Progress Your Health Podcast - Episode 085

Can You Take BHRT During Perimenopause?

Dr. Maki: Hello everyone. Thank you for joining us for another episode of the Progress your Health Podcast. I'm Dr. Maki

Dr. Davidson: And I'm Dr. Davidson.

Dr Maki: How you doing this morning?

Dr. Davidson: I'm doing great. How are you?

Dr. Maki: Pretty good. Pretty good. The weather's nice. We're still in lockdown, but we're getting a lot of podcasts done.

Dr. Davidson: That's certainly are.

Dr. Maki: Good thing, we're going to do another question. We have a few to catch up on so this is very appropriate. This one is from Monica. Dr. Davidson once you go ahead and read the question.

Dr. Davidson: Sure. I know we're on this kind of trend answering questions, but we've got some really great ones on the website and by email. So definitely I appreciate all your listeners and readers, you know sending in your questions so they can help everybody else. So this question is from Monica. Hi, thank you for providing such great information regarding BHRT in this has been a great resource in one of the best sites. I have visited now, you know why we're answering Monica's question, right?

Dr. Maki: She's very complimentary. I like it.

Dr. Davison: We love Monica. No, thank you. Thank you for the compliment. Monica says my question is I'm currently going through perimenopause while back in July. My hormone levels tanked and I started having terrible problems with hot flashes and night sweats and after about three months and no period, the blood test confirmed that my levels were really low. I decided to go with a BHRT so bioidentical hormone

replacement therapy and within a week, I could tell a huge difference. I do have a uterus and my current cream is a biased 50/50 ratio. Plus, progesterone plus testosterone. Does it look like the testosterone is 1 Point 8 milligrams combined with the second of what do you think about this? It says biased 50/50 plus P plus T 1.8 milligrams plus 200 plus 5. I get it. There's a combination cream here that Monica has where there's a bias 50/50 ratio. That's 1.8 milligrams, which would be .6 milligrams of estradiol .6 milligrams of estradiol with 200 milligrams of progesterone included with 5 milligrams of testosterone.

In my second month of this, I started my period, and then in another 10 days, I started bleeding again for three weeks straight during this time. I was given a seven-day supply of a 10-milligram oral progestin. A lot of Doc's does that to try to stop chronic bleeding. That's pretty common, but unfortunately in Monica's case, this didn't help slow down the heavy bleeding. And I returned to talk to my doctor and I was told I was most likely not absorbing the progesterone which I do think she's correct because it was a progesterone cream which doesn't not that she's not absorbing it. It just doesn't have that effect on the uterus to prevent bleeding when someone's taking some kind of estrogen component to it. In some ways, the docs right about that. During this frame of a few weeks of bleeding, I got in with my regular gynecologist for an ultrasound so she did a transvaginal ultrasound, even though she had already had one not too long ago in 2018, but everything was healthy and looked normal. I wanted to make sure that I was getting back on track and started taking oral progesterone. And then using the cream is this a safer option. It was also mentioned that I might consider pairing the Mirena IUD with the BHRT cream, which I understand she says here. I'm not crazy about that. I'm certainly not really crazy about that idea either but she goes on Monica goes on to say I've always had a regular cycle and no issues and only took birth control for a short time in my early 20s. I'm 47 years old and I'm hoping to get on the right track to have a well-balanced using the least I can but still feeling confident in making good choices. Any suggestions or feedback is greatly appreciated.

Dr. Maki: Excuse me. This is certainly a situation that we deal with quite often. She has a prescription. She's she tells us that the end that she's 47, and that would have been the first thing that I would want to have known when she says she's in perimenopause giving a woman in perimenopause biased right off the bat, you're going to probably run into this kind of bleeding issues fairly quickly. I know we always want to know how recent has been there menstrual history been has it been 3 months 6 months 12 months are they are skipping a month. Is it a couple of times a year? Because you put them right on biased right away and the bleeding is going to be potentially unpredictable.

