The TOXIC Truth Sabotaging Your Hormones, Immunity & Recovery EXPOSED! l Dr. Nafysa Parpia l Ep #323 Transcript

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Introduction and episode overview

Welcome back, folks. I'm Natalie Nidam, your host. If you've ever wondered why some people just don't ever seem to get better, no matter how clean they eat, how many supplements they take, How many doctors they see, this episode is probably going to connect some pretty major dots.

Here she specializes in complex chronic illness, everything from Lyme and mold to long COVID, MCAS and autoimmune conditions. We talk about the hidden role of environmental toxins, why menopause can unmask a lifetime of toxic burden, and how therapies like peptides and bioregulators are changing what recovery looks like for highly sensitive patients.

Now, if this episode resonates for you, you can head on over to gordonmedical.com and learn more about the practice. This episode is brought to you by Stem Regen, Magnesium Breakthrough, and Vitali Skincare, all with special offers just for your.

Check out the show notes below for details and enjoy the episode. Welcome to the Show, Nafiza Parpe. I am so happy to be speaking with you today. I am so happy to be here.

I'm just very excited about this conversation. We've met now a number of times under different circumstances. And, you know, one of the many things that I love about you is the it's the humanity that you bring to the approach that is deeply connected and deeply rooted in science.

So it is not something that we always see in the science and I m really excited for this they're gonna get a very unique message in a beautiful fashion.

So thank you again. Thank you. I appreciate that.

Why environmental medicine and womenu2019s health

In getting started, you have an expertise in environmental medicine. What really got you there? Also, like you're in this whole nuanced space, the heavy metal space mold, chronic complex illness, and particularly in women.

A lot of what I'm seeing is there's a lot a noise. There's people who dismiss these things right out of hand. Then we've got people. Who seem to hyper-focus on these.

And is it possible that there is a bit of a hyper focus in some areas, but let's talk about you first and what really got you into this space and focusing particularly on women.

Yeah. You know, I, as I knew a long time ago that. A healer in me. I knew that I wanted to work with people, but not just as a doctor working on only their yeast infection or only there toenail fungus.

I want it to go deeper with and I understood that when you brought up humanity, that's the part I'm talking about. That piece where the spirit meets the bones or the biochemistry meets what's happening in internally in the person.

And so I knew that it was in that, that space of complex chronic illness for sure. Um, as far as working with women, well, I think it's because I am one.

And I understand what women go through in this world, what they have gone, I think they continue to go to in their

bodies, but also just by function of being alive as a woman on this planet, things we experience and how I see a lot of what happens in women's lives, like their traumas, how that intermingles with sickness.

talk a little bit about that later, but that's really what drove me to enter my practice in that zone specifically. You went a bit deeper down a particular funnel here of the environmental medicine.

What pulled you into that space? And again, it's interesting because you're bringing a particularly female perspective to that. And we both know that Medical research on women has been sorely lacking.

We have decades of lost time to make up for. But what took you down the environmental medicine route? You know, I'd see these patients with complex chronic illness and illnesses that didn't exist 20 years ago.

Illnesses, when I was in medical school, starting in 2005, naturopathic medical schools, they didn t even teach us about because they were kind of rare.

Long COVID, that's a new one. I'd say illnesses like Lyme and co-infections, more autoimmune conditions, fibromyalgia, ME-CFS, these were more rare conditions.

And then over the past 20 years, they've become more and more common. You wonder, well, why is this going on? Well, we have more environmental toxins.

Speaking of long COVID, actually you and I had a conversation about long Covid in the past for your summit, but the spike protein can act as a toxin to some people and create the inflammatory cytokine cascade that then eggs on other illnesses.

this toxin load that is not allowing us to walk hand-in-hand with chronic infections or not long as to work hand in hand with mold or Lyme disease. And so I just knew that if I start to try to address patients who have complex chronic illness, and I know they've got multiple chronic infection, if just try and kill the bugs, It's not going to get me anywhere.

They still have high mercury, high glyphosate, microplastics, forever chemicals, all of this. So that's all I got there. All right. When did you first notice that connection between hormonal transitions like menopause and toxic burden?

Was there a moment or a patient story that really kind of went, uh-oh, there's something here. You know what?

Menopause, lead, and toxic burden

I'll say it was when I was learning with Dr. Paul Anderson and Dr Lynn Patrick, and I, I When women in menopause, we tend to lose bone. Even if we have a diagnosis of osteopenia porosis or we don't have that diagnosis, We still tend.

To lose on and lead gets stored in our bones. Our bones are repositories for lead. We all get exposed to it, even though it was banned a long time ago.

It doesn't, it just gets recycled. Doesn't buy a degrade. So it goes into our bloodstream. The half life there is 70 days. And then. 90% of the lead blood gets stored in the bones.

Then we start to lose bone and lo and behold, we can become our own toxicity center. Our own source of toxins. Yeah. The lead starts to leach out into the blood.

So when he told me this, I thought, okay, now I need to start testing this in my patients. That was a long five or 10, 12 years ago, something like that.

And since then I've been testing it and I see it every day in my practice, high lead in women's blood. I'm not talking about a provoked test, just straight up.

What's in your blood? It's high. Hey, folks, I just wanted to throw a little message in here for those of you who are sending me all these incredible questions on social media or through YouTube or even on Spotify, wherever you're listening to the podcast.

I wish I could get back to each one of your personally, but unfortunately, I created, about a couple of years ago now, I've created a membership community where I get to hang out with people just like you.

I do live weekly Q&As, almost weekly anyway. We also do have podcast guests come in to answer everybody's questions and do presentations, you get to interact live with those podcast guests.

We will sometimes do challenges with some of the partners. Like in 2026, we have a mitochondrial enhancement challenge coming up where we're going to be testing mitochondria function.

we are going be to testing people's deuterium levels. If you haven't heard about deutereum, We've got podcasts coming down the pipes on that. And then people will be invited to follow a personalized protocol and then retest their mitochondria on the other side.

We offer that in the membership community and we do it at incredible discounts that you just can't find anywhere else. So if you're interested in hanging out with me and other like-minded people, which actually happen to include some pretty awesome practitioners and even some previous podcast guests who've come and joined the community, then I invite you to check it out on my website natnidam.com slash the dash longevity dash community, or just go to natnim.

com and look for the longevity community tab at the top of the page. Click on that and see if this is right for you. I would love to see you there. and we could make 2026 our best year ever together.

So once again, that's natnidham.com. Just look for the Longevity Community tab at the top of the page. Now let's get back to the show. I thought I saw something recently.

The problem is it was on Instagram and I didn't have time to dig into it. I'm pretty cautious with the stuff I see on the Instagram. You can get really good information from there, but definitely you need to do your due diligence.

But there was a post that talked about, and it think it led in women's lipstick. Is that something that you've come across? Especially in those very deep red pigments?

See, lead was banned in the 1990s in America. It was starting to phase out in late 1970s. But in that dark pigmints, if they were made in another country, Sure.

There are like another country where it's not as stringent. Regulated. Yeah. So probably that's it. I mean, definitely lead. You get lead from the air, right?

