Why Women's Medicine Was Built for Men Transcript

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Opening Advice and Podcast Intro

Don't take no for an answer, keep trying. And if you're not happy with one person, try somebody else and go outside of the conventional medical system into the kind of holistic care that you offer to your patients.

Even if it's not covered on your insurance, it may very well be worthwhile ultimately to take that stuff and try alternative therapies if your just keep hitting a brick wall.

And if you're happy with your current system, stay with it. That's wonderful. I'm happy for you. But if not, there are alternatives out there for almost everybody, certainly people in more urban environments.

So keep trying. Don't give up. And as we've been talking all along, don't accept so many limitations as just what you have to put up with nowadays. Welcome to the TBD Fit Podcast on Dr.

Talks. I'm your host, Daniel Keeley, and I will be guiding you through this wellness journey in terms of optimizing health and longevity, where we unpack the science, the dos, dos and everything in between.

Come join us. Look forward to seeing you inside. Welcome back to another episode of the TPD Fit podcast, Where we explore evidence-based strategies, help you take back your health, optimize your energy and expand your Healthspan.

I am your host, Daniel Keeley, I'm a functional medicine practitioner. My goal is simple. I want to interview whoever is doing best in their category and bring that conversation to light.

Why Women's Health Became the Focus

Today's episode tackles one of the biggest gaps in healthcare, why senior women require different and more targeted health information than they received before menopause and why it's vastly different from what men need at the same age.

Most women enter menopus without a guidebook and emerge post-menopaus into a healthcare system built on male-centric research. So what's the result? Well, inconsistencies and certainly less than optimal health.

To help us unpack this critical topic, I'm joined today by a passionate advocate for women's health, Pat McShane, she is dedicated to her career to addressing the specific risks, needs and opportunities for post-menopausal women focusing on prevention, clinical strategy and lifestyle approaches that dramatically change quality of life.

This conversation is long overdue, super excited to dive into the weeds and go over her decades of experience. So Pat, welcome to the show. Thanks. Great to be here, Daniel.

There's not very much information and that much of the care that we are given in the conventional medical system, at least, is based on male standards historically.

So those are kind of what drove me into this area. Wonderful. Well, it's definitely relevant. I love opening every episode by understanding what brought you to your mission.

Well, I was really lucky to be in the space of gynecology during the initial days of in vitro fertilization because when I first started my fertility training after my general GYN training, At least in an academic subspecialty space, we just didn't have that much to offer people.

If the women had pelvic issues, they had surgery, endometriosis, scar tissue around their tubes and ovaries and so

on. But the surgeries were limited and didn' always work.

And sometimes people got tubal pregnancies as a result of their intrinsic tubule problems. If women's ovaries were faltering early, five or ten years ahead of schedule, we didn't really have anything to offer them.

If their ovulation was a little bit off, you know, We could tweak that system very, very often. Not perfectly, and we had a lot of twins and triplets.

If their partner, their male partner had low sperm quality, not much to be done. So, you know, we kind of hit a brick wall there with a lot of our patients.

And then in vitro came along and donor egg. And, you know, suddenly the floodgates flew open and people started getting pregnant who previously would not have been able to.

And that was tremendously gratifying. Obviously a huge learning curve there for Well, really, there's still a learning curve, but the bulk of it happened in the first like 20 years of in vitro learning how to manage very low sperm counts and just try to keep the number of multiple births down by analyzing the embryos better, growing embryo is better and so on.

Infertility Trends and Environmental Factors

So that was a tremendously gratifying career for me. I'm delighted that I was able to do that for so long and help people. And then I kind of hit my own post-menopause time frame and started looking more into the social media outlets.

And I came across lots of fabulous information, almost all of it aimed for and by men. And that's when I started my own podcast. There started to be more and more information out there about the disparity between how long we live, which is lifespan, and health span, able to function normally and have an enjoyable quality of life without spending all of our time at doctor's offices or on multiple medications that gave us side effects and so on and forth.

So that's kind of how I got to where I am now. So let's perhaps start with this epidemic of infertility. We see that very much prevalent, very on this kind of hockey stick rise.

And anything that you've seen clinically that can explain this, I mean, exponential trajectory in the last couple of decades. So what is the change in our environment that has dictated this rise in infertility?

