Hormones, Aging, and the Importance of Testosterone

There's a misconception out there that testosterone is a male hormone. A young woman has more testosterone than she has her most potent estrogen, estradiol.

And I think you're bringing up one of the most important topics that exists in hormonal medicine. There's a lot of important topics. But when you look at the end of life, When a woman's in her 80s and 90s, there's way too common thing where she loses so much function that she has to make a transition out of her home into an assisted living facility or nursing home.

And the major cause of that is low testosterone. This is Dr. Talks. Today we are honored to welcome Dr. David Rosenzweig, a leading expert in bioidentical hormone replacement therapy and menopause treatment.

He has trained thousands of medical professionals through his Menopause Method and Institute of Bioidentical Medicine and is widely recognized for his work in advancing hormone health.

A sought after speaker, he has presented at top medical conferences and was invited to Washington to speak before the National Academies of Science, Engineering, and Medicine on the safety and efficacy of bioidentical hormones.

So of course, that is what we're going to be digging into today. He's also the author of Menopause and Natural Hormones and Happy Healthy Hormones, which you'll also hear about during our discussion today.

I adore and respect this man so much. So I'm excited to share this interview with you. Well, Dr. Rosenzweig, thank you so much for being here today. I absolutely love the interactions that I've had with you in the past and you're just a wealth of knowledge and your dedication to women and just empowering us on our journey to hormones.

We're so lucky to have that. So thank you for being here today. My honor.

When to Test Hormones and Why Perimenopause Is Unreliable

I am really excited to kind of dig in because this, we are getting into the nitty gritty today of so many controversial, misunderstood, lack of updated information topics that women so desperately want clarity on.

So we are just going full dive into all things, hormones, risks, how to test logistics, how to know if you need hormones, all the things. So what I'd like to kind of open with is tell me a little bit about when you think women should start testing their hormones, how often we should be considering maybe hormonal shifts as we age and move through life.

Never until you start getting treated as far as testing goes. And here's the reason why If we had a young healthy woman who was clockwork regularly menstruating, if we took her blood at the third week, we'd learn stuff.

But these are not the young women showing up to doctor's offices or nurse practitioner's offices. They're not having trouble. Right. Whenever a woman starts getting irregular.

Or even let's go into perimenopause when things can get really irregular. It is extremely unreliable to test hormone levels. Other levels, other testing, oh my goodness, there's so much can be learned about health from other kinds of blood tests, but not hormone levels.

For example, worst case is the perimenopause. Right. A woman comes in, she's having hot flashes in the middle of the night. Her mind is racing. She's still having periods.

There are even uncomfortable periods. And we know what's happening to her. Almost a hundred percent of the time, her hormone levels have dropped. So just in general, a woman's hormone levels and man's peaks at the age of 20, plus or minus a couple of years.

Then it's declined, both men and women. And then there's a more precipitous decline when things get so low that there's not enough to form a menstrual menstruation.

But the decline continues all the way until leaving earth. So we know in life the women are in decline. But the thing about the perimenopause is a woman's body recognizes the decline and doesn't like it and tries to do something about it.

And it's got tools. It's got the brain and the hypothalamus and the pituitary gland that says maybe we could urge the ovaries back into action. And it does.

It puts out these sporadic blasts of stimulating hormones to the ovary and it works initially. The ovary responds and has an output. Now, if you ever looked at the menstrual curves of estrogen in a young woman, what takes place over the course of the month?

She's low during your cycle, then it gradually increases and peaks mid cycle. Then it falls and then it rises again to about two thirds amount and then she menstruates again.

In the peri-menopause, it looks like this. Lower, oops, jolt. As the pituitary tries to wake the woman up. It works, but then it doesn't sustain. And you get these erratic.

outputs and even when you're doing state-of-the-art hormone testing, which is 24-hour urine hormone testing, all you see is the erratic. And here's how I learned this tonight.

I'm sorry to be so lengthy in this. No, I love it. I had a young woman in perimenopause come to me. And tell me the typical story. Her moods were changing.

She was getting vaginal trying. She was waking up in the middle of the night and quite a list. And I knew she was low estrogen, but I was brand new. So I decided to test her and I'm handing her a test result, very sophisticated 24 hour urine hormone test result.

