Introduction to Peptides and Perimenopause

Welcome back everyone. My next guest is someone I am truly excited to have on this virtual stage, because we're about to dive into a conversation that is very popular, and I don't think we can talk about it enough.

It's the intersection of peptides bioregulators and one of the most underserved transition in women's health perimenopause. I think we might not talk too much about Bioregulators here, but we're going to focus on the peptides, which is big.

Doctor Patrick Taylor is a medical doctor and the founder of Live Vital, where he works at the cutting edge of regenerative and longevity medicine. His approach is integrative evidence formed and deeply patient centered.

He's built a reputation for helping women navigate the hormonal and cellular changes of midlife with precision tools that go well beyond conventional care.

Today, we're going to talk about how peptides can support women through the perimenopausal transition from hormonal fluctuations and brain fog to energy body composition, sleep and beyond.

This is the kind of nuanced, clinically grounded conversation but I know this community has been hungry for. So please welcome Doctor Patrick Taylor. Thanks for taking the time.

Yeah, thanks so much, Natalie. Happy to be here and excited to talk about it. Yeah. Well, you know, I think I'm going to ask the first question that is the, you know, might seem obvious.

Talk to me about a relatively young doctor male who's decided that perimenopause is going to be treating, dealing with, helping women deal with period.

Is going to be his superpower. What made you pick this direction? Yeah. Yeah. I mean, I think my entire medical career led me to this. When I look at my personal history, I struggled with Cushing's syndrome after having cancer as a kid and taking prednisone for a year.

I then had 100 pound weight loss while I was in medical school and struggled through that metabolic shift and became deeply interested in how hormones affect metabolism and how that.

Why Perimenopause Became the Focus

And then as I went through my medical training as a family medicine board certified doctor, I realized that there was this huge gap in healthcare where we have an aging population of women.

We have more women from the ages of 35 to 65 than we do of any other age. And we have OB GYNs, who for the most part, you know, know the medicine, but maybe don't have the time or want to do surgery, or don't want to focus on it, or have been telling people it's just a part of the process.

And then there's a family physicians who are too busy and don't have enough time to discuss treatment options and really just don't understand all of the different treatment options available.

And so I saw this huge gap and I said, I can do this. And I became a meta pause certified practitioner and have been able to see how much it truly benefits people's lives.

And as like a former college athlete and somebody who like, likes results, I love that this is a population of people that I can actually help see results instead of just like chronic disease management.

Yeah, no. And in many ways prevent chronic disease down the road, which I think that's the thing that a lot of people miss. So many women and women I even speak to will say, well, I don't get hot flashes.

So I'm not I don't need hormone therapy. And I think what gets missed in the conversation for a lot of people still, which is amazing, is that this is not just about whether you're getting sweaty at night, like it has to do with your bones and your brain and how you're going to age and how you're going to kind of, you know, make it through your 70s, 80s and potentially beyond.

And that it starts now. Yeah, absolutely. And that's just the beginning of the conversation. Right? Is understanding that perimenopause, meaning the 7 to 14 years before you have your last period, is actually the most important time to start therapy, whether it's menopausal hormone therapy, which has been shown to decrease cardiovascular risk, to decrease dementia, osteoporosis, diabetes risk, but also to address the factors that come with paramount pause because other than pregnancy, there's not another time in a woman's life where she develops an underlying inherent insulin resistance.

And I studied under Ben Beekman, who's one of the top insulin resistance and ketogenic diet researchers in the world. And, you know, since that time, I've been all in on insulin resistance is one of the leading causes of chronic disease.

You know, it's not everything. But yeah, when you look at chronic disease, heart disease, hypertension, kidney disease, diabetes, I mean, it really comes down to insulin resistance, which is huge for women.

The Four Clinical Buckets

Well, I mean, it's huge in any body that that develops and honestly. But we're going to talk just about the girls today. So before we started recording, you talk to me about your approach to helping to figure out what's really going to help your patient when she's sitting across the table from you.

And you talked about kind of parsing things out into four main buckets, do you want to maybe just talk about each of those buckets and how they show up for people?

And then what we'll do is coming out of that will then start to talk a little bit about where the peptides fit in, when you're dealing with each one of these buckets.

Yeah, absolutely. I'd love to talk about that. You know, when I look at Paramount pause, not only is it like this massive hormonal shift where you have fluctuating estrogen and progesterone and it's unpredictable and all of those things and the insulin resistance, but I really look at it in four main buckets.