Well, it's hard to get good data about exactly who is experiencing infertility. And there's always been infertilty. But I think probably two things that immediately come to mind.

One is that a lot of people are waiting much longer, much later in their female reproductive lifespan to try to getting pregnant. That does take a toll.

If you look at data from the general population or data from in vitro fertilization, we have a very slight decrease in our fertility in 20s and into our early 30s as far as people just trying on their own using in-vitro.

But then it accelerates after that and by 40 for a lot of people, for women that is, it's much harder to get pregnant and to not have a miscarriage, as well as pregnancy complications on the back end, which we're not going to even go there.

So I think as women have had more financial security and independence and so on and have been able to delay their decision-making about childbearing, that's been a big piece of it.

And then I think our overall lifestyle, certainly being overweight or obese is a risk factor for ovulatory problems as well as just for infertility in general.

So those are probably the main things that are going on or have been going for decades now. How much do you think is largely attributable to the change in our landscape in terms of the air, water, the food, certainly stress and so on?

Microplastics, we'll throw that in there. I think that that is just now starting to be studied in the fertility sphere. And the answer is, I don't think anybody knows, but it's certainly a great concern.

And I think a lot of our health issues, and certainly for older women as well, have to do with the kinds of things that you focus on in your practice, which is sleep, nutrition, just general activity, movement, you know, exercise, social interactions, and the information, the knowledges that those things are going in the wrong direction for a lot of people.

and we're living in an increasingly sterile, isolated, unnatural environment and that certainly can't help with our fertility or healthy childbearing.

Yeah, I know you mentioned in terms of, um, you know, things progressing later on and we're considering people want to be more stable in their careers financially.

I understand that females eggs, uh, the supply is finite, right? It's front loaded. You're born with roughly 2 million eggs. And then what is it about 400,000 or 20% remain after the first period.

Quantity and quality definitely, depreciate and certainly after the age of 35, it's almost like a free fall off the cliff. Similar to what I equate to postmenopausal, what happens with women in hormones.

So that's why your physiology is very, very different than males. But the good part now is we can get ahead of it. We can test early. You can track cycles very, very in depth, you can test specific markers to see what's going on.

I remember my first infertility patient, the problem was actually the male, which largely now is understood, but once upon a time, this was almost attributable to exclusively a female epidemic, right?

we see what's happening that males are now often the driver of infertility. 40% of males, from my understanding, is driven also by varicycle. And when you're looking at semen analysis, and if you repeat that twice in three weeks, you'll be able to really assess for appropriate FSH and LH levels, testosterone, Um, there's a big problem with TRT, but that's all different discourse.

So, um, certainly the, the infertility picture has risen a very stark question mark and so too, with postmenopausal females and how they're navigating that, especially during paramenopause years.

Um. Do you find that young adults, females in particular are going through that process earlier and why and what is happening? I haven't seen any good data about that.

IVF, Testing, and Treatment Challenges

Certainly, I think that our openness to looking at causes for people to have either irregular cycles or infertility is much greater now than it was 20 years ago when we didn't really know what to do or even necessarily how to test for it.

So some of the problems obviously are surveillance bias. If you're looking for something more closely, you are going to find it. But I have no doubt that some the points you raise about environmental toxins and poor diet as well, the prevalence of ultra-processed foods in our diet and the lack of sleep that many of us have in the sedentary lifestyle and fact that we live under artificial light, you know, any time of day or night, those factors could all be part of going through an earlier menopause or loss of fertility earlier in women's lives than happened, 20 or 40 years ago, probably more like 40 Yeah.

I mean, Menarche, average age, I believe, was somewhere between, uh, 14, 15, even sometimes 16, you know, in

the early 1900s and 12. Not uncommon. Yep.

Yep, that has to do with a lot with body weight because our bodies know not to get us pregnant until we have a certain amount of extra body fat in case of famine during pregnancy, for example, or just normal growth of the fetus.

So, as girls have become more, you know, higher percent body fat over time, which is definitely happening, the menarche occurs earlier than used to. So that's probably the main factor there.

Yeah. And with higher adipose, higher toxin levels, that's where toxins obviously love to play and be stored. Um, and obviously fat is metabolically active.