This shows that her estrogens are high. And I say to her, and I'd like to treat you with estrogen. And she looked at me like, I went to a doctor who's showing me eye and he wants to get more.

And I knew what had happened, but. That was the last time I tested a woman with perimenopause. If you catch someone on the wrong day and you get this false information that she's elevated and it goes against what's happening to her clinically.

So that's why we say don't test these women and don't test a woman when she's gone into menopause. I've made this mistake too. woman hasn't had a period for three months.

I did a 24-year-old hormone test on her and I got to tell her for the cost of $340 to her that her hormone levels are low. Now we test a hundred percent of every single woman we treat, but we wait.

They're coming to us with symptoms of too little, too little estrogen, too little progesterone, too little testosterone. We start with low dosages and we gradually increase.

And lo and behold, sooner or later, those symptoms go away. It's wonderful. They feel better. They're sleeping. Their mood's better. Their diet is healing.

Low Progesterone, Thyroid, and Young Womenu2019s Symptoms

And when the woman says to me this magic moment, she says, wow, I think we've got this. I feel good. We test 100% of the women at that point. And interestingly enough, We did a study on this and what we learned that even if a woman says I'm doing great, 50% of those women did not have sufficient estrogen to protect their vagina or their bones.

And 25% of them were on estrogen doses so robust that they were at risk for breast glandular cell proliferation. Right. So we make minor tweaks and that's why we do the 24 hour urine hormone test at that moment.

So we do test a hundred percent to great value, but it's merely to tweak into oscillating into an optimal zone that we do test. I totally agree with that.

And I know that there's some newer sort of ideas that like, hey, when you replace estrogen, for example, you don't really need to test after you've arrived at that dose.

And I couldn't agree more because you do, you want to make sure that you're in that range of efficacy for longevity kind of health span outcomes, but also that these women aren't walking around with so much jarred estrogen.

that's unnecessary, like could they actually have less and feel just as good? I want to back up a little bit to kind of something you mentioned in the beginning.

What about the stage? And I love that you brought up the idea of, hey, we peak really early in life with our hormones and then they start to decrease, right?

This isn't like some switch that goes off when we're menopausal that now we don't have hormones anymore or even perimenopausal. Like this starts years and years and years.

before we have these labels in medicine. So tell me about too, specifically for women, the timeframe even before perimenopause because, and my data may be skewed because my people are thyroid people, right?

But a lot of women show up to modern thyroid clinic with low progesterone symptoms. They start to have low T, sometimes so early, like they're late 20s.

Tell me your thoughts on that and should women if they're having symptoms of lower progesterone like anxiety, irritability, agitation, insomnia leading up to their periods or heavy periods, should we be testing those women too or just low testosterone as well?

I'm so glad you brought this up because I left something out in my testing story. We do test 100% of our patients right from the beginning for thyroid.

Because you know so well that midlife women, a high percentage of them are running functionally hypothyroid. So immediately you get a TSH free T3 free T4 minimum and we get an SHBG minimum and we get some basic blood tests.

Wouldn't leave out the thyroid for a moment. I'd say to women we've been treating in menopause. We also treating for thyroid. You're so right. You're bringing up the big stuff.

When the heck has happened to this planet? I think there's always been menstrual irregularities and difficulties, but I think if I had to make a guess, it's at an all time high.

And younger and younger and younger women, I mean, women in their late teens and early twenties. Oh my goodness. I was one of them. It's like you said.

It's like you said. very often low progesterone. There's reasons for this. These toxins that we hear about and know so well about, they affect us. And what do they turn out to be?

They turn out these petroleum products in a million different iterations, the plastics, everything that you think of that wasn't here 300 years ago, this stuff is trouble.

And what does it do? It gets the hormone receptor sites of all things. It messes with them. And so more and more, I think one of the reasons you've got a lot of young women getting irregular periods, painful periods, and like you said, symptoms of low progesterone.

Because what we know scientifically is that let's take two hormones, the estrogen family and progesterone. Peaking at the age of 20, they're both declining.

However, what we know is the progesterone can decline earlier and deeper than the estrogen. This is very common. So you wind up with stimulation from estrogen and no calming effect from progesterone.