If you live in a major city, air pollution, there's a component of lead in the. Absolutely. And then where else do we get it from? Well, houses built before in 1978, they had lead pipes.

A lot of patients, I'm finding lead on their water. Imagine I see a patient, And it happens every day, their lead is unacceptably high in their blood.

So now I start to think, okay, do you have bone loss? Do you osteopenia? You have osteoporosis? Where are you getting this lead from? It's not only menopausal women, by the way, men.

I have a patient, because these people have persistent inflammation. Some people that persistent information needs their bones. But anyhow, back to what do I do when I see this?

So I wonder, where is it coming from? I'm testing and telepeptide to see if there's bone loss, send them for a DEXA scan. I am also testing the water and people, there is lead.

in their water and they have bone loss. So now I'm like, wow, this is a double whammy. You've got bone mass and you've gotten lead in your water. Wow.

Okay. It's not that uncommon. Well, I literally recently just had a full house filtration system put in because, again, so many of us live in old cities and our pipes in our house may have been upgraded, but we have no control over what's coming in from the street.

And it could be our street, it can be 10 streets away. None of these cities have the resources to really upgrade the infrastructure like they need to.

In fact, I have a patient like that. So speaking of patient stories, her lead is sky high. She does not have bone loss. That's been corrected for already.

I'm like, where is it coming from? She just had a water filter put in. And I was like you know what? It's got to be from the city. Now she's going to testing her neighbors.

Chelation, testing, and detox pathways

We're going see that That's so interesting. I want to do a little sidebar on chelation therapy a bit because people talk about it a lot. People love it, people hate it.

It can be very difficult on the body. Maybe help the audience to understand when is it really necessary or why can you just eat chlorella? That's an important question.

So I think that first of all, there's so many pieces to that question, first there's the right way to do it, and there is a wrong way. We can talk about this later on because it's a big piece of what I want to talk with you about today.

The right to way it is to support the entire system, to to depuration, not just do a cellular detox. When we're doing chelation therapy, we are using substances like EDTA and DMPS sometimes glutathione to pull toxins from outside of the cells, then the toxins recirculate.

And when we're not chelating the right way, when adding that in to an entire depuration process, we can then recirculate the metals. That's why it's hard on the body.

And I want to talk more about that later, but to answer the question about when is it appropriate to chelate and when it is not. If somebody has an acute exposure right here, right now, it's not appropriate to QA, we've got to get them out of that exposure.

And then I'm doing a test, I do a pre-provocation test and a post-provocation test of pre provocations. What's in your blood, what's your urine, that means what is coming at you right here, right now.

If it is at an unacceptable level, but it isn't considered acute, and I'll go into what does that mean. with respect to levels. But just say someone's lead is high enough that I know is contributing to pathologies in their system, but not high that it's considered by a gold standard to be acute.

Then I'm running a post-provocation test, a chelation tests to see if those substances are actually addressing that. If those levels are much higher post-provocation, then I know that this is going to be a therapy that works to pull those topics out.

And if you want to compare the pre-provocation to the post provocation if there is around five to 10% increase, then chelation is warranted. Yeah. And then otherwise you might be able to use other strategies, gentler and then using the binders.

I mean, I remember when I went back to school, one of the things that was impressed upon us over and over again, and I'll never forget it, is before you detox, make sure that the doors of detoxification, the pathways Yes.

And that's the lymph, the sweat, breath, urine, poop. All of those doors need to be flung open or you're just heading for another problem. Yes, and how do I fling those open with herbs that are specific to all those systems, with the bioregulators that is specific for all the systems?

Oh my God, we're going to talk about that. Okay, so before we go into the next thing, A lot of people's ears will have perked up all of a sudden. So what are the bioregulators that you find are helpful in making sure that these systems are upregulated so that they're there to support what's needed when you're doing that work?

Yeah. I want to the organs of elimination. The liver, the kidneys, You know, and the lungs, absolutely. The lungs. And the blood vessels, right? Yeah.

We just said at the same time, the Blood Vessel Bioregulator. It's so important that I have these bioreglies at my fingertips now. I didn't have them at fingertips a year ago, two years ago.

So now I can incorporate that to make the detoxification particle even more efficacious. And have you seen the needle move differently when you've implemented them?

This is the question everybody asks, right? Because especially with the bioregulators, like with certain signaling peptides, I don't know, a thymus and alpha one or a GLP one, or whatever, people will use it and feel it.

The bi oregulator is a much more subtle process. So as a clinician, are you seeing an acceleration of results or outcomes? 100%. because my patient population are people who have complex chronic illness.

These are highly, highly sensitive patients. In every way, they're going to feel everything. Some of them have to open up a bioregulator and put a toothpick in and take a tooth pick dip, and that's enough.

They feel that. You're kidding. Wow. Seriously, a lot of my patients, before I can even get them on the peptides, I use the bioregulators. This is because my patient have mast cell activation syndrome and their immune system, their mast cells are not reactive only to foods and chemicals.

but to all kinds of things. And so because the bioregulars are even more simple and structured than the peptides, highly sensitive… I'm so excited. I am tripping over my own tongue.

Highly sensitive patients can actually tolerate the buyer regulators. You see how excited I am? There's nothing, nothing I've seen people be able to tolerate these highly, highly sensitive people than the bioregulators first.

Yeah. Well, it's because they modulate, right? It's that, their MO. It's motivatory. They're not going to boost, they're going not to suppress, or restore function.

Okay. All right. Let's get back to our regularly programmed program. We went off on a little sidebar there, but that's okay. How have you seen metals accumulate in women, particularly, that becomes so much more problematic during perian postmenopause?

What's actually happening in the body with these metals? They're losing the bone, right? And so there's the bones, obviously, but beyond the Bones, even like, is there like hormone receptors that are being affected as they're also losing estrogen?

Like, absolutely. So this, this I call this a nasty trifecta that I see my patient population all the time. They don't have enough hormone. or they have no hormone.

Now they bone loss. They have too much lead in their system. First of all, I want to talk about what happens when we don't have enough hormone? In my patients, not everybody, but some people have a very, very hard time when they hit menopause.

There is persistent oxidative stress, persistent inflammation, and persistent immune dysregulation. There's that.

And then women have a tendency to disease processes they didn't have before.

Hashimoto's, RA, lupus. We see these diseases in women post-menopause, not so much pre- menopaus, right? So we see this diseases and research shows it has to do with a lack of hormones in certain people.

Well, women's in persistent oxidative stress and persistent inflammation, and now she has lead. That's both of those things are going to contribute to a disease process.

Lead is going put the body into a state of persistent oxidative stress, persistent inflammation. And now people are more, their immune systems are a more permissive to infections.

So just common bugs that we see day to day, Epstein-Barr virus, for example, or mold. Right? So now they're more apt. to get infections in a way that they weren't before.

Not only that, but the immune system was able to keep in check dormant infections, Lyme and co-infections, the herpes family viruses. Suddenly a woman hits menopause and she's got high lead and now she has got chronic Lyne disease and doesn't even remember being bit by a tick.