It secretes very specific signals and inflammatory proteins, um, as well as, you know, aromatization and, estrogen, needless to say is things are, the landscape is changing.

I think the goal ultimately, hopefully with this conversation, we can learn more ways to stay ahead of it. In terms going back, were you ever part of any IUIs or IVF or any, like in terms of helping patients conceive where in that process was, what were your doing?

We were doing everything, starting from diagnostic all the way up to genetically testing embryos for fertility or genetic diseases. So the full spectrum, yes.

And I've hands-on done certainly inseminations in vitro, transferring embryo back into the body and so on. Any risks with any of those? The main risk is multiple births, which of course for many people who've been trying for years, they would love to have at least twins.

Not too many are keen on triplets. But twin pregnancies are more risky for mom and for babies both. So that's not typically something we're aiming for.

And more and more, we're avoiding treatments that have a high chance of twins or triplets. And when we do do in-vitro fertilization and we have an option to put back one embryo, that's usually what we.

We try to find obviously the healthiest embryos that are most likely to result in a healthy pregnancy. So that at least the woman or the couple is going to have one successful pregnancy.

But I know a lot of patients would love twins, but the reality is they can be very complicated pregnancies. In terms of the males, were you testing them?

Were you looking at both partners equally or did that evolve over time? No, I mean, from the, 40 years since I've been doing this, we've pretty much insisted on getting a sperm analysis right up front at the beginning of the study for both the man and the woman.

assuming that the woman had a male partner. You know, every now and then someone would raise a pretty big objection and say, well, my husband has a pregnancy with another woman and blah, blah blah.

And we all say uh-huh, uh huh. you know, let's get the sperm count anyway. Because A, things can change and B, sometimes paternity is not what it was stated to be.

So we pretty much insisted we wouldn't treat women without knowing their male partner's semen analysis results. Okay. And how much of what you were doing at the time was to reshape the internal biochemistry, their internal environment, the use of, I don't know, any sort of lifestyle medicine guidelines?

Not too much. Having been trained and practiced in conventional medicine, we pretty much went by the textbook. If you're not ovulating triclomet or injectable gonadotropins, tell people don't smoke, but that's bad for pretty much anything you want to do in life.

And sometimes we would succeed in getting people to smoke. We would advise them not to drink too much alcohol and not do recreational drugs, which by the way are pretty strongly associated with poor sperm quality.

especially cocaine, but also marijuana to some extent. So, you know, other than that, it was pretty much, well, okay, fine, come on in and we'll work with you.

And there's kind of a backlash now trying to get people to use more natural methods. But the problem with that is that so far, at least, we don't have any magic bullets for a lot of these lifestyle changes, especially nutrition and weight loss.

And, you know, if you say, come back when you've lost 50 pounds, A, they may never come or be it maybe two or three years later, at which point their ovaries have wound down even more.

So, um, You know there's definitely a. point of view that just kind of going ahead with whatever the best you can do on a short session of lifestyle changes will make a difference.

I certainly have heard lots of stories about people who have changed one or another aspect of their lifestyle and gotten pregnant, but we have people who got pregnant after five years of infertility with no changes in their lifestyle also.

So that's part of the problem of measuring the outcomes of fertility therapy is just what the baseline expected pregnancy rate is per cycle. And that might be one or 2%, you know, but it's usually not zero unless you have no sperm or block tubes or never get your period, something like that.

Alcohol is a sperm depressant, cannabis is the sperm-depressant. Vaping is this burden present. People don't attribute heavy metal toxicity, cadmium very prevalent with vaping.

Some of these factors that are easily kind of modifiable. Certainly there's exposures within the environment that we don' realize mentioned earlier on plastics and Um, a lot of things coming from our, um, modern agricultural food system are all going to impact, uh, obviously the quality of the sperm, but also the viability and, and the ability to, to uh conceive healthfully, if you will, no matter what the patient was always a candidate.

It sounded like you're trying to address certain things, that you move forward with IVF, IUI, the, Uh, the results were typically what? 80 to 85%. I think it was par for the course in terms of conception.

