Introduction and Doctor Benu2019s Background

Hello and welcome back to Mastering the Menopause Transitions Summit. I'm your host, doctor Sharon Stills, and I've got the other doctor stills here with me.

I know you're used to seeing me interviewing, but we're live together. And this is we call him Doctor Ben Watts so we don't get confused because I'm Doctor Stills.

I've been doctors longer, but he's been Doctor Ben now for for, gosh, five years and five years. Doctor Ben is my son, and he is also an enterprising medical doctor.

He's a second generation naturopathy, actually grew up in the halls of Southwest College and Natural Path Medicine, which is now called Snoring University, and then went back there after getting two degrees at UT Austin in accounting and biochemistry, ended up back at CNM because I was still at CNN when he went there and he, got his own an MD degree.

He's been practicing for five years and he's working side by side with me. Now. We're opening our 7000 square foot clinic in Scottsdale this fall, and we'll be working.

Our offices are side by side and it's really exciting. And so obviously I'm a proud mama bear, but he is really an amazing, amazing doctor. I learned from him, even though I've been practicing 23 years and he's only been practicing five.

And so he's, just a real gift. He works with women, he works with men. He treats everything from, you know, cute illness to chronic disease and obviously menopause, or I wouldn't have him here.

And a lot of you always ask me, you know, do you have a doctor? You can refer me to? Is there anyone you've trained? And so this is in he has trained.

I can refer you to him. And hopefully at some point in the near future, we will be training other physicians. So we're not the only ones. But for right now, it's him and I.

And so I brought him on today, we're going to have a conversation about testosterone because it's misunderstood. And we want to set the record straight.

And we haven't done that in any of the interviews on the summit yet. So we're going to do a deep dive. And when we're with Doctor Ben, we do deep duty.

We do do deep dives, we do deep dives, and we do do so because, you know, not only is he a physician, but he's a biochemist and he's super, super wicked smart.

So. And funny. So anyway, welcome, Doctor Ben to the summit. Thank you, Doctor Stills. I'm very glad to be here. And, excited to dive into the weeds on testosterone, because, yeah, it's really, it's really important for both men and women.

It's not just, you know, we think of it as a male hormone, but it's, I would argue, just as important for women as it is for men. And so actually, yeah, we are going to talk.

I mean, we're we're talking to you ladies because we know you are here, but we are going to talk a little bit about men because we're getting you all better.

And if you are in a relationship with a man, we don't want to leave him behind. Right? If you're going to age gracefully and have longevity, we want to bring your male partner if you have one with you.

So I think it's important we touch on that as well. So, let's just dive in. As we said, two testosterone and talk a little bit about why testosterone.

You know, it's why is it so misunderstood and thought it's only a male hormone. And, you know, why is it important for women? Well, I think, the main reason it's not thought of as something we want to use for women is because, like you just said, we always refer to it as a male hormone.

But the same way that men do have some level of estrogen and progesterone in their body. Same is true of women with testosterone. And while women are menstruating, it may surprise you to find out that you are actually making more testosterone than either estrogen or progesterone.

Not a very intuitive fact, but it is a fact.

Why Testosterone Matters for Women

And, you know, we all kind of know it's very important for just like, you know, muscle, mood, energy, libido. But, you know, there are aspects of your physiology that depend on testosterone beyond just, you know, what you can find on a Google search.

So how do you go about, evaluating a woman to find out if she is indeed in need of testosterone? What is your clinical experience? So I'm going to use essentially, two approaches to evaluate whether any patient, male or female needs testosterone, estrogen, progesterone, anything.

First half is going to be your clinical presentation. Just what is the patient telling me that they're struggling with? What symptoms are they seeing.

And then second I'm going to test them I like to test as a baseline. I just want to see where you're at before I start any, hormone replacement protocols.

And then assuming your clinical presentation and your baseline test matches with what I expect to see to say, okay, we're going to go ahead and start testosterone or any hormone for you, we will, go ahead and initiate that protocol, allow you to go for anywhere between 4 to 8 weeks.

You know, just patient schedules vary. And then we want to retest and reassess and make sure that the hormones that I've given you are, you know, one doing what they're supposed to do, reaching the levels we want them to reach and then metabolizing correctly.