Dr. Davidson: Exactly, she's 47 I would you know, what a perfect world. I would say she's probably more perimenopausal than actually true menopausal but she does go on to say she missed three months of a period and that when they did a blood test or hormones were low. So that is showing that she's probably goes progressing which is what perimenopause is completely understood having those terrible night sweats and hot flashes. She's not sleeping, she's feeling bad. Those hormones have tanked. But like Dr. Mackey said is you know, she probably would benefit from a little bit of biased but a 50/50 ratio just you know, looking at everybody a 50/50 ratio of estradiol to estradiol is pretty strong normally in the beginning. We usually do an 80/20 where there's 80 % estriol the gentler estrogen and only 20% of the estradiol which is the stronger form. For Monica being 47 and she's put on a 50/50 ratio that might have been a little bit too strong for her to start in the beginning.

Dr. Maki: We would never start a woman that has never been on hormones before especially at 47 years old on a 50/50 ratio. Now the milligram amount does make a difference there. She's at 1.8 milligrams. It's only would you say .96, point nine.

Dr. Davidson: That would be .9 exactly.

Dr. Maki: Almost 1 milligram of estradiol. Like you said, an 80/20 maybe we've talked about this in a previous episode. Maybe even just a straight estriol cream because all she needs the estrogen for is to stop the hot flashes but not exacerbate any bleeding. Now the other thing that I know that you're going to probably say this next the other thing that we don't typically do is especially for our first time BHRT users. We're not going to put all three variables estrogen are biased progesterone and testosterone into the same cream. We like to separate them out. We don't like to use the cream at all specifically for this case, which she came to later her doctor gave her the oral progesterone we would have easily started her on the oral progesterone hundred milligrams and maybe with the idea of going up to 200 milligrams depending on you know, whether she started bleeding or not.

Dr. Davidson: Exactly. That's like kind of two concepts. There is the progesterone as cream and you do it when you do progesterone is a cream you do absorb it through that skin membrane you do absorb it. It does go into the bloodstream, but it doesn't really have an effect on the uterus like a capsule so that progesterone cream didn't protect the uterus. And that extra estrogen on top of Monica's taking made her uterine lining start to get thick hence, she had a period hence, she had another one 10 days later, hence. She had three weeks of chronic heavy bleeding and that's why the progestin probably didn't do much is because that had already kind of started that I guess you could say facilitated that cycle already that by the time they put in the progestin which I don't really like anyway, it didn't work. So definitely I like Dr. McKee said it is keeping that

progesterone has a capsule in a female that has any kind of uterus any kind of BHRT with the uterus. We always use progesterone as a capsule and then like you mentioned is when you put all those variables together with the testosterone the estrogen the progesterone you have no way of balancing it. Let's say this cream gave Monica ton of acne, got a pretty good amount of testosterone in there.

Dr. Maki: Again, for a first-time user giving her 5 milligrams of testosterone, right off the bat. I guarantee you; she's going to have some hair issues some blemish problems and maybe start losing hair in a matter of about a month and a half.

Dr. Davidson: Then what do you do? You don't necessarily want to reduce the cream that she's taking because then you reduce the progesterone and estrogen component, but you don't want it if she's having more hot flashes, but she's having acne. You wouldn't want to increase the cream because then she'd have more testosterone. Then you basically have to take that cream throw it in the garbage and do a new one. That's why we usually separate this out because being a 47-year-old female everybody is different every 47-year-old female is different what works for one is going to be completely different for someone else. Keeping those variables separate allows you to manipulate and be able to find the right dose for that person. And once you do then you can combine it together.

Dr. Maki: Let's say we change it up a little bit. I guarantee you; I don't guarantee. I can't guarantee anything because it's hard like you said in these situations are challenging. She's still in that menstrual window where she Is transitioning from perimenopause and menopause her menstrual history is only three months ago. It's almost a guarantee that you give her some estrogen. She's going to have she's going to start bleeding again. Now that is not a concern when you're on when you're taking hormones and even when you're in perimenopause bleeding in that situation is kind of far for the course. It's a normal process now gynecologist get a little nervous sometimes they want to automatically do a uterine ultrasound or a transvaginal ultrasound, but it's not necessarily. It's not really necessary right off the bat because she's taking hormones so we know why she's bleeding and looking at the prescription. It's pretty clear like so from the beginning, let's say we heard biased was changed when 80/20 ratio 2 milligrams. Just a straight number the progesterone was started out and I do this a lot. I'm not sure how you do the progesterone where she was started a hundred milligrams, take it for let's say seven days if she feels maybe 10 days if she feels good double it up to 200, now she's probably one going to help her sleep a little bit better. But right from the get-go, it's going to protect that lining, she's not going to bleed from the start as opposed to trying to fix it when it already started bleeding like you said a few minutes ago.

