvard. It's like people coming out of Harvard. It's like what's wrong with these people, you what's wrong

with these people, you know? And then the the North American know? And then the the North American Menopause Society, which I was an active Menopause Society, which I was an active me member of, came out and basically me member of, came out and basically supported all of this nonsense in terms supported all of this nonsense in terms of hormones being evil and and that they of hormones being evil and and that they supported all of this craziness. So, I supported all of this craziness. So, I canceled my membership and that was canceled my membership and that was that. I just said, "I'm not giving you that. I just said, "I'm not giving you my money." Like, what are you doing for my money." Like, what are you doing for women? The American College of OBGYn women? The American College of OBGYn supported this nonsense of hormones are supported this nonsense of hormones are bad for you. Use That's when the mantra bad for you. Use That's when the mantra came out. The smallest dose for the came out. The smallest dose for the shortest time. And only use it if you shortest time. And only use it if you absolutely have to cuz you're going to absolutely have to cuz you're going to die from night sweats and hot flashes.

die from night sweats and hot flashes. Bones disappeared from the conversation Bones disappeared from the conversation altogether. So, very few women were altogether. So, very few women were going to use it. They were all afraid. I going to use it. They were all afraid. I begged my patients. I said, "I'm not begged my patients. I said, "I'm not even prescribing that. What I'm giving even prescribing that. What I'm giving you is human identical hormones." you is human identical hormones." Hormones don't go from good for you to Hormones don't go from good for you to evil for you just because you hit the evil for you just because you hit the age of menopause, which is so variable.

age of menopause, which is so variable. The so-called normal age of menopause is The so-called normal age of menopause is 45 to 55. So, a woman who's 46 and goes 45 to 55. So, a woman who's 46 and goes into menopause, which is still into menopause, which is still considered the normal range, but on the considered the normal range, but on the earlier side, her hormones become evil.

earlier side, her hormones become evil. But if a woman is lucky and she doesn't But if a woman is lucky and she doesn't go into menopause till 57, go into menopause till 57, like 11 years later, she has 11 more like 11 years later, she has 11 more years of these hormones and then years of these hormones and then hormones are good, but then they become hormones are good, but then they become evil for her when she's 57. It's like evil for her when she's 57. It's like these are the same hormones that your these are the same hormones that your body is making. What are they talking body is making. What are they talking about? They're talking nonsense. None of about? They're talking nonsense. None of this makes any sense. Look at the this makes any sense. Look at the science. Look at what hormones do in the science. Look at what hormones do in the body. You know, there was a lot of body. You know, there was a lot of research on hormones. It's not like we research on hormones. It's not like we didn't know anything. We did know. If I didn't know anything. We did know. If I knew, it's because I read the research.

knew, it's because I read the research. So, if I knew, anybody could know. But So, if I knew, anybody could know. But yet, it was all lost. It was like yet, it was all lost. It was like screaming in the wind for me. Like, screaming in the wind for me. Like, hormones are good. Hormones do good hormones are good. Hormones do good things. Don't Don't listen to this things. Don't Don't listen to this nonsense. I dropped out of all my nonsense. I dropped out of all my organizations. I quit my membership in organizations. I quit my membership in the American College of OBGYn, in the the American College of OBGYn, in the North American Menopause Society. I North American Menopause Society. I never went to another one of their never went to another one of their meetings. I said, "I'm not giving you a meetings. I said, "I'm not giving you a penny of my money until you apologize," penny of my money until you apologize," which neither organization has ever which neither organization has ever openly apologized for their position 25 openly apologized for their position 25 years ago and was ongoing. So, the women years ago and was ongoing. So, the women at that time were all getting off at that time were all getting off hormones and women who were going into hormones and women who were going into menopause were refused hormones or told menopause were refused hormones or told you can take a tiny dose for a very you can take a tiny dose for a very short period of time. And so I call it short period of time. And so I call it the lost generation of women. All the the lost generation of women. All the women who were denied and or removed women who were denied and or removed from their hormones. And now they are so from their hormones. And now they are so many I see them. They're very angry.

many I see them. They're very angry. They're very resentful for the fact that They're very resentful for the fact that they are now told and there's issues they are now told and there's issues involved in this as well, but they're involved in this as well, but they're told now you're too old lady. Like you told now you're too old lady. Like you missed the window of opportunity. So you missed the window of opportunity. So you missed it and now you can suffer from missed it and now you can suffer from all of these medical problems, all of all of these medical problems, all of these what we would call degenerative these what we would call degenerative diseases of aging which I call diseases of aging which I call degenerative diseases of hormone degenerative diseases of hormone deficiency state. Okay. And yep. So it deficiency state. Okay. And yep. So it was quite a wild ride all these years was quite a wild ride all these years and now I so I've been lecturing and now I so I've been lecturing [clears throat] for you know all this [clears throat] for you know all this time about what do hormones do in the time about what do hormones do in the body? Because if you understand what body?

Why HRT may be necessary before official menopause

Because if you understand what they do in the body, then you'll get a they do in the body, then you'll get a glimpse of what happens when you lose glimpse of what happens when you lose them. And for women, this is like the them. And for women, this is like the crazy, you know, split thinking on this.

crazy, you know, split thinking on this. for women who go nowadays and it's been for women who go nowadays and it's been for a while women who lose their for a while women who lose their hormones early. So we would say like hormones early. So we would say like early menopause is 40 up to 45 or early menopause is 40 up to 45 or premature you know ovarian insufficiency premature you know ovarian insufficiency they call it which would be like early they call it which would be like early early onset of menopause before the age early onset of menopause before the age of 40 like say could be you know the of 40 like say could be you know the worst case scenario is like in their worst case scenario is like in their teens but it could be in their 20s or teens but it could be in their 20s or their 30s. So that would be premature.

their 30s. So that would be premature. So you have either early or premature. So you have either early or premature. The current standard of care. Okay. The The current standard of care. Okay. The standard practice that's recommended is standard practice that's recommended is that you give physiologic levels of that you give physiologic levels of hormones to mimic the levels.

hormones to mimic the levels. You know, it was always an ish of women You know, it was always an ish of women who would be at their healthiest like in who would be at their healthiest like in their 20s to mimic the hormone estrogen their 20s to mimic the hormone estrogen levels of that time along with cyclic levels of that time along with cyclic progesterone. Of course, all progesterone. Of course, all bioidentical bioidentical bioidentical that's recommended as the primary best that's recommended as the primary best option as opposed to like hydroxy option as opposed to like hydroxy progesterone acetate which very very few progesterone acetate which very very few doctors prescribe anymore. that fell doctors prescribe anymore. that fell off, you know, the popularity wagon a off, you know, the popularity wagon a long time ago. And very little Premrin, long time ago. And very little Premrin, although that's still prescribed by although that's still prescribed by some, it's all on the market, but very some, it's all on the market, but very few are using that. And that's not like few are using that. And that's not like the the recommended preferred form of the the recommended preferred form of estrogen. It would be transermal estrogen. It would be transermal estradile. You know, estradile, the one estradile. You know, estradile, the one that the ovaries make, along with human that the ovaries make, along with human bioidentical progesterone. And for the bioidentical progesterone. And for the young women who lose their hormones, young women who lose their hormones, it's recommended that you give it to it's recommended that you give it to sort ofish mimic what a young woman sort ofish mimic what a young woman would have. But that's recommended would have. But that's recommended although there's no like absolute. It's although there's no like absolute. It's like you can do joint decision making.

like you can do joint decision making. Those are the the words that are used Those are the the words that are used now. Joint decision making the patient now. Joint decision making the patient and the health care provider to decide and the health care provider to decide what to do. But in general, it's what to do. But in general, it's recommended that once you hit the recommended that once you hit the so-called normal age of menopause, like

so-called normal age of menopause, like in the 50 to 52 range, that you just in the 50 to 52 range, that you just don't do that anymore. That you don't don't do that anymore. That you don't give physiologically dose cyclic give physiologically dose cyclic hormones. Instead, you give lowd dose hormones. Instead, you give lowd dose continuous or static or none at all.

continuous or static or none at all. That you give tiny doses. you suddenly That you give tiny doses. you suddenly way drop the doses and you change the way drop the doses and you change the regimen because you hit that magical age regimen because you hit that magical age when women typically go into menopause when women typically go into menopause as if that is sort of a prerequisite for as if that is sort of a prerequisite for aging that you just really should lose aging that you just really should lose your hormones ladies you know or get your hormones ladies you know or get very tiny amounts you know not to defy very tiny amounts you know not to defy nature well I defy nature all the time nature well I defy nature all the time that's what medicine is is defying that's what medicine is is defying nature why do we do have artificial nature why do we do have artificial joints why do we have replacement lenses joints why do we have replacement lenses when you get cataracts. I mean, why do when you get cataracts. I mean, why do we have pharmaceuticals? Why do we have we have pharmaceuticals? Why do we have stances in arteries for coronary artery stances in arteries for coronary artery disease? Is that not defying nature? We disease? Is that not defying nature? We want to help people to have healthy want to help people to have healthy longevity. And that means when nature longevity. And that means when nature takes us down the wrong path, we try to takes us down the wrong path, we try to do something to make it better. Because do something to make it better. Because if you don't believe that medicine is if you don't believe that medicine is about defying nature, then you know, about defying nature, then you know, then you don't know what medicine is.

then you don't know what medicine is. Because everything I do in medicine, Because everything I do in medicine, like when I did tons of obstetrics, if like when I did tons of obstetrics, if someone had, you know, a placenta pia, I someone had, you know, a placenta pia, I wouldn't say, "Well, let's see what wouldn't say, "Well, let's see what happens when they go into natural labor happens when they go into natural labor and they hemorrhage to death." No, I and they hemorrhage to death." No, I would do a preemptive C-section. I mean, would do a preemptive C-section. I mean, that's defying nature. Come on. So the that's defying nature. Come on. So the fact that women naturally go into fact that women naturally go into menopause, so we should naturally just menopause, so we should naturally just get rid of the hormones or if we're get rid of the hormones or if we're giving hormones, we give these tiny giving hormones, we give these tiny doses because it's so unnatural to have doses because it's so unnatural to have physiologic levels like you had when you physiologic levels like you had when you were younger. I say, you know, hogwash.