And that's why we harp so much on the, urine hormone test. You know, a blood test. Testosterone is one where you can kind of get away with, but at least from a serum level perspective.

But as far as how it metabolizes, you'll miss that for any hormone, including testosterone. If you are just looking at the blood, the urine is the only place you're going to see you get an accurate readout on that.

So what are some of the clinical presentations that you see with women? And for the women who are watching what what can they be thinking about that's going on?

That could be from a testosterone issue. So, the the waters can be a little bit muddied here. So, you know, a classic one is just, you know, my mood is off.

I don't have that drive for that motivation. You know, I know I should exercise, I know I should diet, I know I should finish my to do list. Those projects around the house.

And yet I just feel kind of. But, you know, I don't want to get up off the couch and I don't want to go do these things, even though I know I shouldn't.

I just can't seem to make myself do it. That can be a testosterone thing. That can be an estrogen thing. That could be an adrenal hormone thing. So like I said, the waters can be a little bit muddied.

You know, you always want to think of hormones as a symphony. They all need to be addressed. They all need to be in balance. You know, if you're a woman and you're feeling like I just don't have that, that gusto for life that I used to, yes, I would expect testosterone to help, but if it's the only thing I do for you, your results will probably be a little bit suboptimal.

Other symptoms, you know, low libido, obviously. Very classic one, again, related to estrogen. Testosterone. You know, I always make a joke with my patients to say, you know, libido with men is, are we awake as a female within arm's reach.

Libido is probably pretty good with women. It's a little more multifaceted. And, you know, you might be like, all right, are my hormones balance? Yes, but my husband's pissing me off. Oh, no.

He actually was well-behaved today on the work. It's driving me crazy. I didn't get enough sleep last night. You know, there's a lot of boxes that need to be checked.

Generally speaking, for women's libido to be where we want. But testosterone is 100% a very crucial component of that. Your exercise, your workouts, if you feel like, oh, man, I just don't tolerate or recover from my exercise as well as I used to, I, I get winded a little too easy.

I'm not able to build that muscle mass the way I want to. Maybe the way I could in my even, you know, early mid 20s. It's just not the same for me. Or testosterone is going to be a very important component of, that it's important for cardiovascular health, can actually be really important as a breast cancer preventative, which is, again, not something you're likely to find on Google.

Just a list, a few I could go on and on about the symptoms we see with low tea and women. So I want to go a few ways there.

How to Evaluate Testosterone Needs

But you mentioned men. So let's just for those of you that have a man you love in your life, let's just talk about that briefly. What what are the women need to be looking for in their men?

Because we know that women like to go to the doctor, right? We're more proactive. And then you know, whenever a husband comes in to see me, I'm always like, okay, so let's just get it out of the way.

Like, did she drag you? She has a rope, right? She had, you know, do you want to be here on your own? How do you feel about being here? Because, you know, you want someone to be engaged and, you know, be part of the process in this kind of medicine.

So, what are the women need to be looking for or telling their husbands to kind of coax them in to, you know, if they think that symptoms and so forth are warranting that they are in need of testosterone.

Yeah. So your general picture with men, there's definitely some crossover here with the symptoms we see in women. You know that same kind of lack of drive motivation feeling I like to call it similar difficulties as far as tolerating recovering from exercise as well.

Decreased ability to put on muscle cut fat, decreased libido, brain fog. Just not, beyond the usual. Like, where do I leave my keys again? Why are we talking about more like, I'm at work and I can't complete tasks as effectively or, you know, I'm not just not crisp mentally.

You know, low libido, even erectile dysfunction is, something. We'll see. So, you know, if he's not 100% successful there and, you know, over even, you know, earlier than over 45, 50, you know, that's kind of like the the old school of thought as far as that's when we need to start looking at testosterone for men.

But I have patients who are in their late 20s who need to need to do testosterone replacement to feel the way they want to feel. Why do you do you have any thoughts as to what that is why we're seeing?

Because I see that too. Like in a lot of my patients who bring their sons and younger and younger, we're seeing lower testosterone. Is it stress? Is it toxicity?

Is it EMT's from keeping your cell phone in your pocket? Yes. It's it's it's a lot of things. You know, there's a million things a million different ways to mess up your hormones.