So you get stimulus, stimulation stuff. So you get cramps, heavy bleeding. It's called estrogen dominance, as you know. And we see this in young women.

And whenever you, if a woman is not clockwork regularly menstruating, I mean, every 28 days or every 27 or 29, I mean clockwork though, she's very unlikely to be ovulating.

And when she doesn't ovulate, she really is low on progesterone. These wonderful bursts of progesterone that occur in the second half of a cycle only occur if she ovulates.

So you've got young women who are having irregular periods. They're not getting that progesterone blast. And so you're so right. So many young women and they have symptoms and you name the big one, anxiety.

And you get young women who are basically healthy. Thinking there's something wrong with them because they're moody. They can get depressed. They can get anxiety.

They can get, let me repeat it again, anxiety. It's the young anxiety in a young woman. I can almost bet that when I started asking her about her periods.

So, supplementing progesterone in young women can do so much good and not force young women into psychotropic medicines, which I'm very much, this is not the remedy, this is not a psychotropic, it's not a Valium or a Xanax deficiency, it's a progesterone deficiency.

And so, yeah, young women. And you know what, it's fascinating. I did not know this years and years ago when I kind of got shoved into the world of hormones that fixing a woman's progesterone, and I mean, we change lives with thyroid.

I am confident that you do too. It's a life-changing experience.

Testosterone Deficiency Across Life Stages

But fixing a woman's progesterone is honestly the most life-changing thing I've seen in medicine because it takes them from feeling so out of control and unlike themselves to calm, zen, feel like themselves again in a matter of like 36 hours, you know?

And it really is profound and it's a bit of a shame because medicine's general approach to this sort of thing, these heavy periods, this PMDD, all of these things is sort of put them on birth control.

right, is a lot of it. And that doesn't really solve that core problem that you do have the opportunity to fix from a root cause perspective, but it is so incredibly symptomatically life-changing too.

I love to spread the word about low progesterone. We see that a lot too in perimenopause as well and estrogen dominance in perimenopause. And addressing that is just, it changes family dynamics, relationships, the whole

gamut, right?

Yeah, it's wonderful. And you can even get progesterone in a decent dose over the counter in a topical green. And it can do so much good. And it's so great that young women become aware of this, that their natural hormone balance is off.

They need progesterone, a little progesterone back in the saddle. Yeah, exactly. And that's sort of the first, at least with thyroid people, that's the first hormone I so commonly see drop.

And then the next is testosterone. So I kind of want you to talk about, and the interesting thing about testosterone is it's applicable across pre-menopause, like in ovulating women, perimenopause, and even post-menopause.

Can you take me through some of the symptoms and sort of timelines that you generally see women show up with lower testosterone levels? I think once again, this is the big stuff.

And there's a misconception out there that testosterone is a male hormone. A young woman has more testosterone than she has her most potent estrogen, estradiol.

And I think you're bringing up one of the most important topics that exists in hormonal medicine. There's a lot of important topics. But when you look at the end of life, when a woman's in her 80s and 90s, There's way too common thing where she loses so much function that she has to make a transition out of her home into an assisted living facility or nursing home.

And the major cause of that is low testosterone. You need the testosterone to preserve the muscles. When you lose your muscles, you move from cane to walker and wheelchair.

You lose the support of your bladder and for other hormonal reasons, you get incontinent and throw in cognition issues. But testosterone is so important throughout the course of life.

Early on, when I was practicing, I did not see these early life testosterone drops. Wow. And I started seeing them. Several decades ago, and how do you find out?

Just asking questions. Like if a woman is developing a flab here in the triceps area, or if you ask her to stand up when she's seated and she has to use her arms, she's losing muscle strength.

She's losing drive. Or the creepiest thing is when a woman doesn't really notice it because it's taking place, so to speak, molecule by molecule, she loses her natural drive.

Like women are used to making 3,000 decisions in a day. And then 20 years later, and I've heard this only when we've replenished testosterone, as we do routinely, that the woman will say, I didn't even know I had lost so much of my natural decisiveness and motivation.

