Want More Estradiol? Why Rhythmic HRT May Work Better | Drs. Valorie & Maki Transcript

(Transcripts are generated by AI and may contain errors)

Static vs. rhythmic HRT

Some people do wonderfully on static Some people do wonderfully on static dosing and it can be magic for your dosing and it can be magic for your joints, for your hot flashes, your night joints, for your hot flashes, your night sweats, your skin, your hair. I've sweats, your skin, your hair. I've noticed noticed noticed >> [music] >> [music] >> [music] >> want more estradiol? Why rhythmic HRT >> want more estradiol? Why rhythmic HRT might work better. Hi, I'm Dr. Valerie might work better. Hi, I'm Dr. Valerie Davidson from the Progressive Health Davidson from the Progressive Health Podcast.

Podcast. Podcast. >> Dr. Mauck from the Progressive Health >> Dr. Mauck from the Progressive Health Podcast. Uh so we've talked about this Podcast. Uh so we've talked about this in the past um but you know, one trend in the past um but you know, one trend that we've seen over the last few years that we've seen over the last few years with our website and ask the doctor and with our website and ask the doctor and the podcast uh is women always want more the podcast uh is women always want more estrogen.

estrogen. estrogen. >> And they need more estrogen. A lot of >> And they need more estrogen. A lot of times I find that a lot of women are times I find that a lot of women are under dosed. Now, I know every under dosed. Now, I know every practitioner has their own philosophy practitioner has their own philosophy and I completely respect that, but I do and I completely respect that, but I do feel like women do need really good feel like women do need really good levels of estradiol that when it's too levels of estradiol that when it's too low, we're not really getting the low, we're not really getting the effectiveness from it. Now, some women effectiveness from it. Now, some women can only tolerate a little bit and that can only tolerate a little bit and that is totally fine. We want to treat the is totally fine.

Why women need more estradiol

We want to treat the patient, not the numbers, but a lot of patient, not the numbers, but a lot of women do need more estradiol and one the women do need more estradiol and one the reason we wanted to do this podcast reason we wanted to do this podcast rhythmic dosing or rhythmic HRT is rhythmic dosing or rhythmic HRT is different than static dosing. You're different than static dosing. You're actually able to achieve physiological actually able to achieve physiological levels of estradiol which I'll go over levels of estradiol which I'll go over the dosings on how much estradiol you the dosings on how much estradiol you take.

take. take. >> that's the shocker. >> that's the shocker. >> It is. Like how much you'll use over >> It is. Like how much you'll use over excuse me, a 28-day cycle. But in terms excuse me, a 28-day cycle. But in terms of static dosing, that's taking the same of static dosing, that's taking the same dose every day. Same as estrogen dose every day. Same as estrogen bio-identical estradiol every day and bio-identical estradiol every day and the same progesterone every single day.

the same progesterone every single day. That's static dosing. Where rhythmic That's static dosing. Where rhythmic dosing is intentionally recreating the dosing is intentionally recreating the menstrual cycle. So you're doing varying menstrual cycle. So you're doing varying doses of estradiol to match that of what doses of estradiol to match that of what the ovary would put out when our ovaries the ovary would put out when our ovaries were working before we went through were working before we went through menopause and the same thing with the menopause and the same thing with the progesterone where you do the progesterone where you do the progesterone from day 14 till somebody progesterone from day 14 till somebody gets a period. Now, like I was gets a period. Now, like I was I have a uterus. I'm 53 years old. I I have a uterus. I'm 53 years old. I have a uterus. I'm in menopause, but I have a uterus. I'm in menopause, but I do rhythmic dosing. So every month I get do rhythmic dosing. So every month I get a period. Now, if somebody doesn't have a period. Now, if somebody doesn't have a uterus, they can still do

rhythmic a uterus, they can still do rhythmic dosing. It's totally fine um to do that dosing. It's totally fine um to do that in some ways. You just they just go up in some ways. You just they just go up to day 28 and start back on day on day to day 28 and start back on day on day one. But we really wanted to get across one.