Well, when I first started, it would be 10% per IVF cycle, but that was in the 1980s, so that a while back. And there would certain weight cutoffs for undergoing the IVP procedures just because it requires anesthesia and surgically inserting a needle into the ovaries.

Or underweight for that matter, which we also see in some people with either extreme athleticism, ballet dancers, classically, or anorexia, obviously.

Those might be the cutoffs on the far end of the spectrum, but for almost everybody else, yes, we would just proceed and keep our fingers crossed. because our experience with weight loss is pretty poor.

Microbiome, Hormones, and Perimenopause

I've been reading recently looking at the new GLP analog agents versus the bariatric procedures and the reality is that the people on the medications might lose 5 or 10 percent, which can make a huge difference in terms of risk of diabetes, blood pressure, and to a lesser extent, heart disease.

But most people wouldn't regard that as an enormous success, whereas the weight reductions with the bariatric surgery would be quite a bit higher than that and sustained, obviously, because you don't have to repeat the procedure.

So those, you know, those aren't great options for somebody who's trying to get pregnant now, and they have been trying for two, three, four, five years.

And then fast forward to things just got a lot better, a little more accurate, more dialed in it seems. Yeah. So success rate seems to be a higher, but yet I still have the subset of the population for years, even IVF, multiple rounds of cycles.

They are unsuccessful. Why do you think largely that is happening? Yeah, well, there are differences in programs. And, you know, it's hard to get comparative statistics, but the CDC Center for Disease Control and the American Society of Reproductive Medicine do publish rates from different clinics.

So if you have a choice, certainly look at those numbers. Because, you know, like everything else, there is a difference in how things are done within the laboratory and then by the physicians, so important to know that.

And then there's just some nuts that are harder to crack. It's very hard to study implantation of embryos. So we have our ways of studying embryo to a certain extent, but our way of study the uterus environment into which we are placing the embryous is much, much more limited.

And that's kind of a basic biology that may just be failing in some people. And sometimes women have uterine issues that are just hard to get around. Major fibroids is a number one problem if you've had multiple surgeries and, you know, your uterus is beat up.

If you've had multiple DNCs, sometimes your uterus can be filled with scar tissue that's impairing the implantation of the embryos. And then there are probably just some biochemical issues that we don't understand very well that may keep somebody from efficiently implanting what we think are normal embryo.

So we continue to learn about this stuff, but a little bit slowly because it's very hard to study human reproduction. People just don't give up their embryos to be studied on a regular basis.

You mentioned fibroids as an example. I see such prevalence of translocation in terms of bacteria or other sort of toxic matter, which the body then begins developing the formation of cysts or in term of fibroid, in turn of polyps.

None of which to me are ever benign, but in modern medicine are often deferred to as benigned. Don't worry about it. The question is, what's happening on a physiological level?

The body is trying to sequester something or grow something to protect you. Let's go back for one sec to the vaginal microbiome, which we're starting to study.

And we know that every portion of our body, you know this way better and probably all your patients and clients know too, but every part of your body that's exposed to outside world contains often healthy and sometimes unhealthy bacteria.

We've been focusing primarily on the gut microbiomes. but there's a microbiome within our upper respiratory tract, and the vagina has a micro biome as well.

And in the last, I don't know, 10 years, maybe, people have been studying the vaginal microbiomes. I presume someone's studying to penile microbiomas.

That may play a role as make a little asterisk there that this may be something that turns out to be relevant, that we learn that people with unexplained infertility, let's say, or failed IVF have something going on in their microbiome, in the reproductive tract that's different than the people who were successful.

So you can see kind of when there's vaginal atrophy or women having difficulty with uh, or pain during intercourse and penetration. And interestingly, when we're administering hormones, as an example, it depends, is someone having pain within their course?

Is someone with insertion? We can be very, very specific in terms of hormone administration to help overcome some of these symptoms and where the deficiency resides.

When you mentioned the microbiome, equally, if not more interesting, we see in terms of the vaginal microbiomes that it likes a very, very specific treating our patients.

The first thing that we're doing very frequently is looking at the urinary pH of. Vaginal micro biome because the lactobacillus species that predominantly reside the, um, there's specific strains, whether it's crospatus or estophilus than anywhere else.

And so when those are depleted, when, from exposure to, again, toxins, chemicals, sexually transmitted diseases, certainly will disrupt the vaginal microbiome.