Yeah. So it's this reactivation. It's reactivation. Yeah. I mean, that makes total sense. Is it just lead? Like, are you seeing this with mercury?

Bioregulators and peptide sequencing

There's a bunch of other heavy metals, right? A bunch a heavy metal. So actually, I think now is a good time to talk about the CDC's data. They created this data set.

It is called the NHANES data and it's the registry, it is the scoring system and is looking at environmental toxins that looks at what's most toxic, what most frequently found in people and in Superfund sites is called the NHANES registry.

It's looking at thousands of Americans and it's updated roughly every four years. So now if a patient, if the person is at the 75th to 95th or even higher percentile, we know we want to consider that there's an acute exposure going on and most people are going to have problems.

If someone's at 50th percentile, I'm considering an acute exposure. The data says you don't need to consider an acute exposure at 50th percentile, but I am considering it.

And pathologies related to low-level chronic exposure are happening. That's the thing, right? Because this is the classic conventional medicine approach.

If you do not achieve a threshold, they do consider it to be a problem. In functional medicine, you're looking at the delta and saying, at what threshold are we seeing like subclinical or, you know, we're seeing the effect, but it's just not getting picked up.

Right. And in conventional medicine, in medical school, were only taught toxicology. Like, we're talking about, like, toxicology is an acute, large exposure that's going to put you in the hospital.

I'm not talking toxicological, totally different subject. What I am talking is environmental medicine, which is It's like chronic low level exposure and then wear and tear the toll it takes on the system, which is so interesting.

And, you know, what you've talked about around bone degradation and this kind of presentation where you have women maybe even on hormone therapy who can't get their levels up.

and whose bones are deteriorating, which also means that all the cognitive problems are happening, the cardiovascular risks are there, like all of the other constellation of issues, and bringing in this consideration of, well,

why?

Why is your estrogen not going up? Like why is this estrogen showing up and doing its work? And ultimately, yeah, it's you've got these bad players getting in the way and preventing that from happening.

That's profound, right? I might be one of those people, we might need to talk. In that data set, you're talking about other metals. Arsenic is number one, lead's number two, mercury's three, cadmium is seven.

There's 240 or 250 toxins on this database. Metals are in the top seven, in top three. Lead's the number 2. So I see all of these metals high in my patients.

I tell my patient, it's never just one toxin. And it's never just one bug. So I'm seeing glyphosate. I am seeing microplastics, pesticides, solvents, forever chemicals, all kinds of toxins.

And what's interesting, like we think about, okay, someone's at 50th, maybe 30th percentile. Oh, I must not supposed to consider that much of a problem.

But what if they're 30 and lead and 30 then mercury? 30th and arsenic, and they're super high in glyphosate, that's a toxic person. That person's immune system, their endocrine system.

Their nervous system is being affected by these toxic guts being effected by the toxins. Well, and to your point, you're seeing people with chronic complex illness.

So these are people that have not been able to be helped within a conventional system. Therefore you have to kind of look outside what would typically be associated with that and say, okay, is there an accumulative load of small amounts of each of these things that's actually getting this person to the place where, it may be overlaid with genetics that don't have great pathways for clearing stuff?

Because I do believe, this is why not everybody has these issues is in some cases people have, I've seen on genetic panels, people with beautiful pathways for clearing stuff and they seem to be able to do whatever they want.

Like it could be like those people that smoke into their nineties, like somehow they were born with a system that is able clear that crap the minute it gets into there bodies.

100%. I want to so clear what you're saying is so important Natalie, that this is not everybody. Some people sail through menopause and I haven't met them in my practice, but I've met some out in the world.

You told me before you don't treat those people because they don t need to be treated. So that's why you have them. Right. But so let's talk about susceptibility.

We just talked about the genes. I'm looking at my patient's genes, it's really important. And what I m looking, what i'm seeing in these people is that They have SNPs or I'd say suboptimal genes in specific pathways, in their detox pathways and their endocrine pathways in the inflammatory pathways.

Some of them in cognition pathways or metabolic pathways so I'm seeing this in genes and then so want to think about the genes. Want to thing about exposures.

A lot of the have malabsorptive issues so not enough amino acids, not minerals. not enough B vitamins on board, we need those in order to detoxify properly.

We're just going to recirculate toxins if we don't have those cold factors on-board. So it's about exposures and genes and stress and nutritional adequacy, the gut, all of the organs of elimination.

Actually, that loops back to our talk earlier about cuation and depuration, but these are the people who are

susceptible. So I have to look at all these things.

I love that you said, look, this is not about everybody running around going, holy crap, I've a problem. This is more about understanding, you know, your unique terrain is going to affect your ability.

And when you get stuck in a health journey, sometimes it's looking at these thing that helps to really move the needle for someone, which I would imagine you see happening all the time in your practice.

Once you figure out that Rubik's cube of that individual, because everyone is different, right? I love that you said that. It is because Rubick's Cube, I'm going to use that because that's what it is.

They're all their own Rubic's cubes. We were speaking privately about Dr. Robert Navio and the cell danger response and his research around mitochondria.

One thing he said to me recently is that in almost all of these acquired complex chronic illnesses, How does someone get there? It's through thousands of different biochemicals that are unique to each individual.

And those thousand different biochemicals, meaning different genes that unique each to individual, and then each person has their own expression of their illness.

They have the same diagnosis, that diagnosis about what end tissues are affected, but really how they got there is so different. Completely different?

brought that to my mind, and he was saying there's no one single gene that's responsible for any of these acquired complex chronic illnesses. Yeah, that's so interesting.

And the challenge is, how do we help more people? Because you are now getting into the most personalized form of personalized medicine, which people listening would be like, well, yeah, why wouldn't we just do that?

Even pharmacogenetics, I recently heard about someone who I actually, I can't remember if they died or got morbidly ill from, it might've been an anesthetic issue.

We have that information and yet standard of care is not to say, is there right now to look at this person's pathways of how they metabolize anesthetic so we can understand is this person going to need more or might we be able to actually give this a little bit less because they have metabolized it so much faster.

You know, I mean, on the one hand, it's inspiring. We have the information. It's disheartening that it is taking so long for the conventional system to adopt these practices, or even to invite a patient to say, get us the info and we'll use it.

And maybe there's not enough clinical trials behind it, but I think at least some of these major pathways are fairly well understood. I have many patient stories where they say I got my genetic work or I did a certain test and I asked my doctor to look at this and the doctor said no.

And what can you do in an 8 to 15 minute visit either? And I mean, there's medical liability, right? I think in defense of the conventional doctor, who sadly gets beat to a pulp in many of these interviews, I just want to say that we need to acknowledge that they have been given very tight guardrails.

And that's why so many are leaving conventional medicine, is because they're realizing that the confines put around them prevent them from practicing the medicine that is really going to help people.

I think it's sad. Most of them mean harm. They want to do the best they can. Even from a liability perspective, I'm sure looking at someone's genes and saying, let's titrate anesthetic differently would open up a can of worms.

I'm sure. And I think people went into medicine because they want to help people. They're good souls. You don't go

into that and go through getting squeezed like a lemon through medical school because you don t care.