And we used to wait in the perimenopause When we started treating women with hormones, we started treating them with bias plus progesterone, always, universally.

Or if it's earlier, like you're saying, maybe we'll just start with progesterone. And we used to hold off on testosterone because I wanted to see the 24-year-old hormone test to see if they were low at about the three-month mark, and then we would deploy testosterone treatment.

Well, that's no longer our method. Women show up in perimenopause with a questionnaire. We see that they're low testosterone and we start testosterone right out of the gate.

And, you know, just to repeat what you said earlier and earlier ages, women are losing this testosterone. If you're losing your drive, you're losing your libido.

Why is this happening? There's two reasons. There's hormone disruption from the toxins. And then there's the fight or flight biology. And we think of adrenaline and cortisol at the vanguard of any kind of fight or flight, and they are, but you can also recruit estrogen and testosterone.

And that's why young women athletes, a lot of them aren't menstruating because their estrogen is going down their stress pathway. and their testosterone.

So when we test women as we do, like I said, once they feel good again, we see low testosterone. And I'll make a claim that there isn't a single woman there's always an exception in medicine.

But most women, by three years into no period, the testosterone is super low, way too low. It's not healthy. And nowadays, I think, if I had to make a guess, I'd say 95% of the women in the perimenopause are already getting low in testosterone.

I can vouch for that, at least in thyroid patients. Yeah, absolutely. And then tell me, so I'd like to segue a little bit into the treatment of these.

And I think we should just start with testosterone because there's a million different ways. I kind of know your stance on testosterone replacement and I think medicine has gone down this one path of pursuing testosterone replacement via pellets and that's sort of become the standard of care and I think it does so many women a disservice.

And so I'd really like for you to talk about different forms of testosterone replacement and what you feel like the value or risk versus value is of the major options.

Well, I'd like to jump around just a little bit as you triggered these other thoughts in my head.

Why Pellets Are Problematic for Testosterone Therapy

Let's do it. The most elegant and passionate revelation about pellets was made by this medical doctor that I ever saw. His name was Sean Tassone. His name is Sean Tassone.

Oh, I think you know him. I know him very well. He's done the most beautiful video. Hi Sean, we love you. He's done the most beautiful video explaining how pellets just aren't acceptable medicine to so many of us.

Yeah, it might be that a few providers get it right, but we are not fans of injecting something that lasts three months. And then if you don't get the dose right, what do you got?

You can't take it out. And then women vary so much, individual to individual, as to how much they need that the method of starting low and gradually increasing, it doesn't matter how much that variance is.

We start low and we gradually increase. You stick a pellet in there. You're not accounting for individuality and the range of how much hormones of any of the four we've been naming is so great.

Just to give you a number in my practice for estrogen, the milligrams of estradiol strength. is ranges between 0.9 and 4.8. That means that wider variation is what serves most and not all women in menopause.

0.9 to 4.8. That's a huge gap. It doesn't matter. We're individuals. So what? We just go through the process. Now, when I said I wanted to jump around, and I hope it's not too confusing, you brought up something, and it slipped by me to speak up at the time.

Progesterone and thyroid. There's such an intimate relationship there. Progesterone is needed, and you know this, this is your home territory, progesterone is needed to facilitate the function of thyroid hormones in thyroid receptor sites.

And this one just as always makes me smile. When a woman is trying to see whether she ovulates and she's taking her temperature and if her temperature goes up, she's ovulated.

Why does that happen? Why does the temperature increase? It's because you get such a burst of progesterone if you ovulate and progesterone facilitates the function of thyroid and thyroid is such a crucial hormone affecting metabolism, how much heat you produce, how much energy you produce.

So there's that wonderful intimate relationship there that shows up a lot midlife. When that woman drops her progesterone, she's not getting all the mileage out of her thyroid.

I mean, a woman's ovary puts out testosterone every single day. And to try and accomplish in the course of like, even in the world of men, Testosterone treatment really began with injecting into a muscle testosterone once a month.

So you have to go super high to make it last a whole month because it gradually declines. Well, they've improved upon that. They got it down to every week and now some are doing twice a week and that's better.

However, physiologic would be to inject every single day, not a pill last three months, not a huge dose of testosterone. These peaks of hormones cause problems.

