Introduction and Hormone Expertise

Today, we are honored to welcome Doctor David Rosen Sweet, a leading expert in bioidentical hormone replacement therapy and menopause treatment. He has trained thousands of medical professionals through his menopause method and the 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, Doctor Rosen, sweet. 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. I am really excited to kind of dig in because this we are getting into the nitty gritty today of so many controversial or 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 practitioners 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. Right. Other levels. Other testing. Oh my goodness. There's so much can be learned about health from other kinds of blood tests.

My but not hormone levels for example.

When and Why to Test Hormones

Worst case is the perimenopause. Right. Woman comes in. She's having hot flashes in the middle of the night. Her mind is racing. She's still having periods.

They're even uncomfortable periods. And we know what's happening to her. Almost 100% 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 years.

Then it's decline. 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 that are in 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. Yeah. It's got the brain and the hypothalamus and the pituitary gland that says maybe we could urge the ovaries into 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 her cycle. Then it gradually increases and it peaks mid-cycle. Then it falls, and then it rises again to about two thirds the amount.

And then she menstruate again. In the perimenopause, it looks like this lower whoops jolt is 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, your hormone testing, all you see is the erratic.

And here's how I learned this. And I'm sorry to be so lengthy in this. No, I love it. The I had a young woman in perimenopause come to me and tell me the typical story.

She her moods were changing. She was getting vaginal dryness. 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 that 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 and went to a doctor who showing me I am more. And I knew what had happened.

But that was the last time I tested a woman in the perimenopause. If you catch someone on the wrong day and you get this false information that she's elevated.

And 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 hour urine hormone test on her, and I got to tell her. And for the cost of $340 to her, that if her hormone levels are low, right?

Duh. She's not anymore. Now, we test 100% of every single woman we treat. 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 moods better.

Their diet is healing. 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 run 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 100% to and to great value. But it's merely to tweak into isolating into an optimal zone. And 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 long longevity kind of health span outcomes, but also that these women are walking around with so much darn estrogen that's unnecessary.

Like, could they actually have a glass and feel just as good? I want to back up a little bit to kind of something you mentioned in the beginning. What about this 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, but 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 two specifically for women.

The time frame 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 tea sometimes so early, like their late 20s. Tell me your thoughts on that. And should women, if they're having symptoms of, you know, lower progesterone like anxiety, irritability, agitation and 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 in 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 FBG minimum and we get some basic blood tests.

Wouldn't leave out the thyroid for a moment. I'd say thank you. Women we've been treating in menopause. Yeah. We also treating for thyroid. Yeah. You're so right.

You're bringing up the big stuff. When the heck is 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 20s. Oh my goodness. I was one of those. It's like you set. It's like you said very often low progesterone.

There's reasons for this. These these toxins that we hear about and you know so well I'm they affect us. Yeah. And what did they turn out to be. They turned out these these petroleum products in a million different iterations to plastics.

Early Hormone Decline and Low Progesterone

Every thing that you think of it 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 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 uterine 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 regularly menstruating I mean every 28 days or every 27 or 29, I mean clock or if though she's very unlikely to be ovulating and when she doesn't ovulate, she really is low in progesterone.

These wonderful bursts of progesterone that occur in the second half of a cycle only occur if she ovulate. So you 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 woman 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.

And let me repeat it again, anxiety. I see an anxiety and woman. I can almost bet that when I start asking her about her periods. So 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 is an annex. No, it's a progesterone deficiency. And so, yeah, young women. And you know what? It's 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. 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 and perimenopause and addressing not 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. Yeah. Yeah. And it can do so much good. And it's so great to that young woman become aware of this that yeah they're their natural hormone balances off.

They need progesterone a little progesterone back in the South. 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 you know 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 a lot. There's a lot of important topics, but when you look at the end of life, when a woman is 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 a nursing home.

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

You lose the support of your bladder. And for other hormonal reasons, you get incontinent. And throwing cognition issues with 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 flab here in the triceps area, or if you ask her to stand up when she's seated and she has to use her arm, she's losing muscle strength.

Look, 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. Her, like women, are used to making 3000 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 that woman will say, I didn't even know I had lost so much of my natural decisiveness and motivation.

Yeah. 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 that 24 year old hormone test to see if they were low in 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, and we see that their low testosterone and we start testosterone right out of the gate.

And, you know, just to repeat what you said in earlier, in 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 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 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.

Well, there's always an exception in medicine, but most women by three years into no period. The testosterone is super low, way too low. So it's not 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 into the system. 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 talc because there's a million different ways.