Right? So these are- Don't forget the zest, everything. All right. Let's get back to our bones. One thing I wanted to point out to the audience that maybe you can speak to is they do that at the expense of the minerals that need to be there.

That's the crux of it, right? Because for whatever reason, just like chlorine and fluoride have a higher affinity for that thyroid hormone backbone than iodine, these heavy metals have the heavier charge than the calcium and the magnesium, like the things that we actually need on our bone.

And so A, they can displace, but B, you can take all the Calcium and Magnesium on the planet even with your D3 and your K2 and all the boron and things, if you have actual heavy metals sitting in that bone, it's cemented until you drag it out of there.

Here's the thing, I can't measure how much lead is in there, So, say I'm appealing to someone and it's safely done and I see that the lead is coming down from testing, I that body burden drop, and saying, yes, this is excellent, right?

Was that burden from the bones? Well, it probably is because most of the leads get stored in the The other metals, the mercury arsenic, cadmium, they're going to get stored in the organs.

The thyroid, kidneys, liver arsenide loves to gets stored the kidneys. So when we're pulling lead out, if most of it is in bones, it probably is coming out of the bones when you pull it out.

But I'm not sure. You don't have a test. You don't have a test. And you know, you would think if somebody was interested enough, they could develop that test, but anyway, we'll leave that for another day.

Okay. Let's talk about heavy metals. Last question on heavy metal is how do they interact with inflammation pathways? Because again, I think you spoke to it a minute ago talking about oxidative stress.

But maybe let's just finish on that point here. about how those heavy metals impact inflammation and then the hormonal signaling. Again, I'm sure it's hitting men as well, but when a woman is going through this menopausal transition, she's so vulnerable that it is really showing up there.

It's really, really showing up. And so these women who are, first of all, more susceptible to immune system dysregulation because of lack of hormone, when the immune systems are already in a state of dysregation, I'm talking about a hyperactive immune and a weak immune simultaneously, meaning a lot of these, women, they've got Hashimoto's or another on immune condition.

and they've got mass cell activation syndrome and that's hyperactivity in the immune system. And yet the new system is weak.

Heavy metals, inflammation, and menopause

I can see their white blood cells are on the low side. They're permissible. The immune is more permissive to chronic infections. So this, I tell them it's like having an untrained fighter in their ring.

Now, the immunity system, that untrained fighter is throwing kicks and punches, but in wrong direction and at the wrong person. And so we need to bring that into alignment.

Actually, we've talked about this before. I use peptide therapies in a massive way to the immune system into an alignment, there's nothing- By all means, go down the rabbit hole.

Again, people's- All right. They hear peptides by a regular, they're like, really? What do you mean? Yeah. Well, I got really, into the peptids nine years ago.

The same time I'd say that the biohackers started to get into them, but the doctors were not yet into the them. The doctors are starting to into it now, I became obsessed with the peptides because I knew I'm still obsessed.

There's something different. These are signaling molecules. I don't have any other substance that is a signaling molecule like a peptide. And back in the day when I trained with Dr.

Klinghardt a long, long time ago after medical school, he would say, you want to modulate the immune system first. So then when we try, I would try when it got into practice, oh, vitamin C and mushrooms and all the herbs to moderate the response.

Didn't work. Well, it blows it up and brings it down. Yeah. 100% didn't works. I was like, well, this is nice in theory, but it's not going to work, nine years ago when i could get my hands on peptides more easily i was like this this is how we're going to modulate the immune system and and i do so starting actually often starting with loracetide i'm totally going on another pack now is this okay No, because lorazetide is going to seal the gut, which is we're going calm down the immune system because all the LPS getting through the got pisses off the system.

So you're basically, you know, this is the theme, right? If you want to stop a process, you have to get to what's driving it in the first place. So please share, lorazetide.

Why is it your first line of defense? So these patients who have mast cell activation syndrome and immune system dysregulation, I said this earlier, but I want talk a little bit more.

They're sensitive not only to foods and chemicals, they're I'd say the different signaling in the body when it's out of whack, right? Yeah. So if I'm sealing leaky gut, I am preventing antigens that should never cross into circulation and preventing that from happening because when those antigins and toxins cross in circulation, they're tripping up the mast cells and like you said, pissing off the immune system.

And you know, so lorazetide, and I've never seen anything be more efficacious in treating leky gut than loroazotide. So, starting with that one first, and then I'm starting to use the peptides that are for mast cell activation syndrome and laxinox.

It also helps open up the airways. A lot of my patients have that issue. They've got inflamed sinuses. They've got issues with insulin. It helps with inflammation.

So I love amyloxinox for those reasons. And people's mast cell activation syndrome starts to calm down when I give them amygdala. KPV is another mast-cell stabilizer, but it also has antimicrobial effects against Candida and staph, right?

a lot of these patients have Candida issues. If I give them KPV right away, it's hard on their system for that reason because it starts to kill the Candidas and they're not ready for a die off.

Yeah. So I'm like, okay, KPB later, you're going to come in later. Loracetide, amyloxanose. I am also giving some low dose naltrexone and I may be giving ketotapine and cromolin from the compounding pharmacy, stabilize the mast cells as best as I can.

Then it comes in KP And then I've noticed though, if I'm to give TB4 or GHK before I treat that mass solidation syndrome in this patient population, those peptides could trip up MCAS, because they're more the repair peptide, and the immune cells might take that as a threat.

The immune cell at this point think that everything is a danger, including- Everybody's the animator. Okay, so back to the bioregulators. I am starting with the for whatever system the patient is out of balance.

Yeah. You know, thyroid, uh, you know the thyroid bivolar and all of the organs, the blood vessels. The thymus gland, I would think. Huge. It's huge. And so that's more coming to their system than bringing in the peptides that way.

Then when the patients is ready, they start to treat infections, TA1, Although these patients have autoimmune conditions, the LL37 can exacerbate auto immune conditions.

So they're not getting Ll37 until I can modulate the auto-immune response. I'm really sequencing, I had to really think in depth about how I am going to sequence these peptides for this patient population.

Yeah. I love that you are saying this because, and this is one of the most important conversations, I think, around peptides, that is, it's kind of starting to happen.

And I don't think it doesn't happen often enough. Peptides are so tempting to the N of 1 enthusiast. We have the biohackers on one side who will throw anything in their body if they think they're going to get benefit out of it.

But even in the, I'm sure you see this in a chronic complex illness situation where someone has been gaslit, they've been told there's nothing wrong with them, there are no options, and they don't know what to do anymore.

And now they start looking at, when they go to Reddit, Facebook, wherever, And they come across enough of this stuff that they're like, okay, This is going to help me.

And I think the most important message to that audience, and yes, this can absolutely help you, but in a situation where you have a system that is so vulnerable and, again, prone to over-under reaction, whatever the case may be, the order of operations, that guidance from a professional for you is it going make the difference between potentially sending yourself into a crisis Or, at best, wasting a ton of money and getting no results.

And that's not a good result. You know what I mean? That's a crappy outcome. The worst case scenario is you're sitting in an ER trying to explain to someone how you just injected something into your body that you bought online that read somewhere was going to help you that seems to have sent you into some kind of a crisis.