How rhythmic dosing mimics the menstrual cycle

But we really wanted to get across the levels of estradiol that you can use the levels of estradiol that you can use with rhythmic. with rhythmic. >> Yeah. Um so, hysterectomy in some ways >> Yeah. Um so, hysterectomy in some ways and then do rhythmic dosing in some ways and then do rhythmic dosing in some ways could be best case scenario cuz now you could be best case scenario cuz now you don't have to deal with the period don't have to deal with the period anymore.

anymore. anymore. >> Well, a lot of women like myself, too, >> Well, a lot of women like myself, too, like having that period. They always like having that period. They always feel like it's a reset.

feel like it's a reset. >> Sure. >> Sure. >> Sure. >> So, of course, a lot of women say, "Oh >> So, of course, a lot of women say, "Oh my gosh, I'm going to have to get my my gosh, I'm going to have to get my period back. Those were awful." period back. Those were awful." >> Oh.

>> Oh. >> Oh. >> The goal isn't to get your original >> The goal isn't to get your original periods back cuz I will say just for periods back cuz I will say just for transparency, um and that's partly why I transparency, um and that's partly why I went into HRT as a young woman. I had went into HRT as a young woman. I had very terrible periods, had very terrible periods, had endometriosis. I've had laparoscopic endometriosis. I've had laparoscopic once, um D&C another time because I have once, um D&C another time because I have I had um endometrial hyperplasia just as I had um endometrial hyperplasia just as a young woman. I was put on birth a young woman. I was put on birth control pills. That was my only option.

control pills. That was my only option. Here, take the you know, take the pill. Here, take the you know, take the pill. And I felt like that is not the And I felt like that is not the solution. Now, granted, this is in the solution. Now, granted, this is in the '90s that that's kind of why I went into '90s that that's kind of why I went into the HRT. So, with my even with my the HRT. So, with my even with my history, I can do the rhythmic dosing.

history, I can do the rhythmic dosing. I'm able to adjust the levels of I'm able to adjust the levels of estrogen and progesterone like I do with estrogen and progesterone like I do with my patients so that their periods are my patients so that their periods are easy-peasy.

easy-peasy. easy-peasy. >> Which is which is the way it's supposed >> Which is which is the way it's supposed to go, right? It's supposed to be no to go, right? It's supposed to be no symptoms, no pain, no cramping, not any symptoms, no pain, no cramping, not any of the PMS symptoms that women deal with of the PMS symptoms that women deal with their entire menstrual history. That's a their entire menstrual history. That's a sign of dysfunction of some sort. But sign of dysfunction of some sort. But when your only options are either drugs when your only options are either drugs or birth control, or excuse me, uh birth or birth control, or excuse me, uh birth control or surgery, there's no really control or surgery, there's no really understanding of how to actually fix understanding of how to actually fix those problems.

those problems. >> And one thing, too, just sorry to >> And one thing, too, just sorry to interrupt, is with rhythmic dosing, interrupt, is with rhythmic dosing, women will say, "Well, oh my goodness, women will say, "Well, oh my goodness, am I going to get my endometriosis am I going to get my endometriosis back?" I'll say just from personal back?" I'll say just from personal experience, no. But all the women that experience, no. But all the women that I've worked with with rhythmic dosing, I've worked with with rhythmic dosing, I've never seen their endometriosis come I've never seen their endometriosis come back. I've never seen their fibroids back. I've never seen their fibroids flare up. Now, I have seen some other um flare up. Now, I have seen some other um patients that have come into me, new patients that have come into me, new patients that their fibroids have flared patients that their fibroids have flared up from doing static dosing because the up from doing static dosing because the estradiol was a little too high. I have estradiol was a little too high. I have seen that.

seen that. >> Yeah, it's it's too high for too long >> Yeah, it's it's too high for too long and then it can create some of that. and then it can create some of that.

When you have the cycle to those When you have the cycle to those hormones, it tends to create a little hormones, it tends to create a little bit of a different environment.

bit of a different environment.