And I think 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 of the major options. Well, I like to jump around just a little bit. Yeah. As you trigger these other thoughts.

And my let's do it. The most elegant and passionate.

Testosterone, Symptoms, and Replacement Methods

The revelation about pellets was made by this medical doctor that I ever saw. His name was Sean to Stone. His name is Sean Tyson. Oh, I think you know him now.

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 last 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 and 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 wine, a variation, is what serves most and not all women in menopause point 9 to 4.8.

That's a huge gap. Yeah, 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's slipped by me at this pick up at the time. Progesterone and thyroid. Yeah. There is 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, this one just is always makes me smile when a woman is trying to see whether she's ovulation, she's taking her temperature, and if her temperature goes up, she's ovulated.

Why does that happen? What's the temperature increase? It's because you get such a burst of progesterone if you ovulate. That and progesterone facilitates the function of thyroid and farrow.

It's 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 in midlife.

And that woman drops her progesterone. She's not getting all the mileage out of her thyroid. Yeah, and so sorry to. Know I love that. I think that's so important.

I mean, a woman's ovary puts out testosterone every single day. And to try and accomplish in the course of like even in, 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 or 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, a physiologic would be to inject every single day. Not in the last three months. Not a huge dose of testosterone.

These peaks of hormones cause problems. Yes, they do 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 propose, why mess with the original design which just replicate in nature, in nature daily and nature isn't injecting and topical application.

It's hormones works beautifully and it's nice and slow. It's not. It 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 damage the liver. Well, it got a workaround there with oral testosterone. It's just new in 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 that many people's livers need extra work.

They're already working. So what does that leave. It leaves topical which is so excellent if topical. Well, we love our organic oils, but they absorb beautifully in daily application.

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 good? When am I going to stop taking my testosterone? This isn't that. This is just an oral syringe. I'm gonna stop taking it when I can't grip the bottle anymore.

Or I can operate the oral syringe to get out the right dose. Yeah. You know, 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, you know, most, most pellet companies, it's not the clinician that you're seeing that's determining your dose of testosterone.

It is the clinicians inputting your data points into a computer. And the manufacturer of the 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.

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

Like, that's kind of normal. I have seen personally women transfer to me and their testosterone level was over 2000, which is double a really robust man's level, over 1200, 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. Yeah. No one wants to switch from pellet to, bioidentical 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 get this really super high testosterone level.

And the problem with hormones is some women and some men love overdose love super physiologically, they don't get symptoms of overdose, but super physiologically, these powerful biochemicals is an experiment.

Nobody wants to do because we got so much historical medical data on how this can make you a train wreck. Yeah. Years later. And the and 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, you know, not not super dosed people. Can I include all the hormones? We're going to go through them all.

Oh, you know, because we're going to go deep with the 11 piece. The best information and the biggest misconception relates to the estrogens in women. Yeah.

And hormonal treatment has been going on for a thousand years. Documented. And it really flourished in the in the 1950s, where they developed horse urine derived estrogen in premature and and by 2002, there was 18 million women on permanent and prime pro.

And that was 40% of all American women. Right. 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 are taking these hormones. But it was false reporting. The original study didn't say that.

The original studies said women who were on permanent 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's there is no increased risk. There's nothing to it.

But it burst out into the press like wildfire and wildflower 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, I'm that's though I'll. Be sure. 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, but risk for hundreds of cancers.

And it's a male. I'm an 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, a 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.

And women who've had breast cancer even happen to be at an increased relative risk for recurrence of that breast cancer. And a woman is for developing breast cancer.

Brand new. But if she's had 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, right? If someone's got its own science to it, the conclusion is, would 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, right?

The science of around the testosterone for men and women is the exact same stuff. Not only that, it's a there is no increased risk. You're playing with fire if you're going to do overdoses, and you may not be, and you're playing with super fire almost guaranteed if you stay under dosed.

And in 1968, I'm a senior medical student, we're getting these, noon lectures by experts, by specialists. And to this day, we being we're being. The lecture was given by a gerontologist.

This is a someone who specializes in older people.

Hormone Therapy Risks and the WHI Misconception

And I was a young guy. I didn't want to hear about older people. Arrogant little one. It's. 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 a light bulb moment.

Yeah, he said, 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 in their osteoporotic bones. And when a couple that with the loss of their cognitive function, this is what's happening to them. I want to do something for the 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 9 to 12 months.

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

Right? Oh yeah. Yeah. Women in midlife, right. 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.