Well, I'm so glad you are bringing this up because it's so common, right? So I'll have patients come in and say, It was so bad. And I say, okay, the right peptide, but at the wrong time, right?

The sequencing for these patients is crucial. You brought up so many important points here. First of all, buying it from someplace online, you don't know what kind of toxin is in there.

Remember that study? I forget when it came out, it was a Swiss study that showed that 80% of peptides just randomly online have some contamination in there.

I'd say some, some extra substance in them. Yeah, I think a lot of the stuff coming in from overseas. Look, the truth of matter is overseas, we all know what I'm talking about, has the ability to make amazing product.

The problem is that regulation is not great, so if they don't rinse the solvents out, if the don t test for toxins, how much is in the vial, and some people are like, well, you know, my company guarantees there's more in vials than they say there is, I'm like that's amazing.

And it literally makes it impossible for you to dose. Yeah. How are you going to know what you're taking? I'm just saying, it's great to get more. When you get a bag of marbles and you've got 40 maribles instead of 30 marbels, you can take away the 10 marples.

But when you add a peptide that's supposed to be 10 milligrams and get 12 or 13 or 14 and a half, and really only need 100 micrograms, how the heck are going figure that one out?

You can't and you could be overdosing yourself right there, or underdo. What if there's less? Exactly. I mean, either like, you know, I picked over because most people would say, well, i'm getting more for my money.

And I'm like yeah, You are. But that may not serve you. Anyway, okay. Good. That was another great little sidebar. So let's talk about the other stressors that come into play.

All right. And this is where we come to our bucket analogy, right? We talk toxic load. What have you seen be the side, the, other players that will interplay with these things?

And you may have mentioned some of them before, but I feel like some might not even be substances. They might be things like stress or whatever the case may be.

What are the things that are pushing women into this overload? Is it the genetics, is the lifestyle environment, the immune, like what is it that you're seeing that's really coming into play?

I'm going to, I love that. You brought up stress because it's a very interesting one. There are some people who they have trauma with a big T in their life and they never get sick.

Yeah. And there are. Some people will have. Trauma with the big tee in the life. When they get very, very sick, That's a lot of my patients. And some of the patients, their only trauma, as if it's not big enough, is the trauma of being ill.

Until they got sick, it was just little T traumas, and they were fine with that. So it is not that everybody who has heavy trauma in their life gets sick.

But it very often that patients who have these illnesses have a history of that kind of trauma. I think internal spiritual, mental, emotional healing that's been done.

It's a time where they understand that often, they say, wow, at the end of it, when they can… Not only at end their illness, but as they start to see results, and I'm going to have to say it's often with the peptides, because that has been able to help me get them their lives faster.

Trauma, sensitivity, and personalized care

It would take me five years to treat on peptide therapies, now two years. someone two years, one year, eight months. Wow. That is crazy. It's crazy, but anyway, so, they start to notice healing faster because of the peptides and bioregulators.

And then they started to say, you know what? I'm glad this happened. I'm starting to evolve in a way that I never did. I am starting really understand that i can have self sovereignty.

i was talking to a woman today, i'm sorry yesterday, a new patient and she said to me, she's had a life of major, major trauma, big T trauma after big t trauma and just nasal activation syndrome and a lot of a complex chronic illness, including Lyme and co-infections and all these toxins and not somewhat early menopause.

And she said, you know, it wasn't until I actually released my anger. that I started to understand that, I can have boundaries and, and I could have self-sovereign, self sovereignty.

And I, started, to feel less, less sensitive. She's still highly sensitive, she has a ways to go, but, understanding this piece, allowing the emotions to express even if they might not be luminous emotions, as long as they're not stuck in non-luminous emotion.

That can lead to illness, I think. But if we experience a spectrum of human emotion, fully experience it so that we can then move through it, that really helps with healing.

I don't know if I told you about this and I usually don' t do this, but I recorded a podcast last week. this exact topic. And this is a physician who wrote a book called The Biology of Trauma, who ties together the impact of trauma on the physiology of a person.

and like both ways. And I would say that anybody listening to this, if you think you're one of these people, you need to go find this book. It's called Biology of Trauma by Dr.

Amy Apigian. I'm only doing this on your podcast, Nefiza, because I think that what she explains, and this is going to be very short, is that one person's big T-trauma is another person is little T trauma.

Right? And your personal life experience will dictate whether that affects your physiology or not. So I'm going to leave it at that. Exactly. And so I, I would invite anybody listening, even you like just check out her work because well, you're seeing this in practice and it would be so power, so interesting to see how she's kind of brought these two worlds together.

Um, because very often they're separate, right? Yeah, Eric recently interviewed her for our for the last one. Yeah. But yeah, that's exactly what you're talking about here, which, you know, so just to give it another shout you guys like I think that didn't listen to Dr.

Gordon said an interview with her too. I Think her work is, again, it's going to be one of those bodies of work that I thing is really can be very powerful.

for any number of people. Okay. Let's get back to our women in midlife with brain fog. So what's the first thing? Because what I want to talk about is testing without over testing.

I think that in a world where people couldn't test for stuff and they want information, people want validation. There's also this line of testing too much or testing the wrong thing or test.

So when you have a woman in midlife, she's got brain fog, fatigue, all this other stuff going on. What's the first thing you want to understand before you start running these toxic labs on toxins or detox?

Yeah. The first I want understand is her her terrain, the terrain of her own system. Basic labs. I'm just running a CBC and a CMP and thyroid panel, sex hormone panel.

Adrenal. And just doing basic naturopathic functional medicine first. Because some people, all they need is their hormones fixed a little bit, their gut balanced off, they go back to their life.

Yeah. I don't think you see that often in your population. My patient population, I do that and they're like, okay, need to consider the toxins. Actually, first run though, in my blood and urine test, along with thyroid and CBC and everything else, I am looking at metals because we're all exposed to them.

Just remember they're in the top three, right? Of all the toxin. So that's just like, that just When I see that high, then I start to think, hmm, are you a poor detoxifier?

Do you have snips in your genetic pathways? Where is this coming from? You have high metal, you'll have other high toxins. What's going on here? And it also depends on how sick the patient is.

If the patients is sensitive to everything, some people are even sensitive Yeah. It's that patient. I'm not even going to want to detoxify them anyways, just yet.

They're not ready for detox. Can't start pulling toxins through a system that's completely depleted. Yeah, I want you to replete their system. And then, you know, at some point after I've repeated them, I supported their organs with the bioregulators.

There's nothing like that, honestly, for this patient population. Then I can start to bring in peptides for immune modulation. Yeah. And I'll be like, let's test these things.

You're starting to get better. Yeah, it's so interesting. The nutrient replenishment that you referred to, what I think is we underestimate often is many of those depletions will affect your body's ability to function at a foundational level.

And so if you restore that a complete deficiency, even if like a vitamin, a B vitamin or whatever the case may be, all of a sudden something that wasn't working might start working again.

I'm sure that what you find is it takes you like, it's like domino effect. It's going to take you down the domina chain and then you'll hit another block.

