What No One Tells You About Perimenopause Transcript

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Introduction to Perimenopause

I'm Dr. Taylor. I am a Longevity Physician and Menopause Certified Practitioner and I will teach you today about perimenopausal and menopas. either don't feel comfortable with all the intricacies and the different treatment options for menopausal hormone therapy and other add-on therapies that you can utilize, or OBGYNs simply don t seem to care.

They don or they're too busy doing surgery to help. That's why there are menopause specialists. There's people like me who have educated ourselves for all the different options for menoppausal hormone therapy, for peptide therapies, and for lifestyle changes that you can utilize to actually feel like yourself again as you go through perimenopaus.

Let's be honest, women have the short end of the stick. Not only do they have to have menstrual cycles for most of their life, but then they get to 40, 45, 50. Perimenopause is the 7 to 10 or 14 years before you have your last period.

Obviously, if you had an ablation or a hysterectomy, It's hard to gauge when that true menopause time is. Menopaus is defined as the time when you have been one year from your last period.

So the average age of menopsis is 51 or 52 in the United States. The average of perimenopas starts around 40 but can start as early as 35. Early menopus is define as having your period before the age 45.

Defining Menopause and Early Symptoms

It's important to point this out because having your last period before the age of 45 is called early menopause or primary ovarian insufficiency or failure.

And this can be pathological, meaning there could be something going on with your hormones or gut-forbidden tumor. Something can happen to where you have your period last before then, and that's something to check in with you physician about.

But after 45, if you have your last period, you go a year without one. It's an appropriate time sometime between 45 and 55 to have you last. So perimenopause is often broken up into early perimentopase and late perimetopose and kind of the stuff in between.

And again, that can last anywhere from seven to 10 years. Perimenophase is really where the rubber meets the road as far as treatment. Number one, because early perimenopause can actually be the time where symptoms are the most severe for women to deal with, whether it's hot flashes, brain fog, night sweats, sleep disruptions, irritability, mood swings, loss of libido, vaginal dryness, all of those things can happen in early perimenopause.

And the reason they tend to be more severe is because you have more hormones fluctuating as compared to late permenopaus or menopas. So you can imagine if your ovaries are still making a good amount of estrogen progesterone, but it's kind of fluctuating.

It's like, oh, we can make that, it takes more signal. So your FSH, which is your hormone that stimulates your ovaries, goes from the brain to the ovary and says, hey, time to make more estrogen.

You're like oh yeah, you can do that. But it take a little longer. And then you spike your estrogen progesterone, your FSH goes back down, and then your estrogen progesterone go back, down and your FSH throws it all the way back up.

And slowly later, they all shoot back out. So you can see how you're having these massive fluctuations in estrogen and progeserones.

Hormone Fluctuations and Testing

As you get later in menopause, as your ovaries are unable to make enough estrogen in projeserons in response to your fsh, then the symptoms can actually be somewhat less severe, although it's very unpredictable from woman to woman.

And one common complaint I get amongst women is, hey, my doctor tells me that hormone testing is not going to be helpful for staging where I am in perimenopause.

So like, can you explain that to me? I'm very frustrated. I'll give you two answers. The short answer is actually that's kind of true, because as I've described, your FSH can be high one day, low one Your estrogen and progesterone can be high one day, low one, day.

And so in early perimenopause, it actually can't be quite difficult without tracking hormones either daily or multiple times throughout the week and multiple time throughout a month to actually see what is happening with your staging of perimentopaus.

That being said, if you do have hormone testing, FSA is a good place to start. AMH can also be helpful, which is marker of your ovarian reserve to say like, hey, how many viable ovary eggs are still in there?

Because that's when you're going to have your last period is when your no longer having eggs passing, right? So early perimenopause, high symptoms, it can be very intolerable.

Late perimentopausal can still be similar. Your periods start spacing out. You can have irregular periods, six weeks apart, two months apart three months, apart six months part.

And then at some point get to the point where you don't have a period at all. One thing to mention is just testosterone in this period. For many women testosterone actually tends to be relatively steady throughout perimenopause although it can decline as testosterone is not only made in the ovaries but also converted from DHEA from the adrenal glands and can be converted to testosterone and peripheral tissues.

Many women do okay with their testosterone levels but many women also struggle with FSAD or Female Sexual Arousal Disorder. Female sexual arousals disorder is defined as having six months or greater of low libido that is distressing to you and your partner.