Yes, they do. They cause biologic, physiologic problems. And I'm not going to dive into that, but the, I think if we copy nature, like Jonathan Wright first proposed, why mess with the original design?

We just replicate nature. Nature is daily and nature isn't injecting and topical application of these hormones works beautifully. And it's nice and slow.

It's not, doesn't go into these huge peaks. So daily application of testosterone. I'm not a fan. In the past, you really couldn't administer testosterone orally because it damaged the liver.

Well, we've got to work around there with oral testosterone that's just new on the market. But it does, it takes so much more because 80 to 90% of it, if you swallow it, goes to the liver first, gives the liver some extra work.

Not many people's livers need extra work. They're already working. So what does that leave? It leaves topical, which is so excellent. It's topical. Well, we love our organic oils, but they absorb beautifully and the application of testosterone for women is what I recommend.

Whenever you sense it's going down for the whole rest of your life, every day you're on earth. Right. When are they going to remove, when am I not going to, when am I going to stop taking my testosterone?

This isn't, this is just an oral syringe. I'm going to stop taking it when I can't grip the bottle anymore, right? The oral syringe to get out the right dose.

Yeah. And I think circling back to the pellet thing to give people a little concrete idea of some of the limitations that I've seen definitely, and you've probably seen this too, is most pellet companies, it's not the clinician that you're seeing that's determining your dose of testosterone.

The clinicians inputting your data points into a computer and the manufacturer of pellets is the one calculating your dose. And so that inherently gives the clinician less control over the whole entire process, which is a little strange.

Hormone Replacement Risks, WHI Misconceptions, and the Science

But in turn, what I've seen, and I'm almost positive you've seen this too, to give women an idea physiologically normal levels of testosterone. Women walking around is optimally 35 to 55, 65. That's kind of normal.

I have seen personally women transfer to me and their testosterone level was over 2,000, which is double a really

robust man's level, over 1,200, over 800, all over those detectable levels from pellets, which is a problem, right?

Like that is not a casual. I've seen it so many times, you know, a woman who has to switch from pellet to bioidenticals and topicals. And I say, well, let's see when the pellet wears off.

And I go to test them at the end of three months and they still got this really super high testosterone level. And the problem with hormones is some women and some men love overdose, love superphysiologic, they don't get symptoms of overdose.

But superphysiologic with these biochemicals is an experiment nobody wants to do because we've got so much historical medical data on how this can make you a train wreck years later.

And that the side effects are often not reversible even if you stop pellet therapy, many of them. So it might feel good, it doesn't mean that it's healthy and that's the the differentiating factor.

I want you to tell me a little bit too in the same line of conversation, obviously thinking about levels that are reasonable. Tell me about risks with testosterone replacement with normal, optimal, not super dosed people.

Can I include all the hormones? We're going to go through them all. You know, because we're going to go deep with the estrogen piece. The best information and the biggest misconception relates to the estrogens in women.

And hormonal treatment has been going on for a thousand years, documented. And it really flourished in the 1850s where they developed horse urine-derived estrogen, Premarin.

And by 2002, there was 18 million women on Premarin and Prempro. And that was 40% of all American women were on. And you know what? It did some good. It's not my choice, but it did some good, a lot of good.

And then out comes this false reporting of a study, false reporting. suggesting that there was an increased risk of breast cancer for women who were taking these hormones.

But it was false reporting. The original study didn't say that. The original study said women who were on primer alone had a reduced incidence of breast cancer, heart attack, and stroke.

And it was a woman on Prem Pro had a statistically insignificant increased risk, which every scientist, every medical provider knows means don't draw any conclusions.

There is no increased risk. It had nothing to draw, but it burst out into the press like wildfire and scared women and providers all over the planet to thinking if they're treated with hormones, They are at risk for breast cancer, heart attack, and stroke.

And there's a similar thing in the men's world as relates to testosterone treatment. But it's the absolute opposite of what's true. So if I may, I'd like to give the science on this.

Yes, that's the most exciting part of this for me. I'll be short. that all of us are at risk for thousands of medical diagnoses, and some of them are not pretty.