You know, I think, plastic exposure, you know, and all those like, I'll just say toxins, for lack of a better term that we get from, you know, drink out of plastic water bottles, you store your food in plastic Tupperware, maybe you get takeout from a place in the hot foods coming in the styrofoam container, plastic cutting board that you're using.

You see the little knife grooves in your plastic cutting board. That means plastic is missing. Where did it go? It went into you and those are known as endocrine disruptors.

That is something that you can just do a quick Google search and figure out that's, you know, I'm not breaking any news there. I don't think, lack of sleep.

You know, especially, you know, maybe this is more so in a country like America where we're very like, go, go, go, go, go work as hard as you can, be glorified, you know, getting 4 to 5 hours of sleep a night and burning the candle at both ends.

But that that has a cost. And usually the cost is, hormones, you know, energy levels, things that are just going to kind of go hand in hand with decreased testosterone.

Symptoms of Low Testosterone in Women

And do you ever use like with younger do you use like respect in to like just simulated from a peptide perspective rather than giving testosterone you can use Kiss captain.

You know, in my experience I'm going to kind of put that under the umbrella of like, you know, you want to get more sleep. There are herbs, you know, other kind of more, you know, will say less invasive.

Not that I consider bioidentical hormone replacement invasive, but, you know, generally if it's that or I want to take just an herbal supplement, people are going to consider that, the less less intense of the therapy.

And while those can move your testosterone numbers in the right direction, I generally see them fail to get the results that I'm going to get by just giving the patient the hormone they're deficient in and as a general rule, you know, at least in my opinion, I believe my mom shares this doctor stills shares this opinion as well.

If a patient is deficient in a hormone, best treatment is given the hormone. Yeah I agree I mean I try like in the younger to get them to. Right. Because if someone's older, if it's a woman in menopause not, you know, older and better.

Or a man and, and your pores, you know, it's normal, right. That they're not producing. If it's a 20 year old I, I do my best to kind of stimulate and see what can we remove to allow for production rather than giving them the external, you know, but sometimes I do find that too, that if you don't go to the actual hormone, I mean, it might sound good in theory.

Oh, we're going to do this, we're going to do that, or we're going to give you this to stimulate that. But in theory, in

clinical practice, which we're both in the trenches working with patients, if we don't see you getting better, then philosophy only goes so far.

And we need to give the actual hormone. Yeah. So okay. Anything else about men you want the ladies to know if they if they can see those symptoms. Are there any other symptoms.

And if they do go see a doctor because there's a lot of like like doc in the box, low tea, you know, kind of drive through. So is there anything that they can be looking for to make sure that their husband is getting proper care?

And then we'll talk about the same thing for them? Sorry. You're asking if there's other symptoms that they're looking for or more how they're being managed if they are already on to both.

Yeah. If there's any other symptoms you didn't mention and then how to know, like the doctor they're seeing is doing the right thing for them dosage wise.

I'm not a big one. I would say would be degenerative, joint conditions. You know, testosterone is an anabolic steroid, meaning it's going to promote building proliferation of tissue.

And so if you're deficient in that, rather than anabolism, you're going to be more on the side of catabolism, where you might get disc height loss, low back pain, starting to generate with, you know, the knees, you know, other joints that are just kind of subject to high impact.

You know, your, your husband or, you know, significant other. It runs outside on pavement, for example. We like running. It's good for, you know, a million different other aspects of your health, but it does tend to be a little bit hard on the ankles, the knees, the hips.

And so if you're seeing, you know, not only just that decreased, ability to tolerate, recover from exercise, put on muscle, but joint pains that maybe wander, you know, from day to day, like I have my back one day and now it's the knee and it just kind of, you know, more kind of mild, moderate intensity, but not getting better, not going away, you know, and then they're leaning on something like, you know, hopefully not ibuprofen or OTC pain relievers, but generally speaking, that's the route most men are going to go okay.

And dosing. So I usually, you know, we'll have a baseline. But generally speaking, I find myself starting at about, 100mg injected into the muscle weekly.

And yeah, I guess injection is, in my opinion, the best route of administration, for men, you know, for women, we like to do trans mucosal, creams if we're going to do, like, an estrogen or a progesterone.