Benefits and safety of rhythmic dosing

>> Yeah, so that's sort of the safety >> Yeah, so that's sort of the safety behind that rhythmic dosing if somebody behind that rhythmic dosing if somebody has a uterus is you're intentionally has a uterus is you're intentionally thickening up that endometrial lining thickening up that endometrial lining and then you slough it off and you have and then you slough it off and you have a period at at the end of the cycle and a period at at the end of the cycle and you start back at day one as opposed to you start back at day one as opposed to static dosing, you do not want a static dosing, you do not want a thickened endometrial lining at all thickened endometrial lining at all because that is a risk for uterine because that is a risk for uterine cancer.

cancer. cancer. >> And that's the distinction between the >> And that's the distinction between the two at the end of the day. And for those two at the end of the day. And for those women like yourself that want their women like yourself that want their brain to work, their body to work, uh brain to work, their body to work, uh you know, all those things that are part you know, all those things that are part of menopause that women don't want, um of menopause that women don't want, um you can only accomplish some of that you can only accomplish some of that with a static dosing. You can accomplish with a static dosing. You can accomplish a heck of a lot more um with the a heck of a lot more um with the rhythmic dosing. Um you cannot compare rhythmic dosing. Um you cannot compare those two as far as uh how someone feels those two as far as uh how someone feels on them. Uh you know, where the mostly on them. Uh you know, where the mostly conventional options for women just, you conventional options for women just, you know, touch on the surface of what uh know, touch on the surface of what uh There's a lot of talk about how amazing There's a lot of talk about how amazing HRT is, but you got to pick the right HRT is, but you got to pick the right tool for the job.

tool for the job. >> Exactly. Everybody's different. Some >> Exactly. Everybody's different. Some people do wonderfully on static dosing people do wonderfully on static dosing and it can be magic for your joints, for and it can be magic for your joints, for your hot flashes, your night sweats, your hot flashes, your night sweats, your skin, your hair. I've noticed with your skin, your hair. I've noticed with the rhythmic dosing, I'll tend to maybe the rhythmic dosing, I'll tend to maybe switch patients to that if especially if switch patients to that if especially if that libido isn't coming up. The that libido isn't coming up. The rhythmic dosing is amazing for putting, rhythmic dosing is amazing for putting, you know, the libido back on the brain.

you know, the libido back on the brain. Uh Uh Uh again, brain brain function. People will again, brain brain function. People will say sometimes that static dosing isn't say sometimes that static dosing isn't quite helping with the brain fog. The quite helping with the brain fog. The rhythmic dosing can be incredible for rhythmic dosing can be incredible for that. And then you think about the hair, that. And then you think about the hair, the skin, and the nails. Um the rhythmic the skin, and the nails. Um the rhythmic dosing is great. Now, not it's not for dosing is great. Now, not it's not for everybody. Like if somebody cuz I've got everybody. Like if somebody cuz I've got it like I'll go over my dosing with you.

it like I'll go over my dosing with you. to change it every few days cuz I'm to change it every few days cuz I'm increasing up my estradiol and then I'm increasing up my estradiol and then I'm decreasing it. I'm starting my decreasing it. I'm starting my progesterone, increasing up that, progesterone, increasing up that, decreasing it, getting a period. You decreasing it, getting a period. You have to be very specific where you are have to be very specific where you are in your calendar, you have to keep track in your calendar, you have to keep track of your dosing, and you have to keep of your dosing, and you have to keep track of your symptoms, too. Like, I track of your symptoms, too. Like, I might have a, you know, if I might have a, you know, if I have sleeplessness on a certain day of have sleeplessness on a certain day of the cycle, I'll know maybe I need to the cycle, I'll know maybe

I need to adjust that dose. Now, if somebody has a adjust that dose. Now, if somebody has a hard time doing that, or it's just hard time doing that, or it's just they're feeling scattered, maybe that's they're feeling scattered, maybe that's not the right, not right for them. Uh, a not the right, not right for them. Uh, a lot of women, too, that are already, lot of women, too, that are already, like, "Hey, I feel really good. I'm fit.

like, "Hey, I feel really good. I'm fit. I eat good. I'm healthy. I want to keep I eat good. I'm healthy. I want to keep it this way for as long as I, you know, it this way for as long as I, you know, as long as possible. I don't want to as long as possible. I don't want to age. I don't want things to start to age. I don't want things to start to backslide." That's where the rhythmic backslide." That's where the rhythmic dosing is really nice for what I call dosing is really nice for what I call the the racehorse, somebody that's the the racehorse, somebody that's already got this amazing lifestyle.

already got this amazing lifestyle. They're eating great. They're, you know, They're eating great. They're, you know, they want to just make sure they're able they want to just make sure they're able to continue that.