And this has to do with both aging and the menopausal shift. But the four main buckets I look at when deciding on peptide therapies to utilize for patients is either insulin resistance, inflammation, hormonal imbalances, or cellular inefficiencies.

And so when you dive into each one of those buckets, obviously there are symptoms. And then signs like laboratory signs and physical exam findings and such that can go with each of those buckets.

So insulin resistance is like the low hanging fruit, right. It's like obviously if you have difficulty losing weight, gaining belly fat, visceral fat, increased joint pain fatigue.

And then obviously the lab findings like an increased fasting insulin and increased fasting glucose increase cholesterol, triglyceride, HDL ratios and even cortisol, which I'll kind of lump into the hormonal bucket.

But that insulin resistance is almost always predictable in women in the perimeter puzzle stage. And it's just when is it going to happen? Yeah, it's part of the package.

Yeah, absolutely. Like I have women who are, you know, 12% body fat and they had a huge increase in their

fasting insulin and their cholesterol, despite no changes in their diet or exercise during perimenopause.

Right. Yeah. So it's it's one of those true times in your life where it's like you're not doing anything wrong and yet you're not getting the results and you're doing everything right.

Yeah. Tell us about fasting insulin, because that's not a number that a lot of people. It's a number that gets missed by a lot of people. So what's the range of fasting insulin that you like to see in your patients?

Yeah, absolutely. You know, I think for so many practitioners, especially in traditional Western medicine, you know, you get a screening A1 for someone and that was normal.

You're not pre-diabetic or diabetic. So you're good and a fasting glucose. But when you look at insulin resistance, glucose changes which are so tightly regulated by insulin and glucagon, is actually one of the last things to change when you are insulin resistant.

So your insulin can be going up and up and up and up for years, and your receptors can become less and less sensitive for years prior to having an agency that's elevated.

Right. Right. And so I typically try to use more optimal levels. So anywhere anything less than five is like you are killing it with your insulin. Like a fasting insulin less than five you are dialed anything above ten, I'm like, okay, we're like, we're definitely an insulin resistance above 15.

You are extremely insulin resistant. The normal level that you'll see on labs can range anywhere from 8 to 15. But I have seen in many of my patients, when we truly start to see the effects of true insulin sensitivity, it's less than five on a fasting insulin, right.

And then where, you know, and again, even with HbA onesie and fasting and glucose numbers, there's a big variant where where are you liking to see those numbers come in.

Because, you know, you've I mean, I think conventional medicine is anything under six is great. And we both know that 5.8 is awfully close to the edge.

Yeah, absolutely. You know, it's interesting I used to use a onesie far more and say like, hey, let's target less than five. You know, anything that starts with the four, you're doing pretty well.

Yeah. The tricky thing again with that is I have seen people with a fasting insulin of ten with an a onesie of 5.2 and people with a fasting insulin of ten with an agency of 4.8.

And so and again, it's because it really is kind of a onesie is such a late stage change in insulin resistance when you look at like what changes first and what changes last, like when you're at the a onesie stage and you're going up, that means you're insulin resistant enough to wear your glucose, which is the most tightly regulated aspect of your insulin pathways, is affected.

So I've actually shifted pretty much. So I still track it, but I pretty much use my fasting insulin as like the main marker.

Insulin Resistance Markers and Visceral Fat

In addition to cortisol, triglycerides, HDL, HDL ratios, non DL cholesterol, all of those things as well as body composition like visceral fat testing.

Yeah. To really guide how well we're treating insulin resistance. Great. And I you know for the audience I would love you to also differentiate because I still feel here people using the term visceral fat wrong and visceral fat is not your belly fat.

Can you help people to again like it's it's there are two different animals your belly fat that soft stuff that you makes your belly jiggle. It's not what you want.

It's not necessarily as bad as you think. Visceral fat is a whole different animal. Yeah. And I think this kind of brings us to the second bucket, really is like the second bucket of inflammation. Right.

So when I talk about visceral fat, you know, I think many influencers who are trying to understand as real fat, they, they point to their belly, but what they really mean is the mesenteric fat, right?

Because for many people, the visceral fat we talk about, it's like, oh, think of your, you know, your grandpa with the pot belly. You know, you poke at it and his belly is kind of hard, but he's got a big belly.

And people say that's visceral fat. And that's why I think they associate it with belly fat. But you're so right. Subcutaneous fat, that jiggly fat that's underneath the skin is actually far less dangerous long term than visceral fat.