This can also be associated with dysparania or painful intercourse because of vaginal dryness or thinning of the vaginomucosa because loss of estrogen.

Testosterone and Sexual Health

So testosterone can be checked in perimenopausal women and can used as a off-label treatment for FSAD. Now that we've defined what perimetopause is and what menopose is, what early and late perimentopase is.

Why does any of this matter? For many women, and for many decades, we have undertreated and underdiagnosed peri-menopas. It either gets treated as an anxiety disorder, a thyroid disorder weight gain, poor sleep, depression, anxiety, or ADHD-type symptoms.

And so what I've seen in my practice is that if you have a woman coming to you in her 40s, and maybe even late 30s having acute changes in their mood, her waistline, thighs, body composition, without significant changes to her diet, lifestyle, no recent traumatic events, divorce or anything like that going on, but they're saying, I don't feel like myself, things are changing, I have more anxiety or I more mood symptoms.

I've low libido. Many women get dismissed and we treat, you know, the symptoms rather than treating the underlying disorder. And so being a provider that can recognize those symptoms and then offer treatment rather then masking it with an SSRI or weight loss or anything like that, can be very beneficial.

So what are your treatment options?

Why Perimenopause Is Often Missed

So the first line is menopausal hormone therapy. For women in early perimenopause, oral contraceptives may actually be slightly better because they have a higher amount of the synthetic estrogen and can overcome the massive fluctuations that are happening in And then menopausal hormone therapy is approximately 115 to 130th the dose of estrogen that is in oral contraceptives.

Menopause hormone is defined as estrogen and progesterone. If you have a uterus, you need progesterone to protect your body from the uninhibited effects of estrogen on your uterus.

So you don't get too much growth of the uterin lighting and increase your risk of endometrial cancer. It should also be noted that there are like contraindications to taking estrogen therapy, like history of breast cancer or history or blood clots or a history estrogen receptor breast or ovarian cancer.

And so being very aware of your medical history, cause there were also relative contra indications like uncontrolled blood pressure, uncontrollable cholesterol, uncontrolled metabolic syndrome or BMI greater than 40. Those are all things to consider when starting menopausal hormone therapy.

When it comes to estrogen, there's really preferred options is transdermal or topical or injectable because they bypass the liver. So they don't have that metabolism in the lever that oral pills have with estrogen.

And the reason that is, is that the oral Pills are associated with a higher risk of blood clots. This is a good time to mention that there was a 2001 study that showed an increased risk.

Blood clot and stroke with Estrogen therapy.

Menopausal Hormone Therapy Basics

We didn't treat women with perimenopause. We say, oh, well, you're going to get a clot, so you probably shouldn't do it. This is just a part of the process.

That's really frustrating for women because they feel like they have no options. And so we've been using SSRIs or gabapentin or venlafaxine or vioza to treat the symptoms without really giving women what they needed, which was their brain to have, their bones and their endocrine system to help modulate estrogen.

Starting with estrogen, transdermal patch, topical cream, injectable, whichever works best for your treatment regimen, and then progesterone. Typically, oral progesterone as trans-derma pro-gest-er-one does not seem to provide the uterine production.

The Mirena IUD does seem provide uterin production and can be used in place of oral-pro-gest-eron. I like using oral progesterone because it tends to have more effect with sleep symptoms as well as mood symptoms, like decreased anxiety, decreased sleep interruptions, decrease mood irritability.

Treating the symptoms is super important because these are super distressing for women, right? If you're having hot flashes constantly, night sweats, sleep interruption, brain fog, irritable, anxiety.

All those things can be super-distressing. But there's also a bigger picture of why I'm so passionate about menopausal hormone therapy. Not only does it help you to actually feel like yourself for the 10 to 20 years that you're dealing with these symptoms, but early initiation of menopausal hormone therapy in recent meta-analysis

has shown that it actually is associated with decreased risk of cardiovascular disease, stroke, diabetes, dementia, and osteoporosis.

So all the major killers of women heart attacks, strokes, diabetes, chronic kidney disease from diabetes as well as hip fractures that then lead to mortality from osteoporosis.

All of those have a benefit with initiating menopausal hormone therapy early in perimenopause. And there's actually recent data that shows that the earlier you initiate it, the more likely you are to get that benefit.