to continue that. >> Yeah, if you take if you go to our >> Yeah, if you take if you go to our website and take the quiz, uh, and website and take the quiz, uh, and you'll determine where you are. Either you'll determine where you are. Either you're in perimenopause, you're an you're in perimenopause, you're an in-betweener, or you're in menopause.

in-betweener, or you're in menopause. Um, Rachel the racehorse is your sort Um, Rachel the racehorse is your sort of, uh, character, avatar, of who's a of, uh, character, avatar, of who's a good fit for rhythmic dosing.

good fit for rhythmic dosing. >> I wrote a free guide that kind of goes >> I wrote a free guide that kind of goes through perimenopause, menopause, and through perimenopause, menopause, and also the in-betweener, because the also the in-betweener, because the in-betweener is also a great one that in-betweener is also a great one that would start that the rhythmic dosing.

would start that the rhythmic dosing. That's right when they're coming out of That's right when they're coming out of perimenopause, or just kind of in late perimenopause, or just kind of in late perimenopause, going into menopause.

perimenopause, going into menopause.

Who is a good candidate for rhythmic HRT

Their body doesn't miss a beat when you Their body doesn't miss a beat when you add in that rhythmic dosing, because add in that rhythmic dosing, because it's like, oh, body's like, "Oh, thanks.

it's like, oh, body's like, "Oh, thanks. Where'd this go? Now we have, you know, Where'd this go? Now we have, you know, back to our cycle, you know, I I I back to our cycle, you know, I I I understand this." You can keep that understand this." You can keep that brain in the in that not technically the brain in the in that not technically the ovaries, because you're in menopause, ovaries, because you're in menopause, but the hormones in the system, the but the hormones in the system, the brain thinks the ovaries are secreting brain thinks the ovaries are secreting these hormones. Now, somebody that maybe these hormones. Now, somebody that maybe hadn't been on HRT, which unfortunately, hadn't been on HRT, which unfortunately, there was a generation of women there was a generation of women that were neglected with their hormones, that were neglected with their hormones, and they, you know, they might be 65 and they, you know, they might be 65 years old, and have never been on HRT, years old, and have never been on HRT, cuz they were told it was going to give cuz they were told it was going to give them cancer, which it does not.

them cancer, which it does not. The Those those women, it is harder to The Those those women, it is harder to matriculate them to the rhythmic dosing, matriculate them to the rhythmic dosing, because their bodies have a It's a because their bodies have a It's a little bit harder to for it to remember.

little bit harder to for it to remember. So, that's where it kind of depends on So, that's where it kind of depends on

the person and of course working it with the person and of course working it with your practitioner.

your practitioner. >> And it also depends on too like their >> And it also depends on too like their previous menstrual history. previous menstrual history.

Um you know, just how their body Um you know, just how their body responds to estrogen, um being pregnant, responds to estrogen, um being pregnant, how they respond to estrogen. Those are how they respond to estrogen. Those are all the factors that we sort of um but all the factors that we sort of um but usually the the Rachel the racehorse usually the the Rachel the racehorse that avatar that avatar um is really at least with our um is really at least with our population is relatively pretty easy to population is relatively pretty easy to spot them. Like you know what this spot them. Like you know what this profile of this person and the things profile of this person and the things that they want to accomplish that they want to accomplish um and they're maybe already on HRT and um and they're maybe already on HRT and they're not accomplishing that. It's they're not accomplishing that. It's really easy to tell that hey, this one really easy to tell that hey, this one is a good candidate.

is a good candidate. >> Yeah, or somebody that's just not >> Yeah, or somebody that's just not getting what they want to achieve with getting what they want to achieve with HRT with static dosing. That's where the HRT with static dosing.