All this work got done without you doing that much other than just providing something Right. Some people, they can't take oral supplements because they've got a malabsorptive issue.

One of the tests I'm doing early on is the microbiome. I want to know what's going on. Often testing what in the sinuses. When we talk about menopause and brain fog, well, there's a big connection between sinus colonization of microbes that shouldn't be there.

I see multiple different funguses or different bacterial infections and biofilm. If that's there, then inflammation from the sinuses, it can easily cross the blood brain barrier through the trigeminal nerve or just through nerves that connect to the cribriform plate.

So it's easy for toxins and inflammatory cytokines to cross The brain fog is not only for menopause, so I correct for the hormones and they still have that and I'm thinking, okay, what else?

I am going to attack the sinuses and very often that there's bugs in there. Once I start to treat those, the brain issues start come back and then I started to use C-max or C.

lank or other nootropic peptides to help bring the rain back online the way it was to bring down brain inflammation. Again, people run to the C max and C length, but if there's a block, if a physical reality, why that's happening, I think that where we're seeing people that don't respond to them and say, oh, it didn't work.

Again it's that guidance, that clarity and guidance. Okay, so what are you seeing as the biggest testing mistake that you're seen with well-intentioned practitioners in this space?

Is it the over, the under, or just not getting it? No, I think it's both. Honestly, there's a lot of in-functional medicine, environmental toxins and chronic infections are missed when the patient has got a complex chronic illness diagnosis.

I want to be clear to people what those diagnoses are. It's long COVID that wasn't fixed at one of the long-COVID clinics with one the protocols. chronic fatigue syndrome.

Those insidious ones. Yeah. So when functional medicine tries to treat those, usually they're balancing the gut. They're working on the hormones, they are working the terrain like I was talking about.

It's so important to do that stuff. But then they haven't been taught how to detox. They haven' been thought how the deal with multiple low-level chronic infections, kind of like multiple, low level chronic toxins.

That's where functional medicine just misses the boat. So that's totally missed. And if they do test that, they don't know how treat it. Okay, so people have to do a lot of extra training if you want to get into this.

Let's get back to metals. What I'm seeing is doctors doing only a post-provocation test. So they're chelating the patient, testing their metals, and then saying, look, you have a high toxic burden.

But you've pushed them out. Yeah. You've push them on. I don't know. Was that patient even ready for a provocation test? They probably felt really bad with the provocations test that they had a malabsorptive issue or if they didn't have enough cofactors, minerals, amino acids, if their depleted.

That wasn't the right thing to do. So we need to an unprovoked test first. and then a provoked test and understand if chelation is appropriate for that patient.

So I see a lot of chELation tests being run without looking at pre-provoked testing first. I love that. Just to quickly explain to the audience, provoked versus unprovoke.

So un-provoked is really where the body's at rest. You're running a blood test or whatever it is, and you're saying, what's floating around in the system when nothing's in your day-to-day?

Whereas a provoke test is you are actually administering a compound that's going to actively push hopefully, we hope, stored toxins, metals, whatever the case may be, out into the circulation where we can see them because we know the body hides them.

Is that a reasonable explanation for that?

Testing strategy and preparing for detox

A hundred percent. Yeah. Okay. There are some people, I expect a high mercury burden. They eat a ton of fish. I test the blood. It's not there. Or I test the blood, it's there, but it is not in the urine.

And I go, wow, you're accumulating it, which you are not urinating it out. It is showing up. But I expect the burden. So then I start to think, what's going on downstream?

You're not able to excrete any of this. You should have high metals. Okay. Maybe you have an issue with your glutathione. Then I want to understand their glutothione status.

Is your Oxidized? Is it under oxidized stress? If it is, then the rest of their body probably is under oxytocin stress as well. So we need to fix that.

Do they have enough glutathione? Do have they enough cofactors to support glutothione, specifically the B vitamins and magnesium and selenium? Okay, I need to correct for the glutathione status first.

Then we'll test. One other little sidebar I wanted to bring in because a couple of years ago I interviewed someone and one of the things that she talked about, and I'm curious if you've seen this as well, is how you can do a panel for, you know, the toxins, co-infections, And you might only see one or two things, but what she talks about is when you remove that one or two, all of a sudden, it's like everybody was hiding behind them.

Like they're, like the cyclists in a peloton. You got the guys that are coasting in the in this stream, the airstream behind the other guys, you don't see them, but they are there.

And they may not even be active. But all the sudden a space has opened up and now they like, are you seeing kind of this all this expression of other stuff that comes up that you didn't even know was there?

Yes, I expected if I don't see it, I'm surprised if I don's see them like, well, we're gonna see i. There's no way I haven't I never see t not happen.

Interesting. Okay, cool. Yeah, yeah. All right. pre talks. Let's prepare the system. Talk to us about that. How like talks and talk to ues about this pre tax philosophy.

Like what are you stablizing before you mobilize those metals like foremost, like How does that all- It's really important that we stabilize the bone loss first.

First of all, we want to make sure the patient doesn't go into a diagnosis of osteopenia and osteoporosis because then that becomes dangerous. But I do want keep that lead cemented in there for now.

If they're still having a lot of bone turnover and losing the lead, I could chelate them forever. To osteo-prosis. Yeah. That's a waste of their money and their time.

and their health. So we want to take care of the bone loss first by working on the malabsorptive issues, by correcting for the hormones, giving all the supplements.

I don't like to give the bisphosphonase that they just lay down weaker bone. Yeah, so usually I can correct for that. Then I'm looking at the cofactors against the nutrient status because if we start to chelate but there's not enough nutrients, not only chelae but maybe use phospholipids to pull out toxins from outside of the fat cells, that would be maybe pulling out glyphosate or solvents or pesticides, phthalates.

So if I'm using phospholipid therapies to pull those toxins out of circulation, and I am using EDTA and DMPS to put metals out the organ cells, but there's not enough minerals on board.

Right. We're going to do a cellular detox. Imagine here's a cell. There's the toxins in there. I pull it out. Somebody's got to go there, let them out, flushed out of the system, not recirculated.

They can get… They could cross the blood brain barrier then. So I've had a lot of people say, I did a detox before and it felt horrible. I could only do that.

Like, well, one day I'm going to prepare you for that, it just means you weren't ready for But then I'm thinking about their organs. Remember, you talked about the amonturys a while ago, right?

So I am looking at those amonterys. So what's going on with the gut? If a patient is constipated, they've got chronic constepation. If I start to do a cellular detox, pulling toxins out of the cells and they're constibated the toxins will just recirculate.

Yeah. or irritable bowel disease. They've got inflammation in their gut. This is not a time that I want to pull toxins out and have them rush through the gut for detox.

It's going to further inflame their cut. So for that, or the liver, a lot of people have elevated liver enzymes. I'm going bring them down with herbs, the Liver Bioregulator.

Find out why it's high. The enzymes could be high because of the toxins themselves. As long as I am supporting the through the process, then we can detox if they're ready for that.

The kidneys, chronic UTIs or interstitial cystitis. A lot of times inter-stitchal cystitus is just mast cell activation syndrome hitting the genitourinary tract.