Granted, if you have a lot of subcutaneous fat, you're definitely going to have a lot of this real fat. Visceral fat is the fact that is surrounding your organs.

It is not as associated with the skin. It's in the mesenteric of the bow. It's surrounding your liver. Those are the two main places that people will get it surrounding their hearts, surrounding their kidneys.

And it's because you have that fat there to push in and provide energy to your main organs, and that's how your body keeps those organs safe. It says, hey, if we ever go into starvation mode, we know we have energy stores.

The problem is that we've seen from long term data is that visceral fat is very highly associated with inflammation and with insulin resistance. And when you look at your risk of the main killer of Americans, which is heart disease, the main causes of heart disease are either going to be endovascular damage.

You get damage to your inside of your blood vessels, which then causes the allowance of cholesterol plaques to form where you have insulin resistance, where your blood vessels are unable to relax and constrict, and also are more prone to inflammation damage which increases cholesterol plaques, which then can increase your risk of heart disease and stroke.

So it's really visceral. Fat is highly associated with those two buckets inflammation in stone resistance. And so obviously body composition testing Dexa bod pod.

You know, at a minimum a is blanking the one that you hold on to the two things. Oh yeah. The, the the blah blah. Yeah. It'll come to us, but yeah, it will come true.

That's hilarious. Yeah. I mean my, my Hume scale has like a little. Yeah. Has a little handle on it. And it's kind of measures the current running through your body to assess.

Yeah. Yeah. Yeah. So eventually the body. Yeah. Oh my goodness. Anybody in body. Jeez. So the in body scan at a minimum. And I think the in body is not as accurate as those other options.

But you can use it for trend I think. Yeah I mean it may not be absolute information, but it'll give you an idea of the direction you're moving it. Yeah. Exactly.

And then when you look at inflammatory markers to track when it comes to visceral fat and inflammation, its scope which your high sensitive, secretive protein, which is highly associated with heart disease and endovascular inflammation, elevated ferritin, elevated platelet lymphocyte ratios or neutrophil lymphocyte ratios where chronic inflammation can actually increase your neutrophils, increase your platelets, but doesn't actually increase your lymphocytes.

And so using some of those replacement markers to trend in addition to body composition testing can kind of tell

you where you're at risk there with visceral fat and long term inflammation.

Cool. All right. So that's two buckets insulin resistance and inflammation which as it turns out or related.

Hormonal Shifts, Cortisol, and Growth Hormone

And I think they're all going to be related. I think we can probably put insulin resistance in the middle of the bucket here. But let's now move over to like those hormonal imbalances which we know.

I mean, everybody kind of gets that. I think the number four is going to be the one that maybe raises a few eyebrows. But yeah, the only thing I'll bring up in addition to obviously the estrogen, progesterone and testosterone changes that happen in perimenopause.

And I talk about testosterone in women often. Number one, to thank you. Yes, yes, to debunk the miss. You know, there are some miss out there that it's going to magically change everything.

But also it has been horribly under treated for so long. It's like women with low libido are being told they needed to go get these super expensive, FDA approved options that work on these different modulators in the brain when there testosterone is less than optimal, and as soon as they start testosterone therapy, they're like, oh my energy, slightly better, my libido is better.

I can actually orgasm. Now, in addition to batch estrogen, which I think is so important and every paramount apostle woman should be on estrogen in my opinion, because it just helps keep your tissues healthy even with systemic estrogen therapy.

So you have menopausal hormone therapy, you have estrogen, progesterone, and whether or not you're using testosterone and vaginal estrogen. But another huge hormone shift that I think is important to address is both cortisol, which would kind of briefly touched on.

And then growth hormone. Growth hormone goes down with age. And growth hormone is interesting because it obviously is anabolic. It helps with muscle growth and bone health.

And at high levels can actually increase visceral fat and influence insulin resistance. But what's so interesting is we have these peptide therapies and we'll dive into this more later.

But like that is FDA approved for HIV lipodystrophy. That decreases visceral fat. And so the growth we see that growth hormone in smaller amounts decreases visceral fat, which obviously decreases our insulin resistance and decreases or inflammation.

They all connect, right? Yeah. And what I have seen in my clinical practice, which is was more of a theoretical when I first started doing this. It was more mechanistically theoretical, where there's the idea that growth hormone actually decreases the conversion from the inactive cortisone to cortisol.