Example rhythmic estradiol protocol

That's where the rhythmic dosing can be such a beautiful rhythmic dosing can be such a beautiful matriculation to that. But let me let me matriculation to that. But let me let me show you what I do. So, this is kind of show you what I do. So, this is kind of a sample of what rhythmic dosing looks a sample of what rhythmic dosing looks like. Now, the thing is with rhythmic like. Now, the thing is with rhythmic rhythmic dosing is you have a protocol, rhythmic dosing is you have a protocol, but you can also tailor that protocol but you can also tailor that protocol for that particular individual. So, this for that particular individual. So, this protocol that I'm doing is actually protocol that I'm doing is actually tailored to me to fit, you know, who I tailored to me to fit, you know, who I am, my blood work and my my goals and am, my blood work and my my goals and how I how I kind of balance my hormones how I how I kind of balance my hormones where somebody else might be a little where somebody else might be a little bit different. So, for example, day one bit different. So, for example, day one would be my period. So, day one to day would be my period. So, day one to day five I take 4 mg of estradiol five I take 4 mg of estradiol transdermal. I put it on my inner thigh transdermal. I put it on my inner thigh cuz I don't want it to get on our cuz I don't want it to get on our animals and that's a nice um fatty space animals and that's a nice um fatty space to kind of soak up the hormones which to kind of soak up the hormones which hormones are all have a cholesterol hormones are all have a cholesterol backbone. They're fat, you know, fat backbone. They're fat, you know, fat soluble. So, I do 4 mg in the morning soluble. So, I do 4 mg in the morning and I do 4 mg in the evening. So, that's and I do 4 mg in the evening. So, that's a total of 8 mg and that's 1 2 3 4 5.

a total of 8 mg and that's 1 2 3 4 5. And then on day 6 7 and 8 I increase And then on day 6 7 and 8 I increase that up to 6 mg of estradiol twice a that up to 6 mg of estradiol twice a day. So, a total of 12 in that 24-hour day. So, a total of 12 in that 24-hour period. So, as you can see in the period. So, as you can see in the natural ovarian cycle, the estrogen is natural ovarian cycle, the estrogen is starting to go up hoping for ovulation.

starting to go up hoping for ovulation. So, on day 9 and 10 I increase it up to So, on day 9 and 10 I increase it up to 7 mg of estradiol twice a day. Then on 7 mg of estradiol twice a day. Then on day 11, I go to 8 mg twice a day of day 11, I go to 8 mg twice a day of estradiol. And then on day 12, which in estradiol. And then on day 12, which in a 28-day, a perfect 28-day cycle, the a 28-day, a perfect 28-day cycle, the body surges this huge amount of body surges this huge amount of estradiol on day 12 to try to cause an estradiol on day 12 to try to cause an ovulation. Of course, I'm in menopause.

ovulation. Of course, I'm in menopause. I'm not My ovaries are checked out. I'm I'm not My ovaries are checked out. I'm not going to get an ovulation, but I'm not going to get an ovulation, but I'm mimicking it. So, on day 12, I actually mimicking it. So, on day 12, I actually do 12 mg of estradiol in the morning and do 12 mg of estradiol in the morning and 12 mg of estradiol in the evening. So, 12 mg of estradiol in the evening. So, that's a total of 24 mg of

estradiol in that's a total of 24 mg of estradiol in a 24-hour period.

a 24-hour period. >> that's not biased. That's straight >> that's not biased. That's straight estradiol. estradiol. estradiol. >> estradiol. And then on the next day, so >> estradiol. And then on the next day, so as that start, you know, then you start as that start, you know, then you start to see the estradiol start to gently to see the estradiol start to gently come down, I go down to 6 mg in the come down, I go down to 6 mg in the morning of estradiol and 6 mg in the morning of estradiol and 6 mg in the evening. Then on day 14, that's the evening. Then on day 14, that's the lowest day, as I go down to 3 mg in the lowest day, as I go down to 3 mg in the morning, 3 mg in the evening. Then on morning, 3 mg in the evening. Then on day 15, 16, and 17, I do go up to 4 mg day 15, 16, and 17, I do go up to 4 mg cuz the estradiol does come up a little cuz the estradiol does come up a little bit towards that end of that cycle is on bit towards that end of that cycle is on that 15, 16, 17, I go to 4 mg twice a that 15, 16, 17, I go to 4 mg twice a day. And then on day 18 until I get my day. And then on day 18 until I get my period, I end up doing 5 mg twice a day, period, I end up doing 5 mg twice a day, so that's 10 mg in a 24-hour period.

so that's 10 mg in a 24-hour period.