We're at risk for hundreds of cancers, and as a male, I'm at increased relative risk for prostate cancer, and there are new reasons for that. This was not always the case.

And women happen to be, again, new. Increased risk for breast cancer was not always the case. Given that we're all at risk, here is the actual science.

Women who are treated with hormones are at less risk for breast cancer, heart attack, and stroke than women who go untreated. Women who've had breast cancer even happen to be at an increased relative risk for recurrence of that breast cancer than a woman is for developing breast cancer brand new.

But if she's had that breast cancer properly treated, that risk of recurrence is reduced by being treated with hormones than if she's not treated with hormones.

That is the science. Testosterone's got its own science to it. The conclusion is, wouldn't it make sense that if you were missing something that you were created with, that it probably is not a great thing?

Especially these most powerful biochemicals. The science around the testosterone for men and women is the exact same stuff. Not only that, there is no increased risk.

You're playing with fire if you're going to do overdoses and you may not be happy. And you're playing with super fire, almost guaranteed if you stay underdosed.

And in 1968, I'm a senior medical student. We're getting these noon lectures by experts, by specialists, and this day the lecture was given by a gerontologist.

This is someone who specializes in older people. But I was a young guy. I didn't want to hear about older people, arrogant little guy that I was. But I remember this lecture as much as I remember anything in medical school.

I can picture this man standing on the stage right now as we're talking. Light bulb moment. Yeah. He said, your University of Michigan medical students, you know, thousands of diagnoses.

Let me tell you what's happening to older people. They're losing their muscles through a process called sarcopenia. They fall on their osteoporotic bones.

And when you couple that with the loss of their cognitive function, this is what's happening to them. Want to do something for older people? Deal with this.

Well, that sarcopenia is 100% related to the loss of testosterone in women and men. Absolutely. And then with that comes your risk for falling, which comes with a massive risk for death within the next nine to 12 months.

It's sort of this cascade that if we can intervene on muscle mass, we can protect health span, lifespan in the elderly, but even leading up to that. I mean, it's shocking the stats on falls and sarcopenia and people who are really, I would not consider to be elderly, right?

Oh, yeah. Women in midlife, menopause, are coming to that first consultation saying, I don't know what's going on with this area. I go to the gym five days a week and I'm losing triceps here and they poke the flab that's occurring there.

That's muscle loss. Yeah. And it's very difficult to build muscle mass even if you go to the gym five days a week if you don't have enough testosterone.

I'd love for you to go back and speak a little bit to listeners because I know, and I know you know this as well, when my patients come to see me and we initiate hormone replacement therapy and then they go to their OBGYN, or they go to their primary care doctor.

There is a lot of fear instilled about this because of that study from the 90s called the Women's Health Initiative that created this fear mongering that has now been generationally passed down in medicine and is still accepted as truth.

Can you speak to those women a little bit and tell them Maybe what they could share with their doctor that maybe would help them feel a little more comfortable and less stuck in the in-between between two different approaches.

And then just reiterate again, I know there's been so many studies that have come out that have disproven the Women's Health Initiative or that whole rhetoric, including one that came out earlier in 2024. Just go a little deeper with that because I know that people are going to leave this conversation and want to know more about it.

Another big one. You bring up the big ones. The stuff that really is taking place and really needs to be addressed. Well, a couple of ways to look at it.

That study has been refuted and the original study committee published in the original journal In 2017, a retraction in which they stated, in essence, that after 18 years of follow-up, there is no increased risk of breast cancer, heart attack, and stroke.

Now that is very unknown still. There's very few providers who know this. Exactly. And this is an issue in medicine and science. You know, something takes place that's monumental.

And how long does it take for popular knowledge to catch up with it, even professional knowledge? My guess is 30 years, and I've got reasons for this.

So we're still under the cloud of that misinformation. And you're right, obstetricians and family docs They don't want to put their women at risk, their patients at risk.

So they're concerned, but that's not their specialty. They haven't been paying attention to that published retraction, for example. Well, one thing is, and if you want, you know, your listeners can have free access to a PDF of my book on this.

Advocating for Care and Finding the Right Hormone Provider

And in chapter three, we go into the subject of risk and depth and they can just download by a link that book. And the Bible on this has been written by Auburn Blooming and Carol Tavris called Estrogen Matters.