But I've seen that clinically, where I use growth hormone secreting dogs to treat high cortisol levels in puzzle women, and they go from a fasting cortisol 14 or 20 to eight with significantly decreased joint pain, gut inflammation, brain fog, despite already being on menopausal hormone therapy.

So that that cortisol growth hormone balance is also a super interesting bucket in that hormone bucket. And then the last bucket is cellular inefficiency, where, you know, most of the things we've been talking about have been pretty macro level, right.

Working on cellular receptors, working in the endovascular, working at the hormone level. And then you go into the cell itself and you look at mitochondrial inefficiencies where women have low energy joint pain, brain fog, fatigue, and you look at how inflammatory markers go down when you treat mitochondrial inefficiencies, when you treat cellular energy for women.

And so it's just another one of those buckets where I try to help my patients, see, hey, we can address all of these, but I don't think we should address them all at once.

And I kind of use that pathway as far as like what is most important to treat first, because you can imagine if you have raging insulin resistance and your cells at a macro level can't even respond to your major endocrine hormones, which insulin does have an effect on even your ability to respond to estrogen and progesterone. Testosterone.

Trying to address your mitochondrial inefficiencies is not going to work super well. Sure. So that's kind of the pathway I take is like we need to address this stepwise, but also address the pathways based off of symptoms and lab values.

Yeah, that's really interesting. So you start with insulin resistance. Or would you start with addressing insulin resistance with the hormone. Because you wouldn't you would think that you'd want to bring start to balance out hormones kind of almost simultaneously with addressing the insulin resistance.

Absolutely. And I think when I, when I talk about peptide therapies, I do it from the perspective, I guess I'm addressing it from the perspective. Either the patient is already on menopausal hormone therapy and we've addressed that right.

Or they're not a good candidate, which I would say 95% of women are good candidates for menopausal hormone therapy. You know, the risk of stroke, the risk of clot, the risk of heart disease was horribly overstated for a very long time.

And we now have great data to show that it is much less, especially with transdermal or injectable forms. But yeah, when I'm talking about peptide therapies for opposites, typically, hey, you've already addressed this aspect.

Okay. So then let's jump in because we let me see. We're 20 something minutes in I want to get to. And not only I, I'm sure people are like okay, now what about the peptides.

This is a peptide summit. Not get to the point. But we needed to lay the foundation.

Peptide Strategy and Nutrition Foundations

And I think what's really you know, and this has been echoed by almost everyone that I've interviewed, is that you can't bypass the foundations just to jump to peptides like you just can't, unfortunately.

And there's we're going to leave a lot of information off the table here because we don't have a ton of time. But I would love to, you know, now have you kind of and you spoke a little bit, you mentioned Tessa Ellen, which is it's a really interesting growth hormone secreted because I think it's almost the only one that's approved by the FDA.

Now. It's not approved necessarily for perimenopausal women, but it was approved for Aids patients going through certain types of therapy to literally target that visceral fat.

And that's to me, that's its biggest superpower, is going after the visceral fat. But let's talk about your next your kind of order of operations on the peptide scale.

Yeah, absolutely. Well, I think I want to echo what you said is like jumping straight to peptides. I talk about this on social media all the time. It's just like if you're not sleeping, if you're not exercising resistance training, like I talk about resistance training and weightlifting for women and how important it is all the time.

If you're not eating 80 to 90% whole food, you know peptides are going to not do nearly as much as you think they're going to do. And I think having that expectation is so important.

When you look at the four buckets, you know, you use symptoms, you use lab values, you use where someone is

in the transition to identify, hey, what is the most likely bucket that is important to address now?

Right. Like if someone doesn't have raging insulin resistance but they have brain fog, gut inflammation, those issues, if they have low energy and joint pain and things like that.

Identify where to start is important. And I will say I do kind of tier them insulin resistance first. So obviously the GOP wants some glue titers up tight are going to be the first line therapy.

And I would say for for most women, especially women who have struggled with PMOs or formerly PCOS, you know, has been my go to because micro doses of trees appetite have been helping these patients so much with regular periods, lack of heavy periods, the hormonal acne and hirsutism, the hair growth.

So starting with the GOP one for insulin resistance is almost always going to be my recommendation. And like I said, I think it will become adjunctive, like first line adjunctive therapy to menopausal hormone therapy, because almost every woman I work with has those metabolic shifts, whether you see it in their triglyceride HDL ratios or you see it in their fasting insulin, it's happening and their increased visceral fat or their increased subcutaneous belly fat, like those shifts are happening.