Adjusting doses and tracking symptoms

Now, I usually get my period right Now, I usually get my period right around day 26, which is pretty typical around day 26, which is pretty typical for me even when I was menstruating. I for me even when I was menstruating. I was 26, 27, sometimes 28. Some women was 26, 27, sometimes 28. Some women will get their periods on day 28 when will get their periods on day 28 when they're doing the rhythmic dosing. If they're doing the rhythmic dosing. If it's closer to 30 or 32, if that wasn't it's closer to 30 or 32, if that wasn't originally what their cycles were when originally what their cycles were when they were younger and menstruating, they were younger and menstruating, then I usually kind of increase up that then I usually kind of increase up that estrogen. It usually means that estrogen. It usually means that estrogen's a little low. They're getting estrogen's a little low. They're getting their periods a little too soon, like their periods a little too soon, like day 21, you might want to decrease the day 21, you might want to decrease the estrogen or raise the progesterone. So, estrogen or raise the progesterone. So, there's all different ways to dose with there's all different ways to dose with that. And then you can also test. Of that. And then you can also test. Of course, we like to do the testing on course, we like to do the testing on this. We'll do another podcast on this. We'll do another podcast on progesterone cuz there's a lot to kind progesterone cuz there's a lot to kind of unwrap with progesterone. I think of unwrap with progesterone. I think with rhythmic versus cyclic. But in with rhythmic versus cyclic. But in terms of the estradiol with rhythmic terms of the estradiol with rhythmic dosing, as you can see, you can you can dosing, as you can see, you can you can really get those estradiol levels up.

really get those estradiol levels up. >> Yeah, and and now granted as a little >> Yeah, and and now granted as a little caveat or a little disclaimer here, this caveat or a little disclaimer here, this is for, you know, educational purposes.

is for, you know, educational purposes. Do not try to recreate this on your own. Do not try to recreate this on your own. This is not the starting point for any This is not the starting point for any woman, right? This is you you work your woman, right? This is you you work your way up to this kind of dosing once your way up to this kind of dosing once your body has a chance to be exposed to it.

body has a chance to be exposed to it. Uh you know, so even with this, we Uh you know, so even with this, we usually start at a much lower point and usually start at a much lower point and then it gradually works its way up. And then it gradually works its way up. And the woman herself, her subjective, you the woman herself, her subjective, you know, situation, how she's feeling, know, situation, how she's feeling, what's what's getting better, getting what's what's getting better, getting worse, will be uh will be adapted as worse, will be uh will be adapted as time goes on. And sometimes it takes 3 time goes on. And sometimes it takes 3 months, sometimes it takes 6 months. In months, sometimes it takes 6 months. In in reality, it is sort of a it's sort of in reality, it is sort of a it's sort of like a a never-ending like a a never-ending um tweaking process. Now, that doesn't um tweaking process. Now, that doesn't mean that you're never going to feel mean that you're never going to feel good. Um the patients that are doing good. Um the patients that are doing well with dosing well with dosing >> Women feel really good on this

>> Women feel really good on this >> good. But you know, might tweak this >> good. But you know, might tweak this here and might tweak that there. And here and might tweak that there. And maybe there's a stressor in her life or maybe there's a stressor in her life or something's going on. So now things get something's going on. So now things get adjusted on the fly as, you know, she's adjusted on the fly as, you know, she's already her body's already had exposure already her body's already had exposure to the hormone.

Who should avoid self-directed dosing

to the hormone. >> So just like Dr. Maki mentioned is don't >> So just like Dr. Maki mentioned is don't do this on your own because this is a do this on your own because this is a protocol that we studied intensely.

protocol that we studied intensely. We've I've been doing this since 2009. I We've I've been doing this since 2009. I think you've been working with women think you've been working with women with rhythmic dosing even before that.

with rhythmic dosing even before that. This is something that really you want This is something that really you want to work with a practitioner that knows to work with a practitioner that knows how to do rhythmic dosing. So that's the how to do rhythmic dosing. So that's the most important caveat because you want most important caveat because you want to make sure that you're doing it right.

to make sure that you're doing it right. But I wanted But I wanted >> And and safely. >> And and safely. >> And safely. But I wanted to show this >> And safely. But I wanted to show this because even when I originally started because even when I originally started on rhythmic dosing, I mean, I've done on rhythmic dosing, I mean, I've done static dosing. I've done it all because static dosing. I've done it all because I like to, you know, hormones are our I like to, you know, hormones are our thing. We're we're the hormone experts.