You then have this presentation of a very different environment, less conducive for fertility. And so now we recognize that there is a huge correlation.

So I appreciate you bringing that to light because that's a component that is often overlooked. It's huge risk factor as well, right? Because it takes two to tango.

Um, I had a patient the other day where, um, we were addressing her vaginal microbiome and I asked her, you know, what about your partner and the health of your, and she was suggesting that, he's an antibiotics because he had contracted something.

And so now she's at a huge disadvantage, which that obviously will be implicated in the, of her hormones and certainly, anytime you're trying to conceive.

So now for hormones in general. I mean, obviously it's one of the most powerful molecules that we produce. It's certainly instruction, how we indicate it with our patient population and excess estrogen, which is often common or obviously a lot of these endocrine disrupting hormones that we're exposed to, which then, you know, there's issues with excessive bleeding or cramping and estrogen every month thickens the lining of the uterus in anticipation of pregnancy.

What are other things that you see that kind of go wrong very quickly early on? We see the problem happening so much sooner now. Yeah, yeah. Again, perimenopause is difficult to study because it's so variable day to day and you may be having your periods every 10 days or every 80 days and there's a little different hormone profile each day of that Span of time so hard hard to study and I think quite frankly the the research just hasn't been there and that's probably because the money hasn' been their which I imagine in functional medicine as a major issue in particular.

In conventional medicine, if we see a pharmacological plan, then we know that we can study something, but a little harder to get the funds to do the research without that background.

So I And again, I think some of it is surveillance bias of women. For many years, we're basically told, sit down and shut up. To put it bluntly, get over it, lady.

Yeah, you're going to have your menopause. We don't want to hear about it. Just wait five or 10 years. You'll feel better. And nowadays, I think people's expectations are much higher than that.

They've been much more used to understanding, you know, taking note of and kind of controlling their own medical experiences and then to have somebody say, oh, we don't know.

anything about that and we can't help you out is not an answer that women want to hear. And we've mostly been or largely a lot of us have been successful in other sides of our lives, our careers, or families and so on.

So we're demanding more than I think we did 20 years ago. It's hard to know if things really have gone out of

control, but I don't, again, have any problem thinking that our lifestyle, our diet, or our toxic exposures would possibly contribute to more problems as our hormones unwind in our menopausal, pre-menopause, perimenopAUSE, and menOPAUSAL years.

be really hard to study some of these patients and they're coming with more and more of this kind of symptom checklist. But foundationally, what holds true that I see in all of the patients is I call it my unlucky seven.

There's an issue either with bacteria, with fungus, parasite, virus, which is how we evolved, or now with environmental toxins, they are kind novel. heavy metals, and then stress, which is a whole other discourse, if you will, when we're comparing ourselves to our peers and social media and will dictate our mental health and with our mental health patients, what I'm seeing too is I don't serve as someone's therapist but we clean up their microbiome going back to what you alluded to earlier and 100% of our patients have all gotten better.

So it really starts kind of with the gut because your microbiomes is your second genome. It's responsible for 95% um, genetic activity and, and the cross talk between the gut and brain, the crosstalk between, um the gun vagina is, as you spoke about definitely your hormones and certainly neurotransmitters.

I mean, we know, what is it? 95% of serotonin is made in the guts, stays in. I was surprised to read recently a World Health Organization listing of disabilities throughout the whole world.

And depression was one of the top 10 disabilities that really impact on people's lives. I'm sure anxiety and other mental health problems, but depression is so prevalent.

What you're saying about the link between our gut and our brain, is so important to understand. But people don't, right? We have so many mental health patients that are referred to us and I ask them, hey, you know, did someone do a simple gut test on you?

And 100% of the time the answer is no. And I understand principle is not that these are not very highly intellectual individuals. It's what I attribute to be is just physicians are uninformed and then patients are misinformed.

And you have a diagnosis that, you know, have to beyond these SSRIs or anti-anxiolytics, antidepressants. Um, and I asked the patient, were you born with this?

Like, did you to take this as a kid? Is this a genetic defect? Cause we're running genes and the answer is no, to me, the, maybe 5% is genetically driven.