And so whether it's a therapeutic dose or a micro dose, depending on your BMI and goals, like I think starting with the GOP, one will almost always be a recommendation if you hit that insulin resistance bucket.

Nice question. Before you go to the next thing, how are you coaching your patients on diet? Because GLP one's great, but what's the are you finding? I mean, does it vary from patient to patient?

Are you finding that there are some universal guidelines that you're able to recommend to your patients? Because, you know, I would say that a lot of women almost develop.

They almost develop an eating disorder around periodicals, because you get so flipped out by how fast things are changing and how you didn't change, like you just don't know where to turn anymore.

Yeah, I kind of make the joke with my patients is you're going to feel like a gym bro, in the sense of how much you have to focus on protein. When you look at the Paramount puzzle shift, you start losing muscle, and muscle is the organ of lung.

Like I will harp on this until the day I die is associated with decreased higher skeletal muscle mass, is associated with decrease all cause mortality, cardiovascular risk, all those things.

So with the GOP starting in one, I always recommend like increased protein for most women, at least 80 to 90, depending on where you're starting. As far as but at least 100 using the 1.6g/kg or the one gram per ideal body weight is a good place to start.

And so, like a universal for most people, is going to be 100g of protein a day, which sounds like so much for many people. And so I pretty much always try to focus on an abundance mindset with food, where it's what can I add in rather than what can I cut out.

So starting with, I can add in lean protein to each meal.

Inflammation, Mitochondria, and Longevity Peptides

I can add in fiber and high volume, low calorie foods to each meal. Because when it really comes down to it, if you're focusing on protein and you're focusing on high volume, low calorie, high fiber foods that are going to help regulate your gut, help with your insulin sensitivity, and help with your bowel movements, you're going to be too full to eat anything else.

Yeah, it's really what it comes down to. So those are typically my universal guidelines. And obviously everyone is

different. And you do need to typically customize that.

But typically my universal guideline there. Cool. All right. Move on. Sorry I, I stopped you just there, but we just needed to make a little stop on diet.

Go ahead. Absolutely. So, you know, a couple of things I also do for insulin sensitivity is, you know, five amino one MQ Mozzie, things like that. Almost always in addition to a GOP one, I think Mozzie has gained a lot of popularity, and people find it good for energy and strength.

And, you know, because it looks like it it blocks myostatin, which blocks muscle growth. So if you block miles stat, and you can support muscle growth, but I would say the effects of mozzie on weight and insulin sensitivity are purely in addition to a GOP one.

I think it works best when it's combined. I don't think it works that great on its own. And just in my clinical experience, then you get into the inflammation bucket where it's, hey, where is this information coming from?

Is it visceral fat, or is it more endovascular and gut? Because that's really where it's symptom based. As far as should we be addressing this with a growth hormone secreted dog like CJC 1295 Marilyn or Maryland or Maryland?

I was obviously the strongest, but I have found that it tends to cause more symptoms in especially women because it's stronger, you get more vivid dreams, you get more groggy in the morning, increased heart rate and anxiety, and so on.

Our CJC 1295 tend to be my go to for women because they're more mild. Someone is FDA approved for growth hormone deficiency in children, but I would say CJC 1295 and is the most predictable result and the least side effects for for me and my patients.

Or are you looking at inflammation from an vascular joint? And because joint pain is a huge symptom of cause. So things like BPC 157, TB 500, which I almost always do together because they have, you know, synergistic effect, whether it's increasing angiogenesis and cell turnover or the actin mobilization of new cells.

Right. And then there's GCHQ, which I think is people think about for their hair and their skin, but it actually activates 4000 genes associated with inflammation and longevity.

And so that's a great option. And then there's CFPB, which CFPB I would say my biggest clinical mistake in the last year has been overlooking CFPB. Because I have this I yeah it is it really is powerful for perimenopause.

I have patients who are saying just a tight and CFPB combo has helped their hot flashes, their joint pain, their gut issues during perimenopause. So trying to tease those things out and doing what's best for your patient.

Obviously we talked about cortisol and growth hormone how Tessa Maryland or 1295 ephemeral and could be helpful for those things. I am a fan of cycling those.

I don't think that anyone should run those long term. And then there's the last bucket, which is cellular inefficiencies. And I feel very strongly that if you're looking at longevity and, you know, looking at how do I not only live longer but live better, addressing your cellular and mitochondrial function is so important, but it's so hard to do that if all those other buckets are raging, right?