That's not necessarily possible with men just because of the anatomy. You guys understand what I'm talking about there. So we might try a transdermal cream, but with men at best, I see that working for a year, maybe two if they're lucky.

But at some point the skin just kind of adapts and the absorption goes in the tank, and we usually end up having to move them to the injection to regain those same results that they may have been seeing on the creams.

So I usually just I don't want to waste the patient's time or money. I just go straight to the injection because I know it's going to work. I know the absorption is never going to be an issue and she's going to be happy.

Okay. So let's let's go back to the ladies because it's actually Doctor been who I forever was prescribing testosterone cream for women. Trans mucosal.

It's the external labia. Which if you've been hanging around me enough, you know that all creams go to the external labia and nowhere else because of what he just talked about.

Because of that dermal fatigue. If you take nothing else from this, at least take that. Because most doctors out

there don't understand that. And they're giving you hormones here and here, and you're just not getting the absorption.

And then you have to use more and more and you're not getting it. So but it was Doctor Ben who told me about injections for women and I was like, no, that's not how I do it.

And he was like, well, you should. And so I listened. And now I have, testosterone. Tuesday every week in my house where I remember to give myself my shot.

Low Testosterone in Men and Contributing Factors

And, you know, for some women who've been with me a long time and are on the cream and it's working for them, I keep them on it. Not everyone's so excited to go to a shot, but for women who weren't like, I noticed a huge difference in giving a shot.

So can you talk a little bit about the shot for women and why it's, more preferable over the cream? So yeah, I mean, you essentially kind of laid it out, you know, it's going to be absorbed better, maybe we inject into the muscle, it's going to be absorbed right into the bloodstream and done testosterone.

Then it's going to start binding to receptors, activating physiological responses for you. You should see the effects of that fairly quickly. You know, if a patient's not seeing results within like a couple weeks, you know, really kind of at the extreme end of things like you might have a problem with dosing or maybe they're doing something incorrectly.

As far as you know, mistakes, that can be made here, not realizing that there is a huge, huge difference in dosing of testosterone for men versus women.

The difference is a factor of 40. So I might start a man on 100mg a week. I might start a woman on 2.5mg a week. So there's a really big difference there.

And it can absorb through the skin. So, you know, I've I've seen it where, you know, I have a husband and wife. As patients, I prescribe testosterone, for the men and the, the wife is doing the injections, and she doesn't wear gloves and happens to get a drop of testosterone on her finger hands.

You know, it can absorb through the skin. And it's 40 times the dose that you should be taking. And the next time I check your labs and be like, well, what does it matter what's going on here?

So there is there is, you know, cross-contamination to worry about there. Because the dosing concentrations are so different from men to women. But the, the logic as far as why do the injection is the exact same for, men as it is for women.

And, you know, the mucosal absorption is better than the dermal absorption. And I'll say women have that advantage of easily accessible mucosal tissue where you can apply the cream.

And like Doctor Stills was saying, it's not a guarantee that the cream will fail for a female patient. And I do have female patients who just are needle phobic.

They don't want to do an injection even just once a week. No matter what I tell them, the arguments I make and something, generally speaking, is better than nothing.

So we we try to dose the cream and for some it works. But I very rarely see the injection fail. That's why I if if it's up to me or you know, if the patient doesn't care one way or the other, I'm always going to recommend the injection over the, the transdermal trans mucosal cream.

Yeah. Thanks, doctor. Ben, my patrons know I sent out a big email saying, you know what I'm personally doing?

And I've been switching women over. And so let's talk about, dosing for women, like the, the range.

And also, I want you to talk about why we don't like pellets because I think that's another one that's pretty common out there for women. Yeah. So I'll start with pellets.

So, yeah. Pellets, for anyone who's unaware, is a pellet that is surgically implanted into a minor surgical procedure, and then it essentially is going to leach hormones into your bloodstream over time.

They generally last anywhere from, you know, I think 3 to 4 months is usually what's average. And then you don't need that dissolves fully and you need to go get another pellet.

The big problem that we run into with that is one it's my miles, the most expensive, invasive way to do any type of hormone. But we can't control the dose.

We can't control the dose. It's. We don't know how your body is going to absorb the hormones. At what rate. And chances are, better or not, they're going to get it wrong.