And they go deep, deep, deep into the science. And what do they come up with? Well, they really give the detail. But they come up with the conclusion, I told you that women who are treated with hormones are less risk than women who are not.

Now, the other part of what you brought up is it's an unusual time in history where patients need to get empowered and advocate for themselves. It's unfortunate, this is not what you want.

And you don't necessarily face this in urology or ear, nose, and throat, or you go to your dentist. You don't have to advocate to yourself for yourself, for your dentist, usually.

If you like your dentist, there's a good chance you're going to be getting some good care. Your pulmonologist or your cardiologist, there's a uniform acceptance of a standard of care, not so in hormone medicine.

Or thyroid. or thyroid especially. Yeah. Thyroid was the very first thing I ever learned, holistic. I mentored with Alan Gaby. I don't know if you know who he is.

I don't. I was shadowing him and we walked into an exam room and we walked out and he said, this woman is hypothyroid and you haven't got a clue what to write down on your prescription pad because everyone's such an individual, but we're going to have her find her own dose.

And he was the one who taught me titration. Wow. And I'm sitting there going, buying your own dose. You went to medical school, I went to medical school.

You're like, this does not sound familiar at all. No, exactly. But unfortunately, in the world of menopause, and even in the world of andropause, it's very unfortunate, but it's important that women advocate for themselves.

It's up to women to know who to go to, for one thing. If you want hormones, you want thyroid, You want to go shopping and find someone at your clinic or the thousands and thousands of providers who have taken on hormones and thyroid with great care and great thirst for knowledge and really have dived deep and know what's so in there.

And that's not true. Like, I know nothing about orthopedic surgery. And yet I could probably sit and I am. But I'm the last person who would want to do this.

I had three weeks of orthopedic rotation as a medical student. And you want to go to the people who take this on with great care in no other field. I've just never seen it.

has been well been poisoned by false information. So you can't necessarily fault your family physician or your obstetrician gynecologist and to sit there and negotiate with them.

I don't think it's a great idea because if they believe that you're at increased risk, then they've got many, many miles to go and rivers to cross to get good at hormones because they don't know the most fundamental thing.

It's around risk. They don't know it. And they're fed the opposite information. I don't recommend negotiating. I love that. And I recommend honor and respect for the great gifts that they have.

Go to them for that. I'm not going to go to my dentist to get my testosterone adjusted. It sounds facetious. I'm not going to go to my family doc to get my testosterone.

I'm not an expert. But the other thing is, and this is probably the most important thing I'm going to say, this whole thing today, it's absolutely imperative from my point of view, that a woman does do one thing in the world of hormones.

And of course I'm including thyroid in this, that they go shopping until they arrive at a provider's office, that they go, wow. I'm home. I trust this provider.

They've really taken on this subject. They're speaking a language that makes a lot of sense to me. Go shopping. And there's many ways to go shopping. Just to give a practical, you're shopping for your provider.

You want an expert in this. Hormones are the most powerful biochemicals in our body. Think thyroid hormone. Oh my God. You start losing your thyroid hormone, your life changes.

Absolutely. And you don't get this done right. Your life doesn't get to where you want it to be. And if I may add, there's ways to do it. Like there's 7,500 compounding pharmacists who are in the United States and they've loved hormones and they've gotten deep into them.

So what I recommend to women, ask your friends, number one, and start looking at older women. If they look good and they're in their 60s, they're on hormones.

But ask around and say, do you know anyone who really loves this work? Are you seeing anybody? Are you taking hormones? Because they're nothing like a reference from a friend.

Or if you walk into, in person, in a compounding pharmacist, these people are busy. But when they see an actual patient in there, they usually love to come out and talk.

And you say to them, I probably need hormones. You're seeing a lot of prescriptions. Who in my town do you think is really good at this? Absolutely. Because they know.

They can tell. They can tell by the quality of the prescriptions and they talk to these providers. So that's a couple of tips. Or go to our website. That's the job.

It's the most important thing I'm saying. Go shopping until you find someone that you feel really comfortable with and is really knowledgeable about this.