Right. But when you look at what truly causes aging in the cell, obviously there's a plethora of things. But I do firmly believe that reactive oxidative species and the damage that they cause to DNA and proteins, right.

And so when you have aging, whether that's the signs of aging, you know, skin, hair, joints, weight, whatever, it's because you got damage to a DNA or you got damage to your proteins or a cellular function to where it could not function and replicate properly.

And so whether that's at a telomerase level or whether that's at like the mitochondrial or or macro level and reactive oxygen species are a huge part of that.

They damage DNA and proteins. And so glutathione like in my opinion, should be a staple for most people once they have addressed some of those other buckets, because it is the body's powerful and oxidant, it is anti-inflammatory and there is great data about the neurocognitive benefit.

There is great trials that have looked at how it decreases risk of cognitive decline. And so that's a great place to start. And then you get into all of the other mitochondrial peptides.

NAD obviously is a molecule, not a peptide, but such an important cofactor SS 31, which, you know, I think if you're on social media, you see a lot of people saying, oh yeah, you can't do any other mitochondrial peptide until you do SS one night.

I don't feel strongly about that. I don't know that everyone has cardio lipid damage as strongly as we believe, but I do think those mitochondrial peptides like SS 31 mozzie five amino one, the ones that are going to act within the mitochondria can be very beneficial once you've got a good foundation.

But I think so many people get lost, I guess get lost in the source, if you will, of social media telling them you need to do this, you need to do this.

And that's why I became so passionate about educating and giving options is so people, number one, are wasting their money on something from someone's garage that may or may not work, but also wasting their money on a protocol that isn't going to do much if they haven't addressed their other buckets well, and it's not personalized to them.

You know, I think that I think what people don't wear, we're getting lost on social media, is all these people hopping on some bandwagon or another. The disaster of this is what helped me, and therefore it will help you and this weirdo belief that with peptides, nothing could possibly go wrong, right?

And I think we both know that a lot can go wrong. And there's some stuff we don't know that can go wrong. And to rob yourself of sitting with a practitioner or a medical doctor who's going to look at your labs, your symptoms, your stage, your goals.

And based on those things, figure out what is your protocol look like. And we didn't you know, we won't have time here today, but we won't. We didn't even get into clearing toxins or pathogens.

Or if you have any underlying issues or heavy metal issues, like all of the things that can actually get in the way, even of the best protocol, you're doing yourself a disservice into your point.

You're wasting time and money. In the best case scenario, in a worst case scenario, you could actually be making things worse. Like people who just jump on the growth hormone streetcar train not knowing where their growth hormone levels are out and maybe too high.

Risks, Personalization, and Where to Find Dr. Taylor

And then you get I've had people say, well, you know, my joints are killing me and I my hands are so swollen and I, you know, or I've got like I've got heart palpitations at night or I'm and I'm like, dude, do you have underlying blood pressure issues?

Like, you got to step back. Yeah, absolutely. I mean, it's just so, so funny to be at the spot where I'm at where it's like, you know, I went to school for 14 years and have educated myself heavily and, you know, part of that school in 14 years, however people feel about medical school and how it's done, like you learn how to read scientific literature.

And being a physician who feels strongly about using peptides to help my patients, like you have to learn how to read the scientific literature, and you also have to know how to combine physiology, pathophysiology and pharmacology, which I hate to tell you, just because you work out doesn't mean you know that, right?

Yeah. Yeah, yeah. So that absolutely I'm 100% on board with you there. Yeah. Well, Patrick, kind of at a time, but I want to thank you for showing up on my riverside today.

Absolutely happy to be here. It's a pleasure to meet you. Can you please let people know where they can find out more about you and working with you? Do you only work in person or do you also work?

Are you able to work virtually with people? Yeah, actually live vital. I work 100% telehealth in all 50 states, and you can find me either at IO or you can find me on social media.

I have my Instagram and YouTube doctor Pat Taylor or TikTok, Pat Taylor MD, which who knows if that'll be the next one day from the next right? TikToks unknown.

I feel the same about Instagram. So you know. Yeah, yeah. So social media or my website and people can also reach out at support at IO on email. And I'd be more than happy to to work with them.

Amazing. Thank you so much. It's been great talking to you and I look forward to doing it again. Yeah. Thank you again. Thanks.