Especially if it's your first time doing hormones. And what if they do get it wrong? Well, then either you're stuck with this pellet for 3 to 4 months and may be experiencing some pretty bad side effects.

We'll get into that. You know, what do we want to watch out for? With women when we do testosterone? Or they have to go in and surgically remove it and put it in another one.

And that's just why do that? It doesn't make any sense. It's worst way to do hormones. You know. So yeah, that's essentially short, spiel. No pellets don't do it. Yeah.

And, and that, that, you know, they tend to overdose you especially with testosterone. Yeah. So you tend to, like, get on a testosterone high initially, and then you crash and then you're waiting for your next, and it's just, you know, around here, we we do our best to copy nature.

And so to pulse the hormones, the way we deliver them, the way you get them. And so implanting them and overdosing you, it stresses your liver. I, you know, in 23 years of practice, I think I've seen one, maybe two women.

Maybe you're watching who who actually were on a pellet. And I was like, all right, you're like a total unicorn.

Testosterone Delivery Methods and Why Pellets Are Avoided

It doesn't seem to be affecting you in a negative way. It's metabolizing, okay. But for the most part, it's it's borderline nightmare. It's it's really not a good scene.

So dosing. You said 2.5mg. You may start if someone's more sensitive. But what what should the women know as far as dosing for testosterone injections for themselves.

What's the range you saying. Is it just once a week? It doesn't have to be once a week. Although if you know. So the the vial we prescribe is the 25 milligram per mil.

So, you know, pulling less than I, you know, wouldn't want to use an insulin syringe. The needle is incorrect. You have to use a 23 gauge one inch needle, generally speaking, 23, not 25, because testosterone is, is, carried in oil, very, very hard to push through a 25 gauge, if you will, jack the hell out of your thumb.

So please don't do that. 23 gauge. I did that. It will not feel that much different pain wise from a 25. You probably won't even notice the difference and your thumb will.

Thank you. And then. So yeah, point one, which, you know, 25mg per mil point one mils, that's 2.5mg. We might go as high as 0.2 or 0.3. So I'd say anywhere from like 2.5mg to 7.5mg a week is generally the range we're going in.

You can go higher if needed, you know, depending on what the patient's goals are. But you're you're going to want to make sure that you're watching out for some of the, the I'll say, the adverse events that can occur if we overdo it with, testosterone.

You know, I can't imagine any other, women watching, want this situation, right, before we go that I have a couple of questions. So is it always just once a week for women, or is there ever an a time where you could do it twice?

You can, you know, with a 0.1 that's probably a little bit more difficult to split just because of the logistics of pulling half, you know,.05 cc's into a syringe accurately, repeatedly.

But if you're doing point two or point three now, it becomes a little easier if you want to split the dose. And this goes for men as well. You know, I have men who do better splitting their dose in half and doing it twice a week.

Generally the sign that that might be the way you want to go would be, you know, I do my injection and for three, four, maybe even five days, I comes as advertised.

I feel, you know, I get that energy, I get that libido. My workouts are great. All the, you know, all the things I want to see. But day five, six, seven.

Before I do my next injection, I'm noticing a drop off. I feel like I'm kind of slipping back into how I was before. Sometimes it's not just okay, just increase the dose, which you can do to a point, but some women and men are going to benefit from, you know, a kind of more metered dosing, more of a baseline, kind of administration of testosterone.

So, yeah, that's certainly something you could do. And would it be too much asking for a friend? Like if you're doing, like, between 5 and 7mg, is it is it too much for a woman to do that twice a week?

Again, it depends. You know how low they were in the first place. You know where you're what your starting point is, where you're trying to get to what what the goals of the patient are.

You know, there are female bodybuilders out there. And if they're competing in competitions, yeah, they're probably want to go want to go significantly higher than that, which can be done safely.

You know, like with all hormones. It's about, you know, are we monitoring, tracking you consistently and effectively to make sure that not only do you feel the way you want to feel, but you do so in a safe manner.

Okay. And so before we get to like over overdosing or if you're sensitive, because we talk all the time about 24 hour wet urine testing because that is the gold standard way to monitor your hormones.

But there are things we do in blood. And one of them is DHT. And can you talk a little bit about DHT? And you can you talk about if you are going to draw blood?