So not only is your brain going to be functioning better, but you're reducing your risk of health conditions later in life because you are treating your perimenopause with menopausal hormone therapy.

So let's say either you're not a candidate for menopausal hormone therapy or you just want to know what your other options are.

Benefits and Risks of Hormone Therapy

So when it comes to the hot flashes and the other, what we call vasomotor symptoms of perimenopause, there's the FDA approved vioza, which works on the neurokinin receptors to decrease the hop flashes.

There's SSRIs, SNRI, gabapentin all off label. For FSA-D, there's FDA-approved Addi and Vilece, which has a peptide analog called PT141 or Bremelanotide which activates the MC4 receptor and increases libido, or there is off-label use of testosterone which is very common because it's cheap and tends to work pretty well.

Testosterone can be done with cream or injectable. Another thing that should be noted when we talk about treatment for perimenopause is GLP wants. When it comes to not only the symptoms of menopause, but also the effects of the hormonal shifts, many women, despite no change in their diet, no changing their activity, and no changes in lifestyle as a whole, gain weight have changes in their body composition, wider waist, and wider thighs.

Changes in the lipid panels, changes to their insulin resistance. And they're very frustrated because they feel like they can't move the scale and they cannot get the results that they want.

They want to reduce their cholesterol. And the reason this is is because when you go through perimenopause and menopausal, you have a massive metabolic shift that happens amongst your cardiometabolic system.

Non-Hormonal and Metabolic Treatment Options

So, increasing insulin resistance, increased cholesterol, increase blood pressure, and increased risk of heart disease and stroke because of those shifts that happen in your hormones.

It would be a disservice to women in perimentopas to not talk about the potential benefits of GOP1s. Not only do GOP1s help with weight loss, but they also have a direct effect on cardio metabolic factors like increased insulin resistance, fasting insulin, fastened cortisol, they decrease the HSCRP, the decreased cholesterol.

And I've seen all of this in my clinical practice where people simply just being on a GOD1 for weight loss or for optimizing their health, we see the influence on all these cardio metabolic factors.

And we've seen this in the trials too. In the Sermount trial looking at terzepatide, they did a post-hoc analysis and saw that despite stopping the medication and even though some people regained weight, as long as they didn't gain more than 50% back to their baseline, the changes in cardiometabolic factors and the benefit there was still maintained despite the weight changes.

Not only that, I have many patients who are perimenopausal and taking a GLP-1 that have said that their hot flashes, their sleep disturbances, they're joint pain, and their muscle aches have significantly decreased simply from just taking in GLp-one without menoposal hormone therapy.

So there is obviously an anti-inflammatory effect that we don't fully understand yet in using GLPs-ones in conjunction with menaposol hormone as a way to not only treat the metabolic shifts that happen, but also to help treat symptoms.

Last thing I'll talk about treatment-wise is vaginal estrogen. Vaginal Estrogen is something I recommend for every single patient I have going through perimenopause.

When you lose estrogen, you get thinning of the mucosa, decreased lubrication, and decreased pleasure. And so by using vagina estrogen twice weekly, from the moment you start perimenopause, you can not only reduce the risk of thinning, dryness, and future painful intercourse, but also reduce a risk UTI-like symptoms.

Vaginal Estrogen and Key Takeaways

Many women with vaginal atrophy or the genitourinary symptoms of menopausal, also called GSM, we treat that with Vaginal estrogen because many women think they have a UTA, just because of the effects on the ureteral mucosa and the vaginomucosal.

from the lack of estrogen. So starting that early will make sure that you not only have decreased risk of all those annoying symptoms, but also just a better healthy sex life that can have throughout menopause and perimenopausal because you still have half your life to live after that.

So I've thrown a bunch of information at you. What are the take home points? Perimenopause and menopausal is a 10 to 20 year process or a quarter of a woman's life that has been horribly undertreated and overlooked for most women.

Knowing your options, knowing the signs and symptoms and the ages at which those present, Knowing the natural progression of menopus and then the treatment options allows you to be empowered to go to a provider and look for the treatments that are gonna be most beneficial for you We haven't even touched on the potential implications of peptide therapies for menopause, which I'll make a video about next.

Subscribe and follow if you want to hear more about menopus, more peptides therapies, and more longevity for women. Because the more educated you are, the empowered you can be for your own health.