Yes, there is certainly. Yeah. And then the other effective antidepressant that never gets talked about is movement, exercise, activity. Those are in studies shown to be as successful as the SSRIs in reversing people's depression.

But again, you don't make any money recommending that people go for walks. You make money writing out prescriptions. that's not going to hit the big news.

You're right. Lifestyle medicine, right? So my foundation five, you might appreciate this, is you got to eat right, sleep right move right talk right poop right and you're going feel right is free, right?

We control what time we go to bed, we control the movement that we engage in, and we can control kind of the community or who we interact with. We can totally put it into our mouth and while maybe there's a cost to that, there is also a higher cost if you're not doing that appropriately.

And people, you are going to pay for it either way, either on the front end or on back end, trying to reverse the chronic disease state. So as we segue into hormones, So what happens?

Okay, perimenopause, we get into menopausal and then postmenopasal. How do you adequately navigate that with your patients? How you educate them into really optimizing the year so that they can age gracefully?

Well, as you are probably aware, there's been a huge change just in the last few months about labeling for hormone replacement therapy, which since the Women's Health Initiative has been the subject of lots of fear and anxiety among practitioners as well as patients.

Hormone Therapy, Testing, and Lifestyle

So even if a practitioner thought that the A woman should be on some kind of hormone replacement when she got that package at the pharmacy. There's a black box warning, maybe associated with all these terrible stroke and breast cancer and so on.

And the FDA just basically removed those warnings, which is appropriate. because the current formulation certainly of bioidentical hormones have not been linked with those conditions in most women.

There are very few exceptions, but so, you know, for many people, hormone replacement therapy, again, bio identical, not synthetic. is the way to go and will help with many, not all, but many of the symptoms of menopause, as one is having hot flashes and mood swings and brain fog and so on.

And I think the jury is still out to some extent about whether the bioidentical hormones really do enhance other aspects of your life expectancy, such as heart disease.

And there's some data that they do improve rather than actually cause heart disease and stroke. But again, the studies have not been on large populations as much as the initial negative study with the synthetic hormones that showed that these hormones were not useful and in fact were harmful for cardiovascular disease in stroke, so.

So that, for most, I mean, again, back to lifestyle. If you're not sleeping, if you are not eating, or if your so stressed out by your mother-in-law or, you know, your spouse or your children, which we're kind of the sandwich generation, typically, between our aging parents and our troubled young ones, The stress piece is huge for a lot of people.

So managing all of that, if humanly possible, and doing what you can do, quit smoking, eat a little bit better, get outside a bit more. Those things in concert with possible hormone replacement usually are very, very helpful for most people Yes, we are a huge proponent of bioidentical.

just as you alluded to, hormone replacement in our post-menopausal and even potentially starting perimenopause with, you know, some DHE or some progesterone depending on kind of certain symptoms, oxytocin.

I just had Lindsay Berkson on the podcast the other day who came out with her new book on oxytoxin and we've been using that especially in terms of our mental health patient population where really enhances connection and a feeling of self-worth.

And interesting, it's all connected, right? As your hormones kind of dive off of a cliff, estradiol and estrone signal the gut wall and it reduces abnormal growth of polyps and cancer.

I mean, I don't know. What is more potent at protecting brain, bone, eyes, breast, cardiac, and muscle? As you said, movement medicine, certainly as we age more than hormones.

When I look at the level of the gut, estradiol, estriol progesterone, they upregulate these adhesive proteins. to protect and heal a leaky gut which 100% of my patients walk into my door with often asymptomatically.

They don't realize they have other symptoms that they just haven't connected with what's happening at the destruction of the level of gut. But testosterone in a regulated secretory IgA, which is the gut immunity where we hear now kind of 70 to 90% in the immune system resides in epithelial barrier.

Estradiol helps maintain this healthy gut bacteria in the gut microbiome and it allows oxytocin to help protect the guts from inflammation, heal from injury.

What I find too, when people are insufficient in estrogen, that's when polyps can begin to take residence as well. Estrogen is very protective of the esophagus all the way down to the sigmoid colon.

It's a necessary mix. I don't think that nature has made mistakes, but with modern medicine, we can live healthier, stronger lives when we begin to replete what's missing.