To monitor your injections and your DHT, and you can try and look at a free testosterone as well? When do you draw that blood? Because I think there's confusion. So I as long as the patient lets me know where they are within the week, I can always adjust my interpretation as needed.

But generally speaking, I want you to run your. If you're going to do bloodwork, I want you to run that 24 hours or less prior to your next shot. So, for example, if I am jacked on a Friday, I want you to run the labs either on Thursday or Friday before you do the shot.

The logic here is I want to see how low your levels are getting at their lowest before you re-up for the next week, and that's really going to help me in combination with their clinical presentation.

Are you seeing that drop off determine does this patient need to go up and dose. Did we overshoot it. And we need to come down and dose or did we nail it from the jump.

And we can keep them right where they're at where everyone's happy. So that's essentially how I want to time blood work. And a note on DHT or dihydrotestosterone, I believe that's no longer covered by insurance.

That's likely going to be a cash pay lab. The office I'm working in currently before we team up.

Dosing, Timing, and Monitoring Labs

We we don't take insurance, but some patients will try to get their labs covered through insurance and DHT. You know, I think years ago at this point was one we could get covered, but that doesn't seem to be the case anymore.

So that's one you may have to request specifically, from your doctor and come out of pocket for that one. But, especially for women, that's a really important one to look at because you want to just jump into it.

Yeah. Okay. So hair, some abnormal hair growth, abnormal hair loss. You know, the more cosmetic concerns, that's going to be the big thing we're watching out for.

But, you know, also, signs of, you know, increased blood thickness or polyps. I mean, if you want the medical term increased, aggression, irritability, you know, kind of like, not quite roid rage, but along those lines, so DHT is going to be kind of the main moderator of pretty much all of those, you everyone makes dihydrotestosterone from testosterone via an enzyme called five alpha reductase.

So if you give a woman either too much testosterone or she's just a hyper converter, that enzyme is really, really active. A lot of that testosterone is going to become DHT.

And women will start to say things like, you know, I'm having to pluck hairs from the chin a little bit more. I'm a little bit more than the usual peach fuzz on the upper lip.

And at the extreme end of that hair loss from the top of the head. If a dermatologist has ever told you you have androgenic alopecia, that's usually DHT mediated, and you might not even have to take testosterone to run into something like that. If you're.

And if your five alpha reductase enzyme is just overactive over stimulated, that might be something you you see, even with, with or without testosterone.

So that's a big one to watch out for. And then just yeah, you know, if you start feeling really like on edge, short fuze, irritable, kind of similar to where if, you know, for a man, if we give them testosterone, some of that testosterone will go through the aromatase pathway and become estrogen.

And if estrogen gets too high in men, they start to get a little irritable. You know, they start to snap and people bite their heads off. You know, the wife walks into the room, hasn't done anything.

So, why are you breathing like that? That kind of thing. You know, for know about from time to time. But, yeah. So, you know, irritability, testosterone is a stimulator of bone marrow where you're going to produce your, your blood cells if we want that up to a point, if that goes a little bit too far, and we do see this a little bit more in men than women, but not impossible to see it in women.

If the blood gets a little bit too thick, you start feeling really hot all the time. You know, it's summer right now, so you might not that might not be obvious in the middle of the day.

So, you know, I tell people to watch out for this at night. And we all like to see you all know we want to sleep in a cold room. Maybe we've got the AC cranking.

The fan is on, we drink some ice water. Maybe we not wearing much in the way of pajamas, or sleeping with thin blankets, or maybe even no blanket on. And no matter what, I just.

I still can't cool down. I just feel hot no matter what I do. Maybe you're seeing acne breakouts with hormones. Generally, that's going to be jawline, upper chest, shoulder, upper back.

Tension headaches. You might feel like you have a headband wrapped around your head a little too tight. If you've ever been dehydrated and had a headache from that very, very similar.

Those are all going to be signs of thick blood. Fortunately, the solution for that is really easy. Just go donate some blood, head up a red cross and help out someone in need and help yourself.

Yeah. So just, summarize that because we, you know, we talk a lot about 24 hour wet urine testing. But we also love blood work. So you know there's a time and a medium for everything.