Exactly. Triceps here. And they they pull up the flab that's occurring there. That's muscle mass. 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, you know.

Yeah. Tell 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 one, 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 I call you bring up the big ones.

Yeah. The stuff that really is taking place and really needs to be addressed. Well, a couple ways to look at it. The 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 that, 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 your listeners can have free access to a PDF of my book on this.

And in chapter three we go into the subject of risk in-depth, and they can just download by link that book and the Bible. This has been written by Abraham Blooming and Carol Tarver.

It's 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 your nose and throat, or you go to your dentist.

You don't have to advocate to yourself for yourself, but your dentist. Usually, if you like your dentist, there's a good chance you're going to be getting some good care.

Yeah, or your pulmonologist or your cardiologist. There's a uniform acceptance of a standard of care that's so normal in medicine for a lot of. Your thyroid.

Or thyroid especially. Yeah. Thyroid was the very first thing I ever learned. Holistic. I mentioned with Alan Gabby. I don't know if you know who he is, I don't and I was I was shadowing him and and he walked 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 in 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 that taught me to education. Wow. The and I'm sitting there going, find your own dose. Yes.

You went to medical school? I went to medical school. You're like, this does not sound familiar at all. Right. So, but, unfortunately, in the world of menopause and even in the world of anthropos, 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.

Your clinic, or the thousands and thousands of providers who have taken on hormones and thyroid. As with great care and great thirst for knowledge, and really dive deep and know what's so in there and that's not true.

Like I know nothing about orthopedic surgery, right? And yet I could probably set an arm fracture, but I'm the last person you would want to do this. So I had three weeks of orthopedic, rotation as a medical student.

Yeah. And you, you you want to go to the people who take this on with great care, and in no other field I'm just never seen it. Has been the well been poisoned by false information.

So you can't necessarily necessarily fault your family physician or your obstetrician gynecologist. Yep. And they sit there and negotiate with them. I don't think it's a great idea because if they believe that you're an increased risk.

Yeah. 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 in their bed. The opposite information. I don't I don't recommend negotiating. I love that. And I recommend, you know, and honor and respect for the great gifts that they have.

Go to them for that and not go to my dentist to get my testosterone adjusted. Yep, it sounds facetious. I'm not going to go to my family doc if they get my test, and 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 then, of course, I'm including thyroid in this that they go shopping. Yeah, 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 pharmacy in almost powerful biochemicals in their body. Think that road 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.

Right. And if I may. And there's ways to do it. Like there's 7500 compounding pharmacies who are in the United States, and they've loved hormones and they've gotten deep into them.

So what I recommend to women is ask your friends. And number one, instead of looking at older women, if they look good and they're in their 60s, they're on hormones. Yeah.

Ask, but ask around. Say, do you know anyone who really loves this work? Are you seeing anybody? You're taking hormones. Yeah, because they're nothing like a reference for a friend from a friend.

Or if you walk into in person in a company pharmacists. These are, 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'm 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 the. And they talk to these, providers. So that's a couple tips. Or go to our website.

But, that's the job.

Finding the Right Hormone Provider and Treatment Resources

That's the most important thing I'm saying. Go shopping until you find someone that you feel really comfortable with. And it's 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 to somehow magically impart the knowledge that they need to effectively do a very nuanced job to help you live 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, how? 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 in in 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 of it. Well, that you, your listeners can download the book from your email because we we're offering a free PDF copy of it.

It's also the printed copies available on Amazon. Happy Healthy Hormones. They love it. And, I think it's excellent, of course. And prejudice. And then a thing I'd like to mention is how these hormones deliver manner 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, you know, 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 on top 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 pharmacies to dispense it in an organic oil base, you know, solvents, pure organic oil.

And we did a lot of research on the well, we chose. So 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. It's how much I shake it in the morning.

Then we got an accurate dose into this oral syringe, squirted on my hand and rub it in my arms. Got it. That's how it that's how it comes. I love organic oil because we all know I did the math once.

I had been treating women for ten, ten years and I never seen a hormone. And I ran a, pharmacist, miss Shift to my office. Patients biased. And I went, wow, I've never seen a hormone.

It came in a white cosmetic jar back then, and I cracked the seal and opened up and out comes the strong odor. And I said, what's this about? And we did research and I strong.

So it was a strong solvent. And I did the math and I was advising I would advising my patients to detoxify. And I

was asking them to apply a strong solvent at the rate of a quart a year for ten, 20, 30 years.

And I said, oh, what's wrong with this picture? Right? 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.

You know, 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.