were younger. I say, you know, hogwash. You know, I want to give what's going to You know, I want to give what's going to give women the healthiest longevity. And give women the healthiest longevity. And of course I can't make people immortal of course I can't make people immortal but all the bad things that happen when but all the bad things that happen when this I call my halo of hormones is gone this I call my halo of hormones is gone and the you know the visible problems and the you know the visible problems the become overt the loss of hormones the become overt the loss of hormones becomes more obvious when women are becomes more obvious when women are going into their 60s and then certainly going into their 60s and then certainly in their 70s whereas it may not be as in their 70s whereas it may not be as obvious in their 50s but there are obvious in their 50s but there are things happening that they don't know things happening that they don't know about like with their bones with their about like with their bones with their arteries with their brains. Some of the arteries with their brains. Some of the things are not less are not so unobvious things are not less are not so unobvious like they may start having incontinence like they may start having incontinence and vaginal changes, sexual changes. So, and vaginal changes, sexual changes. So, you know, they look in the mirror, their you know, they look in the mirror, their skin on their face looks changed, you skin on their face looks changed, you know, they can see visible aging. So know, they can see visible aging. So it's not all invisible in the 50s, but it's not all invisible in the 50s, but it becomes more physically evident with it becomes more physically evident with hypertension and insulin resistance and hypertension and insulin resistance and osteoporotic fractures as women get into osteoporotic fractures as women get into their 60s and beyond. So anyway, that's their 60s and beyond. So anyway, that's a long history, but understanding a long history, but understanding history helps you to understand where we history helps you to understand where we are today and what is still in my view a are today and what is still in my view a nonsensical approach to hormone therapy nonsensical approach to hormone therapy in menopausal women which is still I in menopausal women

which is still I call it the horrible legacy of the call it the horrible legacy of the women's health initiative has not gone women's health initiative has not gone away. It still is pervasive in not away. It still is pervasive in not understanding menopause un Understanding understanding menopause un Understanding that menopause comes with a lot of bad that menopause comes with a lot of bad things is what is now being really things is what is now being really acknowledged. But what to do about it acknowledged. But what to do about it both in terms of emphasizing lifestyle both in terms of emphasizing lifestyle approaches, you know, like exercise, approaches, you know, like exercise, nutrition, stress reduction, sleep nutrition, stress reduction, sleep optimization, toxin reduction in terms optimization, toxin reduction in terms of exposure. That is not emphasized of exposure. That is not emphasized anywhere near enough. Not hardly at all anywhere near enough. Not hardly at all in many medical practices and certainly in many medical practices and certainly less in a lot of the dispensaries that less in a lot of the dispensaries that just give out hormone the hormone just give out hormone the hormone dispensaries where they just say, you dispensaries where they just say, you know, you don't even have to be talked know, you don't even have to be talked to. You just do a text message and you to. You just do a text message and you get your medication, you know, and get your medication, you know, and nobody knows anything. And you know, in nobody knows anything. And you know, in terms of how the hormones are prescribed terms of how the hormones are prescribed matters. It's not like every hormone matters. It's not like every hormone regimen gives you the same outcome. So a regimen gives you the same outcome. So a lot of the hormone terribleness I've lot of the hormone terribleness I've called the legacy of the women's health called the legacy of the women's health initiative is still living with us.

initiative is still living with us. There's still an underlying fear of There's still an underlying fear of hormones. I say there's many things to hormones. I say there's many things to be afraid of. But hormones from human be afraid of. But hormones from human bioididentical hormones, human identical bioididentical hormones, human identical hormones from the ovary should not be on hormones from the ovary should not be on the list of things to be feared. I mean the list of things to be feared. I mean like do you walk around are you afraid like do you walk around are you afraid of thyroid? I mean it's like who like of thyroid? I mean it's like who like what is that? You know, it's like, whoa, what is that? You know, it's like, whoa, I want the t if I have low thyroid, I I want the t if I have low thyroid, I want the tiniest amount of thyroid want the tiniest amount of thyroid hormone that will keep me alive. Like, hormone that will keep me alive. Like, no, you want an optimal dose to give you no, you want an optimal dose to give you what is physiologically most beneficial.

what is physiologically most beneficial. I'm just translating the same kind of I'm just translating the same kind of thinking to human female hormones. You thinking to human female hormones. You want an optimal regimen to make you the want an optimal regimen to make you the optimally healthy. Not the smallest optimally healthy. Not the smallest amount to keep you from having the worst amount to keep you from having the worst symptoms. You want optimal health. But symptoms. You want optimal health. But nevertheless, right now there is no FD nevertheless, right now there is no FD FDA approval for anything for hormones FDA approval for anything for hormones except for the same old same old except for the same old same old reduction of night sweats and hot reduction of night sweats and hot flashes and osteoporosis flashes and osteoporosis prevention. That's all we got now for prevention. That's all we got now for FDA approval. Fortunately, it's not FDA approval. Fortunately, it's not illegal to use medications off label for illegal to use medications off label for other uses and many of us are for other uses and many of us are for healthy longevity. So anyway, that's healthy longevity. So anyway, that's maybe more than you ever wanted to hear maybe more than you ever wanted to hear about the history of hormones, but if about the history of hormones, but if you don't know the past, it's really you don't know the past, it's really hard to understand the present.

hard to understand the present. Hey, Margie here. As a physical Hey, Margie here. As a physical therapist, I know firsthand how therapist, I know firsthand how important exercise is [music] for our important exercise is [music] for our bones, overall health, and happiness.

bones, overall health, and happiness. And unfortunately, there's a lot of And unfortunately, there's a lot of confusion [music] on what exercises are confusion [music] on what exercises are safe and effective for people with safe and effective for people with osteoporosis. [music] osteoporosis. [music] That's why I created this handout that That's why I created this handout that contains a 30inut video [music] where I contains a 30inut video [music] where I explain the concepts so you understand explain the concepts so you understand the dos and don'ts [music] when it comes the dos and don'ts [music] when it comes to exercise. And this is important to exercise. And this is important

because this way you can go into any because this way you can go into any [music] class and know what you should [music] class and know what you should be doing and what you should avoid be doing and what you should avoid because too many people are doing because too many people are doing exercises that [music] actually increase exercises that [music] actually increase their risk of spinal fractures. I also their risk of spinal fractures. I also included videos of me demonstrating included videos of me demonstrating [music] [music] [music] effective balance, posture, and effective balance, posture, and weightbearing exercises [music] you can weightbearing exercises [music] you can put into your day right away. So, all put into your day right away. So, all you need to do to access this [music] you need to do to access this [music] handout, it's free, is go to handout, it's free, is go to tinyurl.com/steoporosis exercises. So, it's t i n yurl.com exercises. So, it's t i n yurl.com again/oststeoporosisex [music] again/oststeoporosisex [music] exercises or you can click the link in exercises or you can click the link in the show notes. Now, back to the show.

the show notes. Now, back to the show. Yes, I think I think that was so Yes, I think I think that was so important and to me I look at it, yes, important and to me I look at it, yes, that was the past, but I see so much that was the past, but I see so much good happening. I mean, the fact that good happening. I mean, the fact that people can't even get their patches people can't even get their patches because they're sold out because because they're sold out because everyone is starting the resurgence. But everyone is starting the resurgence. But so interesting what you said and I think so interesting what you said and I think that's why I have you on here to really that's why I have you on here to really clear up how to do this properly. Who is clear up how to do this properly. Who is it safe for? Who is it not safe for?

it safe for? Who is it not safe for? Because this happens suddenly, you know, Because this happens suddenly, you know, suddenly it's removed that blackbox suddenly it's removed that blackbox warning. And it's interesting because I warning. And it's interesting because I was at the conference, the osteoporosis was at the conference, the osteoporosis conference, and they are so excited now conference, and they are so excited now people are when they go through people are when they go through menopause, we're going to prevent menopause, we're going to prevent osteoporosis. And these were physicians, osteoporosis. And these were physicians, conventional physicians, very excited conventional physicians, very excited about this. And at the same time, only about this. And at the same time, only only for people who were less than 10 only for people who were less than 10 years past menopause. like this was only years past menopause. like this was only for those people. So the question is you for those people. So the question is you know why has it translated to that and know why has it translated to that and my people in so many people in this my people in so many people in this community are in my generation where you community are in my generation where you know nobody would you know people were know nobody would you know people were not put on hormones because of all not put on hormones because of all everything you talked about and now everything you talked about and now they're wondering well is it safe for me they're wondering well is it safe for me is it not safe for me and what are the is it not safe for me and what are the guidelines so why don't we start with so guidelines so why don't we start with so people now I think it seems like people people now I think it seems like people if they're going through menopause if they're going through menopause Because they they now the doctors are on Because they they now the doctors are on board. Am I right about this? I mean, board. Am I right about this? I mean, they didn't even learn those obes about they didn't even learn those obes about estrogen. No, they didn't learn estrogen. No, they didn't learn anything, right? It's like the education anything, right? It's like the education on hormones and menopause disappeared.

on hormones and menopause disappeared. The only message that was being The only message that was being delivered was hormones are really delivered was hormones are really dangerous. You want to use the smallest dangerous. You want to use the smallest dose for the shortest amount of time if dose for the shortest amount of time if you use them at all. Then so let's talk you use them at all.