I think that is such valuable advice because as someone in the world of thyroid and hormones as well, I constantly get the question, well, how can I convince my doctor to run a full thyroid panel?

How can I convince them to get me on T3? And I think there's a delineation. You need to be an empowered, informed consumer of your health. But you need to use and harness that knowledge to find the right partner and leader, right?

You cannot lead yourself to a life full of energy and vitality and great hormone balance. You need an expert to do that, and you will not, one, change the practice of medicine of another clinician or physician.

Or, two, somehow magically impart the knowledge that they need to effectively do a very nuanced job to help you with your best life. So people get stuck in that.

It seems so hard to find a new clinician. And I'll tell you personally, if I had not left my old physician who wouldn't help me with my thyroid problem and went on a journey to find someone who would, I would not have the career I have.

I would probably be on disability by now. Like it can make and break and change everything. And just as you said, hormones are incredibly powerful. They influence every aspect of our lives and our physiology.

And so as overwhelming as that seems, it is so worth it. So I echo that to no end. I would love for you to tell us about your book.

Books, Compounding, and Better Topical Hormone Delivery

And of course, we'll include the link, but tell us a little bit about the book, where they can find it, because I think that's an amazing way for them to start getting empowered on their hormone journey.

Yeah, and that's why I wrote it. And it's really to help a woman know what's going on so they can identify when they're in the office of someone who really knows what they're doing.

And there's a few questions they can ask to find out. Well, your listeners can download the book from your email. because we're offering a free PDF copy of it.

It's also the printed copies available on Amazon. It's happy, healthy hormones. They love it. And I think it's excellent. Of course, I'm prejudiced. And then a thing I'd like to mention is how these hormones deliver matter, matters.

It's like any other field where a lot of people have been paying a lot of attention. Improvements take place over time. And one of them relates to what these topical hormones are carried in.

And what you learn is that in many instances, the hormones are in a strong solvent. They need to be in a strong solvent to come up into solution so that you can administer a toppy click or however you're doing it, the exact same dose every time.

But these solvents are strong and they have toxic potential. So what we did about 15 years ago when I discovered this is we went on to develop a way for compounding pharmacists to dispense it in an organic oil base, no solvents, pure organic oil.

And we did a lot of research on the oil we chose. So the best topicals is in an organic oil base. What's the dispenser look like for that? It looks like this.

Got it. Okay. And you have to shake it before you use it because it's not a solution. It's a suspension, but that's how much you have to shake. It's how much I shake it in the morning.

Then we draw out an accurate dose and to this oral syringe squirt it on my hand and rub it in my end atoms. Got it. That's how it, that's how it comes.

I love that. Organic oil. Because we all know that I did the math once. I had been treating women for 10 years, and I had never seen a hormone. And I ran a pharmacist, misshipped to my office, a patient's biased.

And I went, wow, I've never seen a hormone. Came in a white cosmetic jar back then, and I cracked the seal and opened up, and out comes this strong odor.

And I said, what's this about? And we did research, and I saw it was a strong solvent. And I did the math and I was advising my patients to detoxify. And I was asking them to apply a strong solvent at the rate of a quart a year for 10, 20, 30 years.

And I said, what's wrong with this picture? And people are like, oh yeah, we don't absorb toxins through our skin. Meanwhile, we're giving them hormone replacement therapy to absorb topically through their skin.

So clearly we are actually absorbing things through our skin. So you can't have it both ways really. That's such a valuable, incredible point that I have not personally thought about.

I mean, the compounding pharmacies I generally work with are really high end, but I cannot say that I've gone digging that deep. to figure out what they're putting in those carriers and if they are in fact toxic.

So I'll have to look into that. So exceptional point. Thank you so much. This, I always love conversations that I have with you. I just think you are a wealth of knowledge and just delightful.

And again, such a huge advocate for women. So thank you for all the work that you've done for us that you'll continue to do for and with us. And thank you for having this conversation today.

It really matters. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health. Each day is a new opportunity to make choices that empower your well-being.

For more insights and strategies, subscribe to our podcast and visit our website, www.doctortalks.com. Stay connected, stay healthy, and join us next time on Doctor Talks, real talks from real doctors on the issues that matter to you most.