So I want to correct for that before I start to detox because I don't want them peeing out toxins when that urine going through that system. So really supporting every system of their body, making sure lymphatic flow is adequate.

I won't have a test for them, but we can tell when someone's lymphatics are stuck. Have people get lymphactic massage very, very gentle to start with while I'm supporting the other organs of elimination.

The thyroid, the sex hormones, all of this has to be taken care of before we start to do a cellular detox. I love it. Okay. Well, and I would guess that doing that preparation is ultimately going to determine whether that detox is going succeed or fail.

I mean, I can only imagine, like, if you haven't done all those steps, If you hadn't taken care of all of those things, that's when you're going hit those walls or potentially end up with someone who feels worse than they did when they came in, which is really not the goal.

It's not a goal, so I'm like please, doctors, don't do that. Detox. Don't. If all this isn't taking care, the patient will just be sicker. You talked a lot about how peptides fit into the process, especially for the immune support.

What about mitochondrial support? At any point in your process are you using peptide to support mitochondria in these processes? Yes. I've been thinking a lots about this actually.

Talking to Dr. Navio about his work, the mitochondrion, and in my clinical experience, I've seen it as well. The

mitochondria, when they are experiencing insults, the insult I talked about multiple toxins, multiple infections, stress, bad diet, all of these issues, mitochondrion start to quieten down in their ATP production to be used for energy.

So they stop using intracellular ATP. Instead, they send their ATP outside. It's called extraceller ATP, and that's the mitochondria ringing the alarm bell and telling the rest of the Mitochondria, hey, we've got a problem here.

We've an insult. to contain the slowdown ATP production, increase oxidative stress, increased inflammation. The mitochondria do this to contains the insulin.

People think of mitochondrion as just ATP producers, but as you and I were talking about before we even got on there, they're organelles that sense the environment, they speak to the immune system, and they're not just pumping out our energy.

Not blindly, that's for sure. They have a big job. I was telling Dr. Navio, I've noticed that when the patient is stuck in a state of persistent inflammation and persistent oxidative stress, if I start to stimulate the mitochondria, it's like tickling an angry person.

They're not going to find that very funny, right? So the It's programmed, it's on purpose. They have quietened down their HP production but increased the oxy of stress to contain the insult.

Now a lot of these patients, we get rid of the insults, clear the toxins, kill the bugs. and they still are in a state of persistent oxidative stress and inflammation.

It's still happening, but they're stuck in the cell danger response, that they don't know how to quieten down. So this is a great time to bring in peptides after.

I really thought in depth, what sequencing do I want to use the peptide in? Well, I wanted to stop inappropriate apoptosis from happening. So I'm going to come in with human in first.

Interesting because human then it, it the mitochondria release that to tell the cells it's time to stop that inappropriate apoptosis. So that one comes in for us next.

I want to bring in SS 31 because it can stabilize the inner mitochondrial membrane. When we stabilize, the inter mitochondrium membrane, now the Mitochondria can actually start to make more ATP.

It actually stabilizes the electron transport chain and starts to bring down reactive oxygen species at the source. Remember, when the person has those bugs, I want the mitochondria to increase their ROS.

I wanted them to release their inflammation. It's not that inflammation in reactive species is bad. It's bad at the wrong moment when it's stuck in a loop.

The pep has to get unstuck. That's a word. Stop that stuck pattern. It is breaking the loop, it is what you just said. and then I can bring in MOTC after because that's about metabolic reprogramming.

But if I bring MotC before I'm bringing human in, it doesn't make sense to shift metabolic programming in cells that are inappropriately dying, or it makes sense ask the metachrono to increase ATP Um, after I, I shifted the signaling.

Mitochondrial support and peptide therapy

So, so that's how I like to think of it. this patient population. You're kind of understanding why is the mitochondria slowing down. And that is a respect for the innate wisdom in the body.

That doesn't mean that sometimes we don't get stuck in loops. It doesn t mean sometimes things go offline. But even, for example, someone who's very, very stressed, one of the things I learned was And we look at the thyroid

and it's like, oh, well, the thyroids not performing, so we try to boost thyroid function.

But really that is because the adrenal glands are asking the Thyroid to slow the heck down because they can't keep up with the demands. And here you're saying pretty much a similar thing.

You know, what I think is important for us to sometimes understand is even though how we feel is like a bag of broken toys and we don't have energy and can't move, if we can take a minute and pause and understand, is this something that the body is doing to somehow protect?

the rest of the system. And can we solve that first? And now we ask for more, you're going to get a better outcome. Because I think Montse, it has this, this aura of just use Montsee, You're gonna have more energy, Yes, but not if the system's already on its knees.

That's a very powerful message, I think, that I hope lands with a lot of people. Okay, we're going to start winding down here, and I believe I know what you're gonna say, for the audience, how do lifestyle tools like sauna, fasting, or exercise benefit or deplete?

Again, where do you see them fitting in? Yeah. If somebody can tolerate the sauna, it's an excellent way of excreting metals. I mean, really any way is sweating, but the sun gets deep, right?

And yeah, sweating off those talks. But some of my patients can't be in the sonar for more than five or 10 minutes. So if somebody has post-exertional malaise, Don't push yourself past that point.

Whether it's with exercise, whether it is with sauna, these things that are supposed to be good for you, they're not good anymore when your system is stuck in that loop.

When your organs of elimination are not optimal, then this is only going to push you off the edge. For somebody who I've worked with them for, maybe it's going to take two years to get them better, and they're through year one.

They were sensitive to everything. They couldn't walk up a flight of stairs. I had to just take a deep breath after and then go to sleep the rest of the day.

Of course, these people have to get checked out by the ologist, the proper cardiologist, pulmonologist. Whatever it is, they get They're within normal limits.

Theologist sends them back, you're normal. That's my blessing. I know I can go on with what I need to do, right? But I just have to throw that in there because it's important that people- 100%. Yeah.

Right. But so these patients, they cannot tolerate anything. No sauna, no exercise that's going to cause post-exertional malaise. Just do what you can.

but now say they're one year in and they can walk up five flights of stairs now, but they still get a little tired. Instead of being bedridden, they just need a nap for an hour every day.

At that point, They can tolerate the sauna more, they can't tolerate more exercise and they start to be more like a normal person. And then patients see me and now I'm going to become a biohacker.

I'll be like, you go ahead, go do that. Careful. Yeah, yeah. What about things like binders with sauna? Because I think one of the things about sauna is, and especially, well, there's some interesting literature around infrared versus traditional sauna.

Um, the infrared can sometimes have real benefits for people who are more sensitive because they're not, their body's not being asked to ask, to deal with as a high heat.

And there was a really interesting study called the bun study and it compared the differences in compounds that

were released. from the extreme heat versus the infrared, especially full spectrum.

Like it goes at different tissues in different ways. But have you found, again, like, I mean, a population of people that can handle three minutes of sauna, that's just not for them.

but if you've found as that tolerance goes up that using binders at the right time can kind of assist in kind catching those toxins until the body can release them properly.

Yes. I'm so glad you brought up bindors. I want to bring up binders and peptides and how I use those together. There are many patients who cannot tolerate a binder and they read books that talk about, but you have to use specific bindings for specific- Like bentonite clay.