How to access HRT in a safe and effective way

Then so let's talk now what what is the optimal like now what what is the optimal like talking to people what you know how do talking to people what you know how do you tell people what they where they you tell people what they where they should go who they should work with how should go who they should work with how to do this in a safe and effective way to do this in a safe and effective way because what I'm seeing which is just so because what I'm seeing which is just so amazing a prevention b I always look at amazing a prevention b I always look at the

CTX to see bone breakdown and when the CTX to see bone breakdown and when people start the bio identical you know people start the bio identical you know it's amazing to see that number really it's amazing to see that number really reduce from the hormones. It's reduce from the hormones. It's incredible. You see it pretty quickly.

incredible. You see it pretty quickly. Within a couple months, you're not Within a couple months, you're not getting that bone breakdown. So, we know getting that bone breakdown. So, we know how powerful this is for our bones, how powerful this is for our bones, which has always been known. But, it's which has always been known. But, it's just exciting to me that now this is just exciting to me that now this is back in the forefront and people are back in the forefront and people are realizing how important, but we want to realizing how important, but we want to do it properly and we want as many do it properly and we want as many people as possible to benefit. Well, in people as possible to benefit. Well, in terms of menopause, the official terms of menopause, the official definition is man- made and it is late in definition is man-made and it is late in the game of ovarian aging. The official the game of ovarian aging. The official definition is 12 consecutive months with definition is 12 consecutive months with no vaginal bleeding. That's it. Okay?

no vaginal bleeding. That's it. Okay? So, you don't know when you're So, you don't know when you're officially in menopause based on this officially in menopause based on this definition until 12 months have passed definition until 12 months have passed and you haven't had a period. So, what and you haven't had a period. So, what what is that? That is man-made. And by what is that? That is man-made. And by the time that happens, you've already the time that happens, you've already suffered all kinds of harm. And there suffered all kinds of harm. And there are many doctors that still think you are many doctors that still think you don't start hormones until you reach don't start hormones until you reach that official time of menopause, which that official time of menopause, which is completely absurd. If a woman goes 11 is completely absurd. If a woman goes 11 months and then starts bleeding, there's months and then starts bleeding, there's not an OB/GYN that says, "Oh, I see not an OB/GYN that says, "Oh, I see you're fertile again. You're ovulating you're fertile again. You're ovulating after 11 months." That would be after 11 months." That would be suspicious bleeding. Like, why are you suspicious bleeding. Like, why are you bleeding after 11 months? It's bleeding after 11 months? It's arbitrary. Just because we have 12 arbitrary. Just because we have 12 months of the year doesn't mean you have months of the year doesn't mean you have 12 months of no bleeding and then you're 12 months of no bleeding and then you're suddenly automatically called suddenly automatically called menopausal. So if you think of it menopausal. So if you think of it differently, forget the uterus. The differently, forget the uterus. The uterus is just a target organ among all uterus is just a target organ among all the other organs that have receptors, the other organs that have receptors, which is all of them for these hormones.

which is all of them for these hormones. So it's just an obvious thing. Like I've So it's just an obvious thing. Like I've had patients, they had a hyerectomy.

had patients, they had a hyerectomy. They said, "Does that mean I don't go They said, "Does that mean I don't go into menopause?" It's like doesn't work into menopause?" It's like doesn't work that way. It's not about the uterus.

that way. It's not about the uterus. It's that's just one organ that you can It's that's just one organ that you can see the effects of when the hormones are see the effects of when the hormones are changing. So, it's about ovarian aging.

changing. So, it's about ovarian hormones. And we now It's about ovarian hormones. And we now know there's this period of time called know there's this period of time called the perry menopause. Of course, life is the perry menopause. Of course, life is always a continuum. You could say always a continuum. You could say pmenopause is the day you're born. But pmenopause is the day you're born. But you know in terms of when things really you know in terms of when things really escalate we call it the decade before escalate we call it the decade before the official menopause is pmenopause and the official menopause is pmenopause and things really escalate in the five years things really escalate in the five years before the official menopause. Now how before the official menopause. Now how would anybody know what those five years would anybody know what those five years when that's happening? Right? Well, some when that's happening? Right? Well, some women will have symptoms that if you women will have symptoms that if you actually do a little investigative actually do a little investigative reporting, you'll find that they do have reporting, you'll find that they do have altered sleep or mood or

achiness or altered sleep or mood or achiness or vaginal symptoms or bladder symptoms, vaginal symptoms or bladder symptoms, things like that. So, but if you just things like that. So, but if you just know the normal age of menopause is 45 know the normal age of menopause is 45 to 55, then by age 45, to 55, then by age 45, statistically speaking, virtually all statistically speaking, virtually all women would be in pmenopause. So there's women would be in pmenopause. So there's nothing wrong and there's nothing nothing wrong and there's nothing dangerous in giving some I call it dangerous in giving some I call it supple supplemental hormones and of supple supplemental hormones and of course you can do some measurements you course you can do some measurements you can certainly do like CTX you can look can certainly do like CTX you can look for bone breakdown products and see is for bone breakdown products and see is that happening you know are you losing that happening you know are you losing bone because we know that you can lose a bone because we know that you can lose a lot of collagen in your skin you know lot of collagen in your skin you know like skin changes occur before the like skin changes occur before the official menopause you can lose a lot of official menopause you can lose a lot of bone before the official menopause OS bone before the official menopause OS you can have vascular changes all these you can have vascular changes all these things happening before the official things happening before the official menopause. So understanding that these menopause. So understanding that these hormones particularly estradiol hormones particularly estradiol prevent these things. Okay. And prevent these things. Okay. And progesterone has a role as well. But so progesterone has a role as well. But so if you start the hormones and this is if you start the hormones and this is becoming more trendy too because I becoming more trendy too because I wasn't doing this my whole career. If wasn't doing this my whole career. If you start the hormones as a supplemental you start the hormones as a supplemental hormone in the permenopausal hormone in the permenopausal years, even if they're having regular years, even if they're having regular cycles, like I'll do menstrual mapping cycles, like I'll do menstrual mapping where using urine metabolites of these where using urine metabolites of these hormones, you can map out a normal hormones, you can map out a normal menstrual cycle and we'll say a classic menstrual cycle and we'll say a classic perfect menstrual cycle hormone. We'll perfect menstrual cycle hormone. We'll say for estrogen, it starts low, it say for estrogen, it starts low, it builds up, you get like a spike, and builds up, you get like a spike, and then it dips and then it comes up. So, then it dips and then it comes up. So, it's at this level. Okay? And then you it's at this level. Okay? And then you do the same thing in a woman who's 45.

do the same thing in a woman who's 45. She's still having cycles, but the same She's still having cycles, but the same hormones are like here. It's like hormones are like here. It's like they're miniaturaturized. Everything is they're miniaturaturized. Everything is lower. Okay, that's you know their eggs lower. Okay, that's you know their eggs are older. They're not fertile are older. They're not fertile particularly. They can they're not particularly. They can they're not sterile, but their fertility at age 45 sterile, but their fertility at age 45 is so much reduced. You know, women who is so much reduced. You know, women who say I want to have a baby and I'm 45.

say I want to have a baby and I'm 45. The probability is not great. It's like The probability is not great. It's like pretty low, not impossible. But their pretty low, not impossible. But their hormones, their eggs, you know, you have hormones, their eggs, you know, you have to have healthy eggs to make healthy to have healthy eggs to make healthy hormones. And it's like all linked in hormones. And it's like all linked in together and it becomes like a downward together and it becomes like a downward spiral in terms of the less estrogen you spiral in terms of the less estrogen you have, the less estrogen you make because have, the less estrogen you make because the estrogen estradi is made in the the estrogen estradi is made in the mitochondria in the ovaries. And in mitochondria in the ovaries. And in order for mitochondria to be healthy and order for mitochondria to be healthy and functioning optimally, you need estradi.

functioning optimally, you need estradi. And so when you have less estradiol your And so when you have less estradiol your mitochondria which are the energy mitochondria which are the energy powerhouses but they also that's where powerhouses but they also that's where you make steroid hormones. So they you make steroid hormones. So they become less functional. So then less become less functional. So then less estradi less mitochondrial function less estradi less mitochondrial function less estradi production and it comes like a estradi production and it comes like a downward spiral. And understanding this downward spiral. And understanding this can help to get doctors and health care can help to get doctors and health care pro professionals to start prescribing pro professionals to start prescribing these hormones that are so critical for these hormones that are so critical for every organ system. And you know we every organ system. And you know we focus on bone because

bone has not been focus on bone because bone has not been as popular an organ system. You know the as popular an organ system. You know the musculark eeletal system has not been as musculark eeletal system has not been as talked about as the cardiovascular talked about as the cardiovascular system, the neurological system. You system, the neurological system. You need all these systems, you know, and need all these systems, you know, and and bone is in, interestingly enough, an and bone is in, interestingly enough, an endocrine system, you know, it's like so endocrine system, you know, it's like so many functions that have not been really many functions that have not been really talked about enough. So all of these talked about enough. So all of these systems will be benefited by getting systems will be benefited by getting hormones on board to a somewhat hormones on board to a somewhat mimicking physiologic level so that you mimicking physiologic level so that you don't have that miniaturization of your don't have that miniaturization of your hormone levels years before you actually hormone levels years before you actually lose all your hormones and lose all your lose all your hormones and lose all your cycles when you go into the official cycles when you go into the official menopause. So my recommendation is for menopause. So my recommendation is for those of you who haven't yet reached those of you who haven't yet reached that official menopause which is not a a that official menopause which is not a a lot of us have already missed that lot of us have already missed that window that you start hormones and find window that you start hormones and find a practitioner who understands hormones a practitioner who understands hormones whatever that takes to get you on board whatever that takes to get you on board with some hormones. Not heavyduty high with some hormones. Not heavyduty high high doses but just enough so that high doses but just enough so that because we know even a small amount of because we know even a small amount of additional like you mentioned a small additional like you mentioned a small amount of additional hormones can really amount of additional hormones can really help the bones a lot. So the bones are help the bones a lot. So the bones are very sensitive to hormones. So even a very sensitive to hormones. So even a tiny amount of estradiol can help tiny amount of estradiol can help prevent bone loss. To have bone growth prevent bone loss. To have bone growth you need much higher amounts but to you need much higher amounts but to prevent bone loss is not not that much.