Dr. Davidson: And I completely agree with you, and keep the testosterone out in the beginning because I do like testosterone but I consider testosterone more like I always call it like the frosting on the cake like you don't want to add the frosting until you created the cake. So that's like the fun accolades of adding a little bit of testosterone here to really help that picture the help that that woman feel really good, but you don't want to start off with testosterone because just on a side note is testosterone as a molecule looks almost mirror exactly the same as estradiol. Sometimes, when given female testosterone, it will aromatize and turn into estrogen and then they have more estrogen than they really think that they have.

Dr. Davidson: You're right, and five milligrams as we already talked about five milligrams to start out is kind of a lot, some women can tolerate a whole bunch of testosterone. Some can tolerate very little, most women that we even have on testosterone. They're usually not on even five milligrams. They might be on two-three, maybe four very fewer on five or above. Some are tolerated well, but the majority of them, especially when you're starting out, for the even for the first six months maybe only on a milligram or two as supposed to start them right off the bat at five milligrams. That's potentially going to create some problems that again you'd have to troubleshoot on the back end of that, two months in when she's having a male hair growth that acne problems.

Dr. Davidson: And hair loss on the head exactly. And I do understand I'm glad she got into her gynecologist and talked with her gynecologist, and that she had that ultrasound and everything looked good. That's good to know but you know the idea of doing an IUD a hormonal IUD, which is the Mirena is or the Kyleena or what's the other one? Skyla?

Dr Maki: Skyla, it's called Skyla.

Dr. Davidson: They're all you know, they're all IUDs. I do think they're way better than doing birth control, but at the same time, it's hormonal. You're adding more hormones into a 47-year-old female that's already taking some hormones. It just ends up being a little bit too much of a hormone salad.

Dr. Maki: Right, and you don't like the progestin is anyways, taking bioidentical progesterone again if she would have started out that way with 1 to 200 milligrams of the oral capsule. She probably wouldn't have been in this situation, to begin with, and we see these women that are approaching menopause being suggested to use an IUD. I just don't understand that cause, I just don't understand from a gynecology perspective. They have limited options at least what they're used to and what they recommend to people and I just think that that's a really bad option in most cases.

Dr. Davidson: Because the idea here, of course, is that Mirena that hormonal IUD will thin the lining of the uterus and she'll stop bleeding a lot of women with IUDs don't have any periods, or if they do, they're very light because that lining is made thin. I'm glad that her gynecologist didn't jump right into suggesting an ablation, which is also really common with somebody that's having chronic heavy bleeding, but I can understand. She's been bleeding for three weeks heavy. She's probably anemic at this point for Monica that you've got to stop the bleeding. But when you look back on why she's having the bleeding it's definitely that progesterone and just like, Dr. McKee said maybe because this cycle has already facilitated itself that doing the 200 milligrams of progesterone might have been a maybe even a wiser idea than doing a hundred milligrams of an oral capsule.

Dr. Maki: Because as I stated in the beginning, she's 47 her period was only three months ago. You have to take that into consideration. Now if she had not had a period for a full year right the likelihood of her getting a getting some bleeding back is still somewhat dose-dependent. If we put her on some of that let's say hypothetically Monaco. Let's fast forward five years. She's 52. She isn't a period for a year and a half and we put her on a high enough level of the same thing. We put her all-in-one cream three different things progesterone cream bias 50/50. She'd still have the same problem. More than likely.

Dr. Davidson: It might take a little longer. It might take more like four months before she had bleeding, but she would eventually with the way with having that 50/50 and not having the progesterone as a capsule. She would eventually have some bleeding and we always say don't freak out about bleeding; we don't want you to bleed all the time. Sometimes a uterus has a little bit of lining accumulated and just wants to clean house. Three days