thing. We're we're the hormone experts. But when, you know, I started in my I But when, you know, I started in my I got went through menopause about 50 and got went through menopause about 50 and a half. And so I've been doing this a half. And so I've been doing this protocol for a couple of years, but I protocol for a couple of years, but I did kind of start off a little bit lower did kind of start off a little bit lower and work my way up, but even the lower and work my way up, but even the lower doses are still a tremendous amount of doses are still a tremendous amount of estradiol compared to somebody on a estradiol compared to somebody on a biased.

biased. biased. >> Yeah, now one thing that does happen on >> Yeah, now one thing that does happen on the practitioner side is when you see the practitioner side is when you see the patch that has 0.05 or 0.075 or the patch that has 0.05 or 0.075 or 0.1 and you look at the doses that you 0.1 and you look at the doses that you take there, it freaks people out, but take there, it freaks people out, but you cannot compare the the patch or even you cannot compare the the patch or even biased to this biased to this >> static >> static >> static >> because they're all completely different >> because they're all completely different and the woman herself, whoever whatever and the woman herself, whoever whatever form of hormone she's using, she's going form of hormone she's using, she's going to respond to each one of them to respond to each one of them completely different. Even now, there is completely different. Even now, there is an idea and I see the same thing with an idea and I see the same thing with thyroid, which we're going to talk about thyroid, which we're going to talk about that later, too, is that um whatever the that later, too, is that um whatever the dose is, everyone assumes that those dose is, everyone assumes that those doses are doses are um they convert to the other form and um they convert to the other form and that is when you've been doing this long that is when you've been doing this long enough or even a real you realize real enough or even a real you realize real quickly that those doses are not the quickly that those doses are not the same when you transfer from one to the same when you transfer from one to the other to the other.

other to the other. >> Yeah, you're right. I think at some >> Yeah, you're right. I think at some point we'll do a thyroid conversion point we'll do a thyroid conversion about the different thyroids, so not on about the different thyroids, so not on this episode, we'd be here for another this episode, we'd be here for another couple hours, but but either way, I just couple hours, but but either way, I just wanted to kind of show everybody, you wanted to kind of show everybody, you know, if you're not getting the know, if you're not getting the satisfaction that you want with the satisfaction that you want with the current HRT that you're on or you're current HRT that you're on or you're

having symptoms of maybe the estrogen's having symptoms of maybe the estrogen's too high and too low at the same time, too high and too low at the same time, which is another podcast, is perhaps which is another podcast, is perhaps rhythmic dosing might work better for rhythmic dosing might work better for you or something for you to consider.

you or something for you to consider. >> Yeah. Uh and if you're interested, um >> Yeah. Uh and if you're interested, um you can also uh look at our community, you can also uh look at our community, the Progesterone Hormones Community, the Progesterone Hormones Community, where we sort of educate on how to do where we sort of educate on how to do this uh in a safe way.

this uh in a safe way. Um so you're not flying blind, you sort Um so you're not flying blind, you sort of know what's going on, you know what of know what's going on, you know what to expect because we tell you.

to expect because we tell you. Uh Uh Uh now, granted, we're only we're we're now, granted, we're only we're we're licensed in what, five states, so we can licensed in what, five states, so we can prescribe in the five states that were prescribe in the five states that were you know obviously where we're licensed.

you know obviously where we're licensed. Um but we've worked with some other Um but we've worked with some other people that they've learned a tremendous people that they've learned a tremendous amount and are able to translate that in amount and are able to translate that in their with their own practitioners.

their with their own practitioners. Yeah, so Yeah, so we're going to probably circle back we're going to probably circle back around on this on the progesterone side.

around on this on the progesterone side. If you have any questions at all, write If you have any questions at all, write them down below them down below in the comments. You can always reach in the comments. You can always reach out on our website if you don't feel out on our website if you don't feel comfortable with that, but comfortable with that, but until next time, I'm Dr. Mackie.

until next time, I'm Dr. Mackie. >> And I'm Dr. Valerie. >> And I'm Dr. Valerie.