If you look at growth hormone, I mean, after your mid-20s, it begins to decrease precipitously, almost like 10% to 15% every decade, such that in your eighth decade of life, you're about 5%. And I equate that to your most potent fat burning hormones in some capacity and largely will dictate the quality of your life.

And so if that's not on board, why not begin to replace it if you can do it in a very safe, controlled manner? Uh-huh. Agreed. Yeah. I'm not familiar with the growth hormone replacement or oxytocin, but, you know, uh, conceptually it makes a lot of sense.

Yeah. And when you mentioned too about the vaginal microbiome, I mean less C2, less testosterone as we age weakens this vaginogut access. So we see in our postmenopausal females when they have kind of this atrophy, there's downstream issues, There's the quality of life and pleasure and sensation is going to be adversely affected.

And so too, I think it's almost like we begin to abnormalize the normal, right? So as we age, we just stop engaging in intercourse and then hormones just kind of.

We let them fall off a cliff and we normalize the fact that we're not, you know, in our younger years where the engine was up and running. But I certainly think that that, we can replace that very healthfully in a manner that is protective rather than proliferative.

And so many of our patients that are referred to us, I see their hormones are largely mismanaged. Were you finding that in the case as well in terms of your patient population?

Well, I think for the most part, it's that people were afraid to prescribe them or so that's definitely mismanagement or the women were. Afraid to take them.

So either either way and then measuring hormones in the, you know, bloodstream versus purely symptomatically, et cetera. So there hasn't been a good standard of how to follow someone on hormone replacement in conventional medicine.

And I recently went to a conference where the speakers had a number of different ways of following their patients on hormone replacement therapy. Some people were using spot urine, 24-hour urine.

Blood doesn't work very well if you're using topical or vaginal hormone replacements. And then the message that I took home from that conference was, ask your patient, how does she feel?

which is so obvious, you know, rather than, how's your blood level today? It's like, are you feeling better or okay still? So that's another way to follow how people are doing on their hormone replacement.

And again, it's back to expectations, what you just said. If we expect to feel less energy and more brain fog and sleepy, then that is what we're going to just accept.

Yeah, and I mean, the three modes of testing is relevant depending on the administration. And so at some point we're always do a urinary because we are looking at the cortisol metabolites.

We're looking the metabolite of the hormone. So how well the body is actually utilizing these hormones and how, while we were eliminating these hormone, that's the first thing I think that often is overlooked is that most of our patients that are referred to us, making sure the phase three detoxification elimination is adequate.

All right. So that you're not recirculating your hormones because you need to make them, you break them down

and you eliminate them. And what works for one typically doesn't always work for another.

Now what does hold true is lifestyle as you spoke about, right? Eliminating certain factors that confer higher risk. But in terms of administration, have you found just kind of clinically over time, certain administration was better or certain ministration was not, right?

You have the topical, you have patches, the oral. Obviously, we know what happened with the WHI. Well, this has not been my direct clinical focus except for those rare fertility patients who were menopausal, in which case we used multiple different forms of estrogen to try to prepare their uterus.

So I haven't had a lot of experience with the direct women who are going through a normal menoppause at an expected time in their life. answer that it's mostly from secondhand from other people that you know I've been chatting with about it so.

But again, at this conference that I just went to all kinds of different modes of administration were advocated by the different speakers. So, you know, vaginal, topical patches, creams, all those kinds, of tranches, sublingual, even for some of the hormones, I don't think for estrogen, but yeah.

So if you could maybe provide, if there's any misconceptions that you want to dispel or, um, If you wanna provide any sort of advice, any takeaways, uh, for females to, to help them on their journey navigating this whole, obviously, I don't want where decades of experience.

What I would say is that with the given constraints of the conventional medical healthcare system and the very small amount of time that is allotted for most patients in most settings, don't take no for an answer.

Keep trying and if you're not happy with one person tries somebody else and go outside of the conventional medical system into the, you know, the kind of holistic care that you offer to your patients, Dr.

Daniel. And there's naturopathic doctors and MDs who have branched out into functional medicine, etc. And even if it's not covered on your insurance, it may very well be worthwhile ultimately to take that stuff and try alternative therapies if you just keep hitting a brick wall.

current system, stay with it. That's wonderful. I'm happy for you. But if not, there are alternatives out there for almost everybody, certainly people in more urban environments.