prevent bone loss is not not that much. It's amazing. So it's really important It's amazing. So it's really important but we lose so much bone before you even but we lose so much bone before you even have a clue that you're already have a clue that you're already officially in menopause. So starting officially in menopause. So starting hormones early I you know in men perry hormones early I you know in men perry menopause is is important and then menopause is is important and then [clears throat] in my opinion you just [clears throat] in my opinion you just keep going once you get on the hormones keep going once you get on the hormones you never stop like why would people up you never stop like why would people up it's changing now but until relatively it's changing now but until relatively recently there was considered a hard recently there was considered a hard stop like if you were on them not stop like if you were on them not starting but ending so now they don't starting but ending so now they don't want to start women who are over 60 but want to start women who are over 60 but it wasn't long ago that they wanted to it wasn't long ago that they wanted to stop all women on hormones when they hit stop all women on hormones when they hit 60. It's like, you're too old, lady. Now 60. It's like, you're too old, lady. Now you have to stop your hormones. It's you have to stop your hormones. It's like so that you can just start the like so that you can just start the clock ticking and start losing all your clock ticking and start losing all your bone, all your collagen, your joints bone, all your collagen, your joints will degrade, and then all the other will degrade, and then all the other organ systems will follow suit. So, what organ systems will follow suit. So, what is there about age 60 that would dictate is there about age 60 that would dictate that you should suddenly stop the that you should suddenly stop the hormones? Nothing. So, that that's hormones? Nothing. So, that that's fading away, but not everywhere. There fading away, but not everywhere. There are still some doctors that haven't are still some doctors that haven't gotten the message. I don't know.

gotten the message. I don't know. They're in a La La Land and they just They're in a La La Land and they just don't know that you don't have to ever don't know that you don't have to ever stop hormones. I mean, ever. There's no stop hormones. I mean, ever. There's no hard stop date. It's like I call it the hard stop date. It's like I call it the end of life. That's your hard stop date.

end of life. That's your hard stop date. So, why would I stop them? Because as So, why would I stop them? Because as soon as you stop hormones, bone loss soon as you stop hormones, bone loss escalates rapidly. Why on earth would escalates rapidly. Why on earth would you just stop them? But many women have you just stop them? But many women have been, you know, they were on hormones been, you know, they were on hormones

and then they reach 60, maybe 65, and and then they reach 60, maybe 65, and then they're stopped. If you're on then they're stopped. If you're on Medicare, Medicare doesn't want to cover Medicare, Medicare doesn't want to cover hormones if you're 65 or older. They hormones if you're 65 or older. They think you're too old. And they used to, think you're too old. And they used to, I'm not sure if they still do, but they I'm not sure if they still do, but they would send a letter to women saying, would send a letter to women saying, "You're no longer going to have coverage "You're no longer going to have coverage for your hormones, but you can go on for your hormones, but you can go on Prozac." Prozac." Prozac." >> That's >> That's >> That's crazy. I just have a quick question for crazy. I just have a quick question for you. Early on, do you do blood value so you. Early on, do you do blood value so you know their blood levels early on you know their blood levels early on that 45year-old? like are you starting that 45year-old? like are you starting blood work at that point and monitor?

blood work at that point and monitor? >> I will sometimes get like the menstrual >> I will sometimes get like the menstrual mapping. The problem with estradi is mapping. The problem with estradi is that the levels are shifting throughout that the levels are shifting throughout the entire cycle. So if you're going to the entire cycle. So if you're going to do it, which I do sometimes do, you do it, which I do sometimes do, you would want to get it at a timed point.

would want to get it at a timed point. So you'd want to get it on one week So you'd want to get it on one week before if you have a 28 day cycle. You'd before if you have a 28 day cycle. You'd want to get the levels of estradile and want to get the levels of estradile and progesterone on day 21, which is what progesterone on day 21, which is what we've done for women who are having we've done for women who are having fertility issues to see are you getting fertility issues to see are you getting a good spike of progesterone. Where are a good spike of progesterone. Where are you at with your estradile? Because then you at with your estradile? Because then you would be at your peak ludial phase you would be at your peak ludial phase levels. So that would be but even that levels. So that would be but even that has a a significant range even in like has a a significant range even in like healthy 25 year olds like progesterone healthy 25 year olds like progesterone like what's a normal peak progesterone like what's a normal peak progesterone level well it should be over 10 it could level well it should be over 10 it could be up to 30 I mean that's like one heck be up to 30 I mean that's like one heck of a big range and I've seen it so many of a big range and I've seen it so many times that we test it and it's like oh times that we test it and it's like oh it's just 11 and then they have a it's just 11 and then they have a perfectly normal pregnancy you know or perfectly normal pregnancy you know or it's like 25 and then they don't get it's like 25 and then they don't get pregnant you know so you know it's h the pregnant you know so you know it's h the range of normal is so significant if you range of normal is so significant if you look at the ludal phase levels for look at the ludal phase levels for estradiol it could be I mean if you got estradiol it could be I mean if you got a ludial phase level and it was 50 a ludial phase level and it was 50 you're in trouble okay this is poggrams you're in trouble okay this is poggrams per mill but so normal could be up to per mill but so normal could be up to over 200 but it could be like 125 in over 200 but it could be like 125 in some women and they have a healthy some women and they have a healthy pregnancy you know it would be great if pregnancy you know it would be great if we got lots of like every year from the we got lots of like every year from the time you're 25 we did, but nobody's time you're 25 we did, but nobody's doing this. You know, you get like peak doing this. You know, you get like peak ludial phase levels, assuming you're not ludial phase levels, assuming you're not on birth control pills, in which case on birth control pills, in which case you have no none of this is applicable, you have no none of this is applicable, but you get a peak level of the ludal but you get a peak level of the ludal phase like day 21 of a 28 day cycle and phase like day 21 of a 28 day cycle and you do it every year, you know, and then you do it every year, you know, and then you see, well, how is this changing over you see, well, how is this changing over time? That would be really interesting.

time? That would be really interesting. Nobody's doing that. I haven't been Nobody's doing that. I haven't been doing that, but that that would be like doing that, but that that would be like to me really amazing to do that and then to me really amazing to do that and then see if there's a trend over time as you see if there's a trend over time as you get say around age 40 where it's really get say around age 40 where it's really clearly dropping even though it could be clearly dropping even though it could be so-called in the normal range. Right. So so-called in the normal range. Right. So very very interesting.

very very interesting. >> Basically though what you're saying is >> Basically though what you're saying is the low dose at that point just to give the low dose at that point just to give you a little additional can make all the you a little

additional can make all the difference in the world.

difference in the world. >> It's like a safety net. >> It's like a safety net. >> Yeah. Yeah. So that's great. And then >> Yeah. Yeah. So that's great.

What Dr. Gersh says about different HRT regimens

And then once people hit menopause and they're once people hit menopause and they're not cycling, that's when we can do more not cycling, that's when we can do more monitoring. So talk about okay, so now monitoring. So talk about okay, so now what is safe? Because you also hear all what is safe? Because you also hear all different things and you know sometimes different things and you know sometimes you just want to cringe. You hear you just want to cringe. You hear pellets, you hear this, you hear that.

pellets, you hear this, you hear that. Do you want to share your feelings on Do you want to share your feelings on what's safe and how to go about it in what's safe and how to go about it in the best way?

the best way? >> Sure. Well, the current most popular >> Sure. Well, the current most popular hormone regimen is not in any way hormone regimen is not in any way physiologic. It's actually not based on physiologic. It's actually not based on any science. It's just convenience. And any science. It's just convenience. And I there's a certain point in having I there's a certain point in having something that's easy to use and something that's easy to use and convenient. But I'm a very sort of if it convenient. But I'm a very sort of if it doesn't match with human physiology, doesn't match with human physiology, it's not my favorite. Okay. Is it better it's not my favorite. Okay. Is it better than nothing? Well, clearly for the than nothing? Well, clearly for the bones it is better than nothing. Is it bones it is better than nothing. Is it better for the brain than nothing?

better for the brain than nothing? That's so that's unclear. That's like That's so that's unclear. That's like which we can touch on. So the most which we can touch on. So the most common popular method protocol for common popular method protocol for hormones now is a very small dose not hormones now is a very small dose not like minute although some people are on like minute although some people are on like the patch comes in five different like the patch comes in five different doses. Many women are put on the very doses. Many women are put on the very lowest dose 0.025 025, which is not an lowest dose 0.025 025, which is not an ideal dose even for reducing nights, ideal dose even for reducing nights, sweats, and hot flashes. That's not the sweats, and hot flashes. That's not the ideal dose at all. But most women are ideal dose at all. But most women are probably on the 0.05. That's like the probably on the 0.05. That's like the most popular. That is the dose that was most popular. That is the dose that was used in the study called the keep study used in the study called the keep study that they did for just a few years back that they did for just a few years back I don't know like around 2007 something I don't know like around 2007 something like that to see if that by using more like that to see if that by using more bioidentical hormones that study used bioidentical hormones that study used a 045 millgram dose of primer and the a 045 millgram dose of primer and the women's health initiative was 625 so women's health initiative was 625 so they used a smaller dose of primer and they used a smaller dose of primer and they used an estrogen patch of 0.05 they used an estrogen patch of 0.05 and then they combined it with oral and then they combined it with oral progesterone 200 mg for 12 days and in a progesterone 200 mg for 12 days and in a cyclic regimen. They measured the cyclic regimen. They measured the estradiol levels and the vast majority estradiol levels and the vast majority of women never got out of the menopausal of women never got out of the menopausal range of estradi on that dose. It was range of estradi on that dose. It was higher than like some women in menopause higher than like some women in menopause their levels will be like less than 10 their levels will be like less than 10 like like rock bottom it'll be like like like rock bottom it'll be like seven eight it's like really really seven eight it's like really really really low levels of estradile some will really low levels of estradile some will be more like 20 and their levels were be more like 20 and their levels were higher but it rarely got above like a 40 higher but it rarely got above like a 40 which is anything below 50 is still which is anything below 50 is still considered in the menopausal range so I considered in the menopausal range so I wouldn't call that like that would not wouldn't call that like that would not be a level that you would see in women be a level that you would see in women who were healthy 25 y olds for more than who were healthy 25 y olds for more than just maybe a couple of days of the just maybe a couple of days of the menstrual cycle. That would be at the menstrual cycle. That would be at the like when they're bleeding when the like when they're bleeding when the estradiol level is the lowest. It would estradiol level is the lowest. It would not be a

continual that's their level not be a continual that's their level because that's what they would give the because that's what they would give the estradiol patch at 0.05 every day. That estradiol patch at 0.05 every day. That was the dose of patch that was on them.

was the dose of patch that was on them. So their levels would never get above So their levels would never get above that which is not physiologic that which is not physiologic but it does do good some good stuff for but it does do good some good stuff for bone. So I have to say that and then it bone. So I have to say that and then it would be combined with an nowadays the would be combined with an nowadays the most common is oral progesterone most common is oral progesterone typically at 100 milligrams. Now oral typically at 100 milligrams. Now oral progesterone progesterone progesterone when you take it like we have moved away when you take it like we have moved away most of us from oral estrogen because we most of us from oral estrogen because we know it has what's called the first pass know it has what's called the first pass through the liver. When you swallow it through the liver. When you swallow it goes through the digestive tract and it goes through the digestive tract and it goes to the liver. The liver is the goes to the liver. The liver is the master organ of metabolic master organ of metabolic transformation. It has all these enzyme transformation. It has all these enzyme systems that convert one molecule into systems that convert one molecule into another molecule primarily for the another molecule primarily for the purpose of either making proteins or purpose of either making proteins or converting something from fat to water converting something from fat to water soluble so you can exit it from the body soluble so you can exit it from the body because that's part of the like bot because that's part of the like bot transformation or detoxification transformation or detoxification function of the liver. So when the liver function of the liver. So when the liver was never designed to suddenly see these was never designed to suddenly see these large bololises of hormones showing up large bololises of hormones showing up because that's not how it works from the because that's not how it works from the ovaries. When the ovaries produce these ovaries. When the ovaries produce these hormones, it goes into the bloodstream hormones, it goes into the bloodstream in little pulses throughout the day and in little pulses throughout the day and night. It doesn't have like whoa a big night. It doesn't have like whoa a big bunch comes out at first thing in the bunch comes out at first thing in the morning and just you know like just morning and just you know like just inates the body with hormone. It's not inates the body with hormone. It's not how it works. So when you have the liver how it works. So when you have the liver suddenly seeing this huge amount of suddenly seeing this huge amount of estradile, it's like what the heck is estradile, it's like what the heck is going on here? Anyway, it converts the going on here? Anyway, it converts the vast majority of it to a different form vast majority of it to a different form of estrogen called eststerone of estrogen called eststerone which has a different binding ability to which has a different binding ability to different receptors. It binds to one different receptors. It binds to one predominantly the alpha whereas estradi predominantly the alpha whereas estradi has affinity for all the different has affinity for all the different receptors the three receptors alpha beta receptors the three receptors alpha beta and groin coupled receptor. It's in the and groin coupled receptor. It's in the family of estrogens. But just like all family of estrogens. But just like all fats are not the same. There's fats are not the same. There's saturated, monounsaturated, saturated, monounsaturated, you know, there's polyunsaturated, all you know, there's polyunsaturated, all these different fats, even though they these different fats, even though they belong to the family of fats. So they're belong to the family of fats. So they're different estrogens. They belong to the different estrogens. They belong to the family of estrogens, but they have family of estrogens, but they have different abilities to do different different abilities to do different things in the body. So you swallow things in the body. So you swallow estradi, but in the blood, it comes in estradi, but in the blood, it comes in as estrone. So we've moved away from as estrone. So we've moved away from that because we want estradi. That's the that because we want estradi. That's the estrogen that the ovary pops into the estrogen that the ovary pops into the bloodstream. Well, what happens when you bloodstream. Well, what happens when you swallow progesterone? Well, it goes to swallow progesterone? Well, it goes to the liver just the same through the the liver just the same through the digestive tract. And about 90% of that digestive tract. And about 90% of that progesterone is converted by the liver progesterone is converted by the liver into other stuff called metabolites.

into other stuff called metabolites. Like over 30 different molecules are Like over 30 different molecules are made from progesterone. And only a small made from progesterone. And only a small amount, really small amount of amount, really small amount of progesterone actually gets into the progesterone actually gets into the bloodstream. and it gets in like a bloodstream. and it gets in like a little spike and then it's down pretty little spike and then it's down pretty fast. Like within two hours it's all fast. Like within two hours it's all gone. It goes drip pretty much. And the gone. It goes drip pretty much. And the dominant metabolite that's coming from dominant metabolite that's

coming from progesterone through this change of it progesterone through this change of it in the liver is called alopregnanolone.

in the liver is called alopregnanolone. Now alopreganolone is not progesterone. Now alopreganolone is not progesterone. It doesn't bind to the same receptors.

It doesn't bind to the same receptors. It's a different molecule but it's a It's a different molecule but it's a very important molecule in the brain in very important molecule in the brain in the right amount. When you have the the right amount. When you have the right amount of alopignolone in the right amount of alopignolone in the brain, it seems to be neuroprotective.

brain, it seems to be neuroprotective. It may reduce the risk of Alzheimer's It may reduce the risk of Alzheimer's and it binds to the GABA A receptor.

and it binds to the GABA A receptor. GABA is an a neurotransmitter and of GABA is an a neurotransmitter and of course it's elsewhere because all these course it's elsewhere because all these things are multitasking. But in the things are multitasking. But in the brain, it's an inhibitory brain, it's an inhibitory neurotransmitter.

neurotransmitter. neurotransmitter. So it kind of calms the brain down. It So it kind of calms the brain down. It makes you sleepy. It like reduces makes you sleepy. It like reduces anxiety. It facilitates sleep. Okay, anxiety. It facilitates sleep. Okay, that's why you know people like GABA.

that's why you know people like GABA. And when you take a tranquilizer like And when you take a tranquilizer like Valium or Xanax, it also works on GABA, Valium or Xanax, it also works on GABA, it works on the GABA A receptors at a it works on the GABA A receptors at a different spot, but in a similar manner different spot, but in a similar manner to facilitate calmness and sleep. So to facilitate calmness and sleep. So that's why a lot of women, they take that's why a lot of women, they take progesterone orally, and they say, "Wow, progesterone orally, and they say, "Wow, I'm sleeping better, lady. I'm sorry to I'm sleeping better, lady. I'm sorry to tell you this. You're taking a sleeping tell you this. You're taking a sleeping pill. you're taking a tranquilizer pill. you're taking a tranquilizer because it's being converted in the because it's being converted in the liver to the molecule alopreganolone liver to the molecule alopreganolone which is not a benzoazipene. It's not which is not a benzoazipene. It's not you know it's not addicting in the same you know it's not addicting in the same sense like if you took Valium all the sense like if you took Valium all the time but it works in a very similar time but it works in a very similar comparable manner to increase GABA. And comparable manner to increase GABA. And you know, it's like you're like you're you know, it's like you're like you're taking a sleeping pill or tranquilizer taking a sleeping pill or tranquilizer every night and you're getting very every night and you're getting very little progesterone, but you're using it little progesterone, but you're using it really as what is called, this is the really as what is called, this is the official word, a pro drug. You're using official word, a pro drug. You're using it, you're taking it as progesterone, it, you're taking it as progesterone, but it you're actually liking it because but it you're actually liking it because it's turning into something else. Okay?

it's turning into something else. Okay? And you get very little progesterone. And you get very little progesterone. And progesterone has a whole bunch of And progesterone has a whole bunch of really good effects, but you don't get really good effects, but you don't get much of them when you do that. But the much of them when you do that. But the interesting thing is that somehow it interesting thing is that somehow it alters the genetic priming of the alters the genetic priming of the endometrial cells, the lining cells of endometrial cells, the lining cells of the uterus to lower the risk of uterine the uterus to lower the risk of uterine cancer. It doesn't actually convert it cancer. It doesn't actually convert it to like the way that progesterone to like the way that progesterone converts the uterine lining to converts the uterine lining to secrettory like the change effect in a secrettory like the change effect in a normal menstrual cycle. It doesn't normal menstrual cycle. It doesn't really do that. It does something really do that. It does something genetically to the uterine lining cells genetically to the uterine lining cells that lowers the risk of turning into that lowers the risk of turning into cancer. That said, continuous cancer. That said, continuous progesterone with estradiol does not progesterone with estradiol does not seem to be so protective once you get seem to be so protective once you get five years out and that all the data is five years out and that all the data is with also that 0.05 dose. So you with also that 0.05 dose. So you shouldn't be like so cocky, you know, shouldn't be

like so cocky, you know, anybody out there. Oh, I'm so protected anybody out there. Oh, I'm so protected from uterine cancer because it seems from uterine cancer because it seems that effect seems to dissipate by 3 to 5 that effect seems to dissipate by 3 to 5 years and it's only really been shown years and it's only really been shown with that one dose of estradiol, the with that one dose of estradiol, the 0.05. So, you still have to be alert if 0.05. So, you still have to be alert if you start having random bleeding or you start having random bleeding or whatever because it's not like you're whatever because it's not like you're guaranteed you can't get uterine cancer guaranteed you can't get uterine cancer from like an opposed estrogen effect from like an opposed estrogen effect because that progesterone is really not because that progesterone is really not not as good as people like to think it not as good as people like to think it is for that purpose. But here's where is for that purpose. But here's where the problem is. We don't have human the problem is. We don't have human data. We only have rodent data like mice data. We only have rodent data like mice and rats. But if you gave a bunch of and rats. But if you gave a bunch of rats the same protocol where you gave rats the same protocol where you gave them continuous progesterone that in them continuous progesterone that in that manner and you gave them a small that manner and you gave them a small amount of estradile all the time that amount of estradile all the time that constant exposure to stimulated GABA constant exposure to stimulated GABA which is inhibitory.

which is inhibitory. It can also inh like you're not going to It can also inh like you're not going to have the most amazing brilliant thoughts have the most amazing brilliant thoughts as you're falling asleep. You may think as you're falling asleep. You may think you are but you're not. you don't you are but you're not. you don't remember stuff because it impairs memory remember stuff because it impairs memory and it impairs cognitive function and it impairs cognitive function because you're falling asleep. Okay?

because you're falling asleep. Okay? You're not your brain is supposed to be You're not your brain is supposed to be resting. So if you're constantly resting. So if you're constantly exposing your brain to supraysiologic exposing your brain to supraysiologic doses when you take oral progesterone doses when you take oral progesterone like a 100 milligrams the amount of GABA like a 100 milligrams the amount of GABA stimulation the amount of alopanolone stimulation the amount of alopanolone that circulates in the blood is that circulates in the blood is something like like two and a half three something like like two and a half three times the level you would ever naturally times the level you would ever naturally ever have at a peak in a a natural ever have at a peak in a a natural menstrual cycle. And if you're on 200, menstrual cycle. And if you're on 200, it's like five times the level of alop it's like five times the level of alop pregnanolone. And if that and in a human pregnanolone. And if that and in a human female, it would only be for a much less female, it would only be for a much less amount for only 14 days a month. But so amount for only 14 days a month. But so if it's every day, every day, every day if it's every day, every day, every day, every day in rodents, they get demented.

in rodents, they get demented. Now, we don't have human data. So the Now, we don't have human data. So the way I look at it, and I don't have a way I look at it, and I don't have a better way to look at it because I don't better way to look at it because I don't have human data. If I had a study and I have human data. If I had a study and I gave a bunch of rats a drug and most of gave a bunch of rats a drug and most of the rats died, I probably wouldn't the rats died, I probably wouldn't prescribe that drug to all my patients.

prescribe that drug to all my patients. If I have a study with rodents and most If I have a study with rodents and most of them get demented, I don't really of them get demented, I don't really want to give that regimen to my patients want to give that regimen to my patients or to myself. Do I have the absolute or to myself. Do I have the absolute answer? No, I do not. We know that small answer? No, I do not. We know that small amounts maybe of of oral progesterone to amounts maybe of of oral progesterone to get more physiologic levels of alop get more physiologic levels of alop pregnanolone which do tend to decline pregnanolone which do tend to decline with aging may actually be beneficial.

with aging may actually be beneficial. So we definitely what do we need? We So we definitely what do we need? We need human studies desperately. So with need human studies desperately. So with a lack of human studies and with the a lack of human studies and with the standard recommendation that in early standard recommendation that in early onset of menopause women that you give onset of menopause women that you give physiologic cyclic regimens. That's what physiologic cyclic regimens. That's what I think is the preferred regimen pending I think is the preferred regimen pending more data. So I don't want to do more data. So I don't want to do

anything that could increase dementia anything that could increase dementia risk in my patients. I do not want to do risk in my patients. I do not want to do that even for the convenience of not that even for the convenience of not having well hopefully not having having well hopefully not having bleeding. Many women will have what we bleeding. Many women will have what we would call unscheduled bleeding the would call unscheduled bleeding the first year that they're on these first year that they're on these continuous dose regimens. But some women continuous dose regimens. But some women will have them just randomly anytime.

will have them just randomly anytime. And I already mentioned that three to And I already mentioned that three to five years out we don't really have five years out we don't really have great great data that it's really as great great data that it's really as protective as people thought for protective as people thought for preventing uterine cancer. So you know preventing uterine cancer. So you know there's a lot of still research that there's a lot of still research that needs to be done in terms of there was a needs to be done in terms of there was a wonderful study that was in France the wonderful study that was in France the E3N study and that looked at human E3N study and that looked at human identical hormones and it looked at both identical hormones and it looked at both constant dosing and sequential or you constant dosing and sequential or you know like cycling dose and both of them know like cycling dose and both of them did not increase the risk of breast did not increase the risk of breast cancer. I just want to bring that in cancer. I just want to bring that in because that's often a just a fear for because that's often a just a fear for women. That is not not an issue anymore women. That is not not an issue anymore with the bio identicals, but they did with the bio identicals, but they did show potentially a reduced risk of show potentially a reduced risk of breast cancer with the cycling. So that breast cancer with the cycling. So that is another kind of interesting thing. So is another kind of interesting thing. So cycling seems to be re cycling seems to be re not having a breast cancer effect than not having a breast cancer effect than continuous. It's just so continuous. It's just so non-physiologic. There's no human female non-physiologic. There's no human female that ever has a regimen like that. So I that ever has a regimen like that. So I I just say, okay, what is the biggest I just say, okay, what is the biggest failed experiment of we're smarter than failed experiment of we're smarter than nature? We can create something better nature? We can create something better than nature created. I call it than nature created. I call it ultrarocessed food. We can make food ultrarocessed food. We can make food that tastes better. It'll have more that tastes better. It'll have more salt, sugar, and fat. Tastes better than salt, sugar, and fat. Tastes better than any natural food. And guess what? It any natural food. And guess what? It won't spoil. You know, we'll put in won't spoil. You know, we'll put in trans fat. So you can eat that Twinkie trans fat. So you can eat that Twinkie from, you know, a time capsule in a from, you know, a time capsule in a hundred years and enjoy it. Well, guess hundred years and enjoy it. Well, guess what? Real food spoils. And real food what? Real food spoils. And real food tastes great when it's grown, you know, tastes great when it's grown, you know, especially organically when you can get especially organically when you can get it. And the failed experiment of it. And the failed experiment of ultrarocessed food is what has hugely ultrarocessed food is what has hugely contributed to our massive epidemic of contributed to our massive epidemic of diabetes and obesity worldwide. So my diabetes and obesity worldwide. So my thinking is why would we think that we thinking is why would we think that we can create a hormone regimen that's can create a hormone regimen that's better than physiologic hormones and better than physiologic hormones and somehow women will be better off with somehow women will be better off with that. I just figure nature knows best that. I just figure nature knows best and if I'm going to go against nature and if I'm going to go against nature and keep hormones going after menopause and keep hormones going after menopause because I want the benefits of hormones because I want the benefits of hormones minus the fertility part that comes from minus the fertility part that comes from hormones. Forget that part. I just want hormones. Forget that part. I just want the other benefits of hormones. Then I the other benefits of hormones. Then I think why am why why would I think that think why am why why would I think that I can create a hormone regimen that I can create a hormone regimen that never exists in any human female or any never exists in any human female or any creature on the planet and that's going creature on the planet and that's going to be better than what nature created to be better than what nature created that kept women at their peak health that kept women at their peak health like in their 20s and 30s. So anyway like in their 20s and 30s. So anyway that's my simple thinking and so you that's my simple thinking and so you know I say take hormones in the most know I say take hormones in the most physiologic way you know but you can do physiologic way you know but you can do it however you want. I'm just saying it however you want. I'm just saying that I'm just I'm actually really that I'm just I'm actually really conservative. I say why am I conservative. I say why am I experimenting with regimens that have no experimenting with regimens that have no long-term good data and are scary in long-term good data and are scary in rats. So why would I do that when I know rats. So why would I do that when I know the good data that we have on human the good data that we have on human physiologic cycling

and doses and I say physiologic cycling and doses and I say never stop them. Start them early and never stop them. Start them early and not worry that it's unnatural because not worry that it's unnatural because everything we do in medicine is everything we do in medicine is unnatural. natural is you just age and unnatural. natural is you just age and you take you take your lumps. You know, you take you take your lumps. You know, you have all the degenerative diseases you have all the degenerative diseases of aging as they come. And women have of aging as they come. And women have more degenerative joints and joint more degenerative joints and joint replacements than men. As you know, and replacements than men. As you know, and hopefully all your watchers know, women hopefully all your watchers know, women make up 80% of those suffering from make up 80% of those suffering from osteoporotic fractures. They have 23 of osteoporotic fractures. They have 23 of all the dementia patients are women. You all the dementia patients are women. You know, women live longer, but they live know, women live longer, but they live with more chronic diseases. By age 65, with more chronic diseases. By age 65, women 75% of women have hypertension. By women 75% of women have hypertension. By age 75, 85% of women have hypertension.

age 75, 85% of women have hypertension. Women by age 65 suffer more ruptured Women by age 65 suffer more ruptured aneurysms and strokes than do men. Women aneurysms and strokes than do men. Women have a lot of problems. Women have high have a lot of problems. Women have high levels of incontinence, vaginal prolapse levels of incontinence, vaginal prolapse issues, joint issues. I said, you know, issues, joint issues. I said, you know, all these things are happening and all all these things are happening and all of these things can be not prevented, of these things can be not prevented, but we'll say the onset delayed. So, but we'll say the onset delayed. So, it's like delay the inevitable. Well, it's like delay the inevitable. Well, bad things are going to happen to all of bad things are going to happen to all of us because we're mortal, but I call it us because we're mortal, but I call it kicking the can down the road. If you kicking the can down the road. If you can prevent a bone fracture by having can prevent a bone fracture by having good bones, even a little bit stronger good bones, even a little bit stronger bones, can delay a fracture by a decade.

bones, can delay a fracture by a decade. It's like amazing the effect of just a It's like amazing the effect of just a little more bone. And then I just want I little more bone. And then I just want I don't want to end without just giving a don't want to end without just giving a little bit of of you know a praise to little bit of of you know a praise to progesterone for bone health because you progesterone for bone health because you know estradile everyone should know is know estradile everyone should know is really important for bone health. It really important for bone health. It even has the FDA seal of approval to even has the FDA seal of approval to give estradile to prevent osteoporosis.

give estradile to prevent osteoporosis. Although that has never been like a Although that has never been like a standard practice. It has not. But it standard practice. It has not. But it should be but it has not. Okay. In my should be but it has not. Okay. In my practice it is, but not generally practice it is, but not generally speaking. But progesterone speaking. But progesterone is really not appreciated. you know, the is really not appreciated. you know, the dose that you get when you take oral dose that you get when you take oral progesterone is so little because most progesterone is so little because most of it's converted to other stuff and of it's converted to other stuff and then it's just shortlived. But then it's just shortlived. But progesterone has its own really unique progesterone has its own really unique benefits for bone. So, have you talked benefits for bone. So, have you talked about this in with in your podcast about this in with in your podcast before about progesterone and bone?

before about progesterone and bone? >> We really haven't gone in detail into >> We really haven't gone in detail into this, but we have to have you come back this, but we have to have you come back because we have so many other things to because we have so many other things to talk about, but talk about, but >> Well, you tell me. I'm happy about two >> Well, you tell me. I'm happy about two more things before you leave. Talk about more things before you leave.

HRT after 60: did women really miss their window?

Talk about the progesterone and just talk about for the progesterone and just talk about for people who are in their 60s because this people who are in their 60s because this is a large part of our community way is a large part of our community way beyond 10 years past menopause and now beyond 10 years past menopause and now they

hear this.

they hear this. >> Okay. >> Okay. >> Okay. >> And you know, is it a good idea? Is it >> And you know, is it a good idea? Is it not a good idea? Who should they see not a good idea? Who should they see about this? That's about this? That's >> yeah, that's the problem. Who do they >> yeah, that's the problem. Who do they see? Well, if you go back to the women's see? Well, if you go back to the women's health initiative, that seems to be the health initiative, that seems to be the anchor that weighs us down, okay? That, anchor that weighs us down, okay? That, you know, it it it sort of, you know, an you know, it it it sort of, you know, an anchor could be good or bad, right? And anchor could be good or bad, right? And a lot of this is bad. So the women's a lot of this is bad. So the women's health initiative as we mentioned health initiative as we mentioned earlier incorporated older women and earlier incorporated older women and because of you know all the different because of you know all the different prerequisites that they were trying to prerequisites that they were trying to show and what they did seem to show show and what they did seem to show because women in their 50s in the because women in their 50s in the women's health initiative surprisingly women's health initiative surprisingly when they went back and did reanalysis when they went back and did reanalysis of the data actually had a 30% reduction of the data actually had a 30% reduction in all cause mortality. In other words, in all cause mortality. In other words, women in their 50s who went on this drug women in their 50s who went on this drug prempro died from everything that you prempro died from everything that you could think of 30% when you you know as could think of 30% when you you know as a cumulative kind of a picture 30% less.

a cumulative kind of a picture 30% less. There's no drug on the market that There's no drug on the market that reduces you've your risk of dying from reduces you've your risk of dying from everything [clears throat] by 30%. But everything [clears throat] by 30%. But that's what you know here it is when you that's what you know here it is when you have a study you either believe all the have a study you either believe all the data or none of the data. You can't data or none of the data. You can't cherrypick I'm only going to believe cherrypick I'm only going to believe this data and not this data. So it's a this data and not this data. So it's a package of data. So if you believe package of data. So if you believe anything from that study, you have to anything from that study, you have to believe that giving hormones, even that believe that giving hormones, even that sort of ridiculous combination, Prempro, sort of ridiculous combination, Prempro, lowered the risk of dying from lowered the risk of dying from everything by 30%. But once you got everything by 30%. But once you got older, then suddenly more things older, then suddenly more things happened. So what they came out with was happened. So what they came out with was the window of opportunity sort of study.

the window of opportunity sort of study. And then there was also the elite study And then there was also the elite study that came out. The elite study you used that came out. The elite study you used oral I like I love these doctors who did oral I like I love these doctors who did these studies but I wish they knew more these studies but I wish they knew more about hormones before they created their about hormones before they created their studies. So in the elite study they used studies. So in the elite study they used oral estradiol oral estradiol one milligram of like why did you do one milligram of like why did you do that? because you it turns into estrone that? because you it turns into estrone and it's like a silly dose. But they and it's like a silly dose. But they gave estradi gave estradi one milligram orally and then they one milligram orally and then they combined it with a very small dose 45 combined it with a very small dose 45 milligrams of a progesterone gel given milligrams of a progesterone gel given for only 10 days. So it was inadequate for only 10 days. So it was inadequate progesterone dose and it was not a good progesterone dose and it was not a good choice of estradile. But what did they choice of estradile. But what did they show in that study anyway? So it show in that study anyway? So it included two groups. One group was women included two groups. One group was women who were very close to menopause and one who were very close to menopause and one group of women who had to be at least 10 group of women who had to be at least 10 years out. So they would be in their years out. So they would be in their 60s. And what did they show in the 60s. And what did they show in the younger women on this unfortunate younger women on this unfortunate hormone regimen? They actually had some hormone regimen? They actually had some reduction in the incidence of thickening reduction in the incidence of thickening of the lining of their corateed of the lining of their corateed arteries. Reduction compared to placebot arteries. Reduction compared to placebot treated women. So, it showed some treated women. So, it showed some benefit for the cardiovascular system, benefit for the cardiovascular system, which has never been really talked about which has never been really talked about and publicized. They just poo poo that.

and publicized. They just poo poo that. Well, it wasn't that big a deal. I mean, Well, it wasn't that big a deal. I mean, yes, it was a big deal, but they poo poo yes, it was a big deal, but they poo poo it. Even though that was the wrong it. Even though that was the wrong hormone regimen and everything else, it hormone regimen and everything else, it still showed reduction in vascular still showed reduction in vascular progression of, you know, damage to the progression of, you know, damage to the inside lining of the artery. What did inside lining of the artery. What did they show in the women who were in their they show in the women who were in their 60s or older? no harm, no benefit. They 60s or older? no harm, no benefit. They didn't see any benefit on that regimen.

didn't see any benefit on that regimen. They also saw no harm. And so that's They also saw no harm. And so that's what we got. Okay. So based on that, the what we got. Okay. So based on that, the so-called window of opportunity theory so-called window of opportunity theory came up based on the women's health came up based on the women's health initiative heavily and somewhat the initiative heavily and somewhat the elite study that you have a window up to elite study that you have a window up to age 60. when if you're older, you know, age 60. when if you're older, you know, more than 10 years out or 60 plus, then more than 10 years out or 60 plus, then you're too old. You missed the boat.

you're too old. You missed the boat. Okay. Well, if you look at the elite Okay. Well, if you look at the elite study, it showed no harm. That's pretty study, it showed no harm. That's pretty good with that, you know, regimen. And good with that, you know, regimen. And they didn't study everything. I mean, they didn't study everything. I mean, and and it only went for a very few and and it only went for a very few years. So, we really have very limited years. So, we really have very limited knowledge. So, what is the women's knowledge. So, what is the women's health initiative re-evaluation? They health initiative re-evaluation? They did more that study has been did more that study has been re-evaluated like a thousand times plus.

re-evaluated like a thousand times plus. They found that there was no harm in They found that there was no harm in using Premro this like really not good using Premro this like really not good choice drug combo in women under 70. So choice drug combo in women under 70. So there was no increased risk of bad stuff there was no increased risk of bad stuff happening if you were under 70. So if happening if you were under 70. So if you're going to create a window of you're going to create a window of opportunity, it should be up to 70, not opportunity, it should be up to 70, not 60. So in my opinion all women in their 60. So in my opinion all women in their 60s should be evaluated to start on 60s should be evaluated to start on hormones and then you have to choose hormones and then you have to choose wisely like if a woman maybe has a lot wisely like if a woman maybe has a lot of existing diseases maybe you know we of existing diseases maybe you know we don't have good data I mean you have to don't have good data I mean you have to say we live in a world of absent data on say we live in a world of absent data on so many things regarding women's health so many things regarding women's health so then you have to well what are you so then you have to well what are you going to do you know if you have like if going to do you know if you have like if you've already had a heart attack and you've already had a heart attack and two strokes Well, you know, we don't two strokes Well, you know, we don't have data. We don't know. So, what's the have data. We don't know. So, what's the risk anyway? Like what how could harms risk anyway? Like what how could harms how could you get harmed from hormones?

how could you get harmed from hormones? The idea is that as you get older or The idea is that as you get older or you're metabolically unhealthy, which of you're metabolically unhealthy, which of course can happen at any age, your course can happen at any age, your estrogen receptors, particularly the one estrogen receptors, particularly the one called alpha, becomes damaged or aged called alpha, becomes damaged or aged and doesn't work as well. And so if you and doesn't work as well. And so if you don't have fully functioning estrogen don't have fully functioning estrogen receptors, receptors, receptors, then when you add in estrogen, it's not then when you add in estrogen, it's not going to have the same effect because a going to have the same effect because a hormone generally there's other hormone generally there's other mechanisms. It's complex, but the most mechanisms. It's complex, but the most common mechanism is that the hormone common mechanism is that the hormone goes into a receptor like turns the goes into a receptor like turns the lock, you know, and then things happen.

lock, you know, and then things happen. But what if that hormone receptor, you But what if that hormone receptor, you know, you have the hormone, but the know, you have the hormone, but the receptor is like it's like should be receptor is like it's like should be like this, like that. So it's not like this, like that. So it's not working right. Then

there's other working right. Then there's other processes like you could end up processes like you could end up triggering like collateral issues that triggering like collateral issues that you don't want because the hormone can't you don't want because the hormone can't get into the proper receptor and create get into the proper receptor and create what is the normal effect because of the what is the normal effect because of the receptor issue. So that is the sort of receptor issue. So that is the sort of mostly hypothetical because we don't mostly hypothetical because we don't really have any human studies that show really have any human studies that show this harm. It's all like the this harm. It's all like the hypotheticals because the only real hypotheticals because the only real study we have that's using not Prempro study we have that's using not Prempro which is not still the right stuff which is not still the right stuff anyway is the elite study and it didn't anyway is the elite study and it didn't show harm. It didn't show benefit but it show harm. It didn't show benefit but it didn't show harm. So we know we're didn't show harm. So we know we're living in a world of absence of data.