And we just like testing things the proper way. So we do saliva. We do still we do all the things. But when you're on testosterone you want to get a CBC with a differential so you can look and see.

Do you have high red blood cells, hemoglobin, hematocrit? Do you need to be doing what Doctor Bone is saying and donating blood? You want to be checking your DHT?

I've seen way too many women who've been on testosterone for years. Hair is falling out, and no one ever bothered to check a DHT or do anything about it.

So at the very minimum, like, those are things, you know, a sex hormone binding globulin can be good to monitor as well, but really important, the DHT in the CBC.

And so we are running at a time. But before we finish, can you talk a little bit about like if you have a high converting five alpha reductase or you have high DHT like it doesn't mean you're totally sunk.

Like, what do you what do you do? So the thing that tends to work the best is, using prostate support formulas. So like saw Palmetto, you know, again, pretty commonly known at this point, if a man has prostatitis, BPH, prostate cancer or anything going on with the prostate, it's just regular large but no diagnosable conditions.

Got to give them saw palmetto, pygmy African bark, Beta Sea castor oil, pumpkin seed. You know, it's very common ingredients in prostate support formers.

But you can use these for women over converting to DHT because what those herbs supplements are going to do is slow down that five alpha reductase enzyme.

We don't necessarily want to turn it off again. Hormones are a symphony. There's a balancing act. We don't want to send something to 100 or 0.

Managing High DHT and Special Considerations

We want to be in an optimal range. And so that is usually what I will do. I don't run into this problem too much with women, but when I do, this usually fixes it or at least significantly attenuates the issue.

Yeah. And I I always write in my notes, I, I'm not making a mistake. I know you don't have prostate. Right. Because it can be confusing like oh wait did she have like a moment.

Did you get me confused. So okay. I think we did a good job I agree, but. Anything else you want to share? Any other tidbits? We didn't talk about testosterone or anything that we missed.

Or did we get it all? think we got most of it. If you have a sesame allergy, most testosterone are usually carrot and sesame oil. Had one patient neglect to mention that to me.

A week later, they. After starting testosterone blemishes all over the entire body. And then the wife at the end

shows me the food sensitivity panel showing that sesame is, three out of three in terms of sensitivity.

So so what's the alternative? The alternative. It's a little bit tough. You know, I don't like using depo testosterone. Because the main reason I don't like using it is technically a bioidentical version, but it's carried in cottonseed oil, which is not great.

It's much more hepatic, toxic, liver toxic. But, you know, if a person needs testosterone and they carry that sesame seed allergy, we can usually support the liver via other means and kind of, you know, get them the best of both worlds, give you testosterone, not trigger an allergic reaction, and just take extra steps to protect and detox the liver and make sure that that doesn't become more of an issue for you.

Again, very, very rare if you don't have the sesame seed allergy. We're not even talking about this. This is for that very, very small percentage of people who just can't do, sesame oil carry testosterone.

But that's good to know. Okay. I told you I learned something from him every time. It's. So, shout out for Doctor Ben. So if you want to learn more about Doctor Ben, he he is, you know, working with us now, he's available.

So you just reach out to Dylan at my office or, our new our new hire. So we're building our team is we're building our clinic, and, you can reach the office at (602) 363-3143 or, support at are still.com.

And say you're interested in learning more about Doctor Ben and you'll be seeing him a lot. We do a lot of webinars and he'll be joining me. And you know he's really phenomenal, as you say.

And I you know, I'm I'm I'm obviously proud, but I'm honored to have such an amazing doctor because we really do. And at the clinic, you know, we'll be doing like the meeting of the minds where we talk.

And he may see something I don't see or I see something he doesn't see. And that's really the best of both. When you have, like, more than one doctor collaborating on your, your case.

And so it's really awesome. And so, Lasting Wellness Center is coming soon. But doctor Ben is available for test plus consults and all the things. So shout out some love for Doctor Ben.

I'd love to hear it. And, and now you have, like, go through this again because if you, like, took notes, you pretty much have a very good overview on what you do and don't need to be doing for your testosterone.

So, sending you all love. Thank you for being here. We'll be back with another talk. And thank you, Doctor Ben Stone. You can call me Doctor Mom, you know.

All right. Bye. All right.