So keep trying. Don't give up. And as we've been talking all along, don't accept so many limitations as just what you have to put up with nowadays as, we get a little bit older.

Practical Takeaways for Aging Well

would you ever suggest someone not to start hormones or not consider a hormone, bioidentical hormone replacement? Well, if someone's not very symptomatic, I don't think that we have the data at this point to say that it's preventive of any particular cardiovascular diseases, the number one killer of women and the one that if we had a magic bullet to prevent it, that would be wonderful or cancer, So I don't think the data is there to recommend that someone take hormone replacement therapy preventatively, but certainly if you're symptomatic, I would give it a try.

When you said, you know, don't give up, Don't lose hope. There's alternatives, um, that should be considered because I can't tell you how many countless women were referred to us that where their hormones were certainly mismanaged and they were symptomatic.

Um, obviously if someone's not symptomic, usually they're not sick. They're often enough in our modern society, especially in the U S it's, we don' practice preventative medicine.

We practice reactive when it is too late. Uh, I think too often we are given a diagnosis and then that becomes our

identity rather than trying to usher in new team, new research, and new guidance, a new understanding that there might be something more here than what the diagnosis is.

And so sometimes we don't always get it right. I know there's been largely data subset for males, certainly in the cardiovascular risk protection with the administration of testosterone replacement.

Again, that black box warning being lifted finally. so many women can get the care I think is necessary. The other thing I would say is any small step, any start that you can do, whether it's get up after lunch and walk for five minutes or do 10 squats or five pushups against the counter in the kitchen, you know, These, your lifestyle habits don't easily change.

You have to make an effort, but even a small effort and a smaller change, you know, pat yourself on the back. If you can just avoid that second teaspoon of sugar with the coffee in the morning, go for it.

Whatever you do, it all counts. Yeah, you're 100% right. Especially the movement part and stressing the bone, stressing muscle to regenerate osteoblasts, growing new bone collagen formation, protecting the muscle, certainly is absolutely critical as we age.

And so that's why sometimes you don't get symptoms until it's too late. practice proactive medicine is finding a practitioner evaluating what is your risk potential look like, right?

As women age, obviously the risk as hormones just fall off of a cliff, your risks for osteopenia, worse yet osteoporosis is exponentially increased and what's released in the bone marrow is often some sort of heavy metals and then eventually what do you have?

Some sort brain fog or fatigue or some of these symptoms that then begin to be expressed only years later when can have been prevented so many years prior.

So you're right definitely getting up being active is certainly the least that we can do but at a minimum you know insurance covers hormone testing at least in the blood starting there is absolutely prudent.

I think that prudence is on us practitioners to provide that education and guidance. And then from there, make the best decision that's gonna be the most appropriate for the patient.

Uh-huh, agree. Appreciate that, Elise, you're championing a topic that has been overlooked for so long, and senior women definitely deserve a tailored approach, not just generalized advice based on male physiology.

So to our listeners today, if that is struck a chord, Definitely we invite you to find a practitioner that can guide you through this time. I love ending every episode with asking the guests if they could have one superpower, what would it be?

Oh, if I could myself. Oh. Go on a vacation for two weeks. That would be lovely. Anywhere I wanted to go. Right now would It's like this notion of obviously disconnecting and looking internally and reconnecting internally is certainly some things we don't prioritize anymore.

We're in this modern culture where it's go, go go and then when the gas is empty, we just caffeinate and go further. Get that extra tank going. Yeah. Only to our detriment, obviously.

So this has been wonderful. Where can people reach out, find you, or kind of tune into what you're up to? Women's HealthSpan is my Facebook and my website.

Those are good spots to start. Thank you. Well, thank you for your time as well. If you all have enjoyed the conversation, certainly please like, review, and subscribe.

Share this message with someone that you think can benefit in terms of navigating the challenges of our modern

complex aging society. And until next time, stay healthy, Stay wealthy, my friends.

Thank you so much. Take care. Thank you for tuning in to the TBD Fit Podcast on Dr. Talks, where we unpack all things health and longevity. If you enjoy the show, like, review, and subscribe.

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