living in a world of absence of data. But we do know from the women's health But we do know from the women's health initiative that in older women they initiative that in older women they still had benefit to the colon and to still had benefit to the colon and to the bone. So even if you don't have as the bone. So even if you don't have as much cardiovascular benefit and we know much cardiovascular benefit and we know from Dale Bredesen's studies on from Dale Bredesen's studies on cognitive decline and Alzheimer's cognitive decline and Alzheimer's disease and he gave all his women disease and he gave all his women patients and these were women up to 75 patients and these were women up to 75 and these were women who had not been on and these were women who had not been on hormones and these are not healthy women hormones and these are not healthy women these are women with significant stages these are women with significant stages of dementia and there was no harm. I of dementia and there was no harm. I spoke to them about their study. There spoke to them about their study. There were no incidents and it was like were no incidents and it was like year-long study. There was not a single year-long study. There was not a single incident of a heart attack or stroke in incident of a heart attack or stroke in these women who were really high risk.

these women who were really high risk. So that's in like an interesting study. So that's in like an interesting study. They were all put on hormones all of They were all put on hormones all of them. So I mean that so we actually do them. So I mean that so we actually do have data that it's probably safe and if have data that it's probably safe and if you start with a low dose in this case I you start with a low dose in this case I would start you know at low and try to would start you know at low and try to revamp like reawaken the receptors and revamp like reawaken the receptors and you know I've done some research on how you know I've done some research on how can you reinvigorate the receptors of can you reinvigorate the receptors of estrogen and there is actually research estrogen and there is actually research on that and so you know looking at on that and so you know looking at antioxidants mitochondrial booster antioxidants mitochondrial booster supplements suppments. Exercise. Oh my supplements suppments. Exercise. Oh my gosh. Exercise. Exercise, which I know gosh. Exercise. Exercise, which I know you're a big fan. Exercise can also help you're a big fan. Exercise can also help to like revamp and rejuvenate the to like revamp and rejuvenate the estrogen receptors. So, you go and estrogen receptors. So, you go and giving low doses of estradile can also giving low doses of estradile can also help to like wake like reawaken the help to like wake like reawaken the receptors. So, there's ways that we can receptors. So, there's ways that we can help improve receptor function. We can't help improve receptor function. We can't measure it. I can't like I'm going to do measure it. I can't like I'm going to do the receptor test. I I don't have that, the receptor test. I I don't have that, you know? So, it's all like you know? So, it's all like hypothetical. It's all research oriented hypothetical. It's all research oriented and so on. But if you're under 70, I and so on. But if you're under 70, I don't think you should be written off at don't think you should be written off at all. I think, you know, that there are all. I think, you know, that there are ways that we can work with it. We have ways that we can work with it. We have no proof of harm. I can't say we have no proof of harm. I can't say we have proof of lots of benefit, but we do have proof of lots of benefit, but we do have some benefit. And we know we can monitor some benefit. And we know we can monitor bone. I mean, of all the wonderful bone. I mean, of all the wonderful things that we can monitor really well, things that we can monitor really well, it's monitoring bone. And we need more it's monitoring bone. And we need more studies and we wish we had more money studies and we wish we had more money put into women's health for women over put into women's health for women over 70. You know, I would say we also have 70. You know, I would say we also have some lack of data for bioididentical some lack of data for bioididentical hormones is the elite study wasn't hormones is the elite study wasn't looking at that group. So we don't have looking at that group. So we don't have data. We don't have data showing that if data. We don't have data showing that if you give bioididentical human hormones,

you give bioididentical human hormones, you're going to hurt women. We do not you're going to hurt women. We do not have human studies like that. It's all have human studies like that. It's all hypothetical based on estrogen receptor hypothetical based on estrogen receptor function. So I think every case has to function. So I think every case has to be looked at individually. Start low, go be looked at individually. Start low, go slow, you know, and decide like is this slow, you know, and decide like is this the best way to go at this age or should the best way to go at this age or should you focus more on eating phytoestrogens you focus more on eating phytoestrogens which are helpful at every age and they which are helpful at every age and they bind to the receptors. So like duh, bind to the receptors. So like duh, there's got to be something there. We there's got to be something there. We know that estrogen receptors are alive know that estrogen receptors are alive and kicking because you can give and kicking because you can give estrogen vaginal cream or other forms of estrogen vaginal cream or other forms of hormones to the vagina at any age. You hormones to the vagina at any age. You can give it to a 90-year-old and the can give it to a 90-year-old and the vagina is going to improve. It won't be vagina is going to improve. It won't be 20 again, but it's going to improve. So, 20 again, but it's going to improve. So, we know that many organs of the body, we know that many organs of the body, their receptors are still working their receptors are still working because there's studies that you could because there's studies that you could take estrogen cream and put it on the take estrogen cream and put it on the face and in two weeks you have visibly face and in two weeks you have visibly fewer wrinkles. These we know with bone fewer wrinkles. These we know with bone these receptors are not dead everywhere.

these receptors are not dead everywhere. The main worry is cardiovascular. So we The main worry is cardiovascular. So we if we can have even neutral if we can have even neutral cardiovascular benefit neutral but not cardiovascular benefit neutral but not harmful not beneficial but we can help harmful not beneficial but we can help all the other organ systems especially all the other organ systems especially like bone like why would we not do that like bone like why would we not do that so you know with with informed consent so you know with with informed consent I'm not willing to write off any woman I'm not willing to write off any woman at any age not at all but every case has at any age not at all but every case has to be individualized once you get over to be individualized once you get over 60 and especially over 70.

60 and especially over 70. >> Okay well Dr. Please tell people how >> Okay well Dr. Please tell people how they can so if you live in California they can so if you live in California right or you're willing to travel to right or you're willing to travel to California tell people how for those who California tell people how for those who are thinking oh my gosh I have to work are thinking oh my gosh I have to work with Dr. Gersh actually you call with Dr. Gersh actually you call yourself. So um yeah how could you know yourself. So um yeah how could you know just share how you work in your clinic?

just share how you work in your clinic? >> Well I'm in my office right now. I have >> Well I'm in my office right now. I have a patient in a few minutes and this is a patient in a few minutes and this is actually a converted exam room that actually a converted exam room that [laughter] I'm in here. And so my office [laughter] I'm in here. And so my office practice is in Irvine, California.

practice is in Irvine, California. That's beautiful Southern California. That's beautiful Southern California. And it's called the Integrative Medical And it's called the Integrative Medical Group of Irvine. And I'm oldfashioned. I Group of Irvine. And I'm oldfashioned. I see patients in person. I can do tele see patients in person. I can do tele medicine in California for anybody any medicine in California for anybody any time in another state they have to come time in another state they have to come and see me initially because I don't and see me initially because I don't have a license in all those different have a license in all those different states and then we can do some tele states and then we can do some tele medicine and then periodically you come medicine and then periodically you come back and visit me and have a little back and visit me and have a little vacation here and I have an Instagram vacation here and I have an Instagram that's pretty busy. I try to keep that's pretty busy. I try to keep posting. I have a YouTube channel that posting. I have a YouTube channel that has a lot of stuff. I'm starting my own has a lot of stuff. I'm starting my own podcast called Female Healthspan. So, podcast called Female Healthspan. So, that should be coming out in the next that should be coming out in the next few weeks. And I just have a mission of few weeks. And I just have a mission of educating. I have three books out and educating. I have three books out and I'm hoping to have more come out in the I'm hoping to have more come out in the next year or so. And I'm just having a next year or so. And I'm just having a lot of fun learning new things and, you lot of fun learning new things

and, you know, meeting people and talking. I know, meeting people and talking. I speak all around the world at lectures, speak all around the world at lectures, giving lectures and at conferences, giving lectures and at conferences, having lots of fun and really just having lots of fun and really just striving to think logically, striving to think logically, scientifically to optimize women's scientifically to optimize women's health and still waiting for a few health and still waiting for a few apologies from some of those medical apologies from some of those medical societies, but you know, we just move societies, but you know, we just move forward. We never we look back to learn, forward. We never we look back to learn, but we look forward to a beautiful but we look forward to a beautiful future.

future. future. >> Oh, I love that. and you really you are >> Oh, I love that. and you really you are a voice who's making a difference and a voice who's making a difference and this is what we need using the evidence this is what we need using the evidence so we can make forward and benefit so we can make forward and benefit everyone. So, I can't thank you enough everyone. So, I can't thank you enough and I'm gonna have you come back because and I'm gonna have you come back because we have a lot more things to do.

we have a lot more things to do. >> Yeah, we'll come back. Well, this is >> Yeah, we'll come back. Well, this is like a a cliffhanger. What does like a a cliffhanger. What does progesterone do? Tune in later.

progesterone do? Tune in later. >> Yes. And we have some other DHEA and we >> Yes. And we have some other DHEA and we have some other things. have some other things.

>> Oh, yeah. Testosterone. Oh my gosh, >> Oh, yeah. Testosterone. Oh my gosh, there's so much to talk about. there's so much to talk about. >> Part two will be coming. [laughter] >> Part two will be coming. [laughter] Thank you so much for joining me today.

Thank you so much for joining me today. I hope you enjoyed my interview with Dr. I hope you enjoyed my interview with Dr. Gersh as much as I did. It's so Gersh as much as I did. It's so important that we understand where we important that we understand where we were with hormones, where we are now, were with hormones, where we are now, and what's possible. All the links that and what's possible. All the links that Dr. Gersh talked about will be in the Dr. Gersh talked about will be in the show notes, ways to get in touch with show notes, ways to get in touch with her. Also, I wanted to mention that I her. Also, I wanted to mention that I have a membership, the Happy Bones Club, have a membership, the Happy Bones Club, where every month we have a question where every month we have a question answer. So you can ask your questions answer. So you can ask your questions and I can help you on your path to both and I can help you on your path to both optimal bones and overall health. So optimal bones and overall health. So that will be that link will also be in that will be that link will also be in the show notes as well. So thank you so the show notes as well. So thank you so much for tuning in and I look [music] much for tuning in and I look [music] forward to seeing you on the next forward to seeing you on the next episode.