Yeah. All this stuff. Try all them and it's not good. It's lots of people like that. I really think that's about the immune system. just even thinking that the binder is, is dangerous.

So the way I use, I've talked about using peptides, you know, that's it. Like it actually, and I don't know if I, no, like I'm bringing up another podcast.

I dunno if, if you saw Kent and Dr. Holthorpe and doing a webinar together on, on Sears chronic inflammatory response syndrome. Oh yeah. He talks about that a lot.

Yeah. That's right. And so, so binders, They're not always gonna work for people. They are not ready for it. So if we start to use the peptides to modulate the immune response the way I was talking about earlier, people are gonna start eliminate toxins on their own.

Their detox pathways are going to start normalize when their immune system is in line. At that point, I might start do more active detox with the patient and at that they're actually more tolerant of the binders.

Yeah. I love that you said that because I think binders get positioned as a blanket solution for people. Oh, just take a binder. And I loved that. You're bringing up that there's real nuance in even in that space because, you know, whether it's activated charcoal or bentonite clay, or there are some very, there're some prescription ones that are, I, if there was one in particular that I know people really like, Cholesteramine.

Yeah, which is kind of like a good news, bad news thing. I think that, again, bringing nuance to that conversation, and frankly, not even just for the complex chronic illness people, just, for our run of the mill people is a really important distinction.

So thank you for that. All right, let's look ahead. And as we close up, I mean, you know, obviously we could keep going here, but in terms of what you're seeing, what's the most exciting emerging science in environmental illness and longevity that you are seeing right now?

Like what is on the horizon that really kind of floats your boat? Plasmapheresis. We actually do it at our clinic. So we have been doing it for the past three, four years.

for our patients or if people want to refer, we usually focus on people who have complex chronic illness because that often allows us to remove enough toxin or enough antibodies to make room for us do the other treatments that we need to do.

The more toxins we are able to actually remove from the system, the more the immune system is going to start to modulate. Some people have such a high toxic burden that It's going to take years to detox.

The way I see it, it's a little bit, and maybe you could briefly explain what plasmapheresis is, but just for people who may not have heard about it. But I think it is a bit like in certain, not to go down the cancer road, sometimes you just have to remove the tumor.

Sometimes you have just to get rid of the physical that physical peace, so that you leave space for healing and, and everything else.

Sauna, binders, and plasmapheresis

And, you know, maybe without the plasmapheresis, it just would take so much longer, but you're able to kind of lower the levels on that bucket of toxins, So that people can actually see a better benefit.

So maybe quickly define for the audience, what is plasmapheresus? So plaspherisis is a technique where we pull out the toxins from the blood. The toxins are stuck to albumin.

Albumin is like a sponge for the toxin, so we pull it out and then we filter it and the fresh blood is introduced back into the system. So what gets filtered out?

All kinds of toxins. There is a paper done probably eight months ago now that show that total plasma phoresis removes glyphosate, mycotoxins, metals, forever chemicals, a host of chemicals that it would otherwise take a long, long time to detoxify from.

So then we replace the albumin and we Go ahead. Yeah. And also IG, IVIG. So plasmapheresis, I'm thinking that that sounds more like total plasma exchange, TPE.

It is. They're the same. Oh, that's so interesting because I thought there were two different processes, so maybe I am wrong about that. Because I though plasmaferesis was returning everything back, well, minus the bad actors, and that the TPE is where we replace albumin.

So question about TBE, what are your thoughts on sourcing of albumins? Because I know that that is a real hot topic right now, not a lot of people ask that question.

We've asked that questions. I'm sure you have. It is tested for. it's clean. It's important. So guys, just so you know, like what we're talking about here is, and this is a medical procedure, this has been done in hospitals in very extreme cases for a long time.

This is pretty intrusive procedure. But I think what you're taking about is how powerful it can be in treating chronic complex illness where the load is just so high.

And what do you think of people just running around getting TPE because it sounds like a good idea? I think there's too many of those. I mean, some people, they say it really helped them.

They feel differently. they didn't realize how fatigued they were. But here's the thing, Getting TPE without having the appropriate support around that, I think that's inappropriate.

I don't think it's not going to work as well, but we need to support. Like I was talking about, support the body with the amino acids, with minerals. We'll give spermadine to help kill off the zombie cells.

Interesting. So we're going We're going to do some cellular detox before giving the plasmapheresis as well. Support the body in what we're asking it to with the Plasmaphoresis.

After that, we are then supporting the buddy again. Some people might get NAD. They might exosomes after it. Right? They'll get more peptides after that because now we want to reprogram the cells.

So plus this on its own without the support before and after. I don't think it's going to be as effective at all. Last question on this, even though this was supposed to quick fire.

Is it one TPE or is it a series? It depends on the person. So for somebody who is pretty well, they just want to clear out zombie cells. They want do this for anti-aging.

Usually two is good. And they could do one in one month. They could one another the second month, or they can do another week in a row. For people who have complex chronic illness, they might need five or seven over the course of a year or two, year and a half.

Based on their tolerance, I would think. We go very, very slow. So the other clinics that do this, then they go a lot faster. But we can't do that because our patients are sensitive.

they're going to get really tired. They're gonna have a mass cell reaction maybe. So if we run it really slow, maybe it's a five hour process instead of a three hour.

That's okay. We just want them to be comfortable. Yeah. I love it. Okay. All right. Couple of quick questions and I'm going to release you to go back and heal the people.

If you could rewrite the standard menopause conversation, what would change? What would you change about this standard Menopausal conversation that's happened?

There's so much, there's good noise about it, it's But what would you change about what's happening? I really want women to feel like they are self-sovereign, not only in their health, but in our lives and that their help is a reflection of their life.

That women don't have to suffer. We are taught, even though the message is starting to change, for decades, it's been, hey, you don' have enough hormones, that's just aging.

It doesn't have to be that we age unhealthily. There are many things that can do to support that, and I'm all for it. Yeah. Well, and that ties into the next question.

What gives you optimism about, about women aging well, despite the toxic world we live in?

Menopause, longevity, and closing thoughts

What, what gives your optimism? We have so many tools, you know, now there's so may tools to even help with the nervous system. Amy Opikian's work, Captain King's, work with primal trust.

Like this is what women want. They're hungry for that. internal healing. And then that ties in with all the work that I do to shift their biochemistry, to work with their genes.

But I'm doing more than that. Women will tell me everything. What an honor it is to hear the depths of our heart and soul, and when they're witnessed by their doctor who's working on their biochemistry, that's when I get to be seen as a whole person.

And so that gives me hope. I love it. Dr. Nafiza, this has been a really wide ranging and fantastic conversation, which I knew it would be. So I want to thank you so much for being here today and for taking the time.

And please tell people where they can learn more about your work, about the amazing clinic. Yeah. Our clinic is Gordon Medical and we're in the San Francisco Bay area.

And it's just gordonmedical.com. And there's information about me and all of our doctors on the website. So that's all there. Thank you. It's been a pleasure and an honor.

I look forward to many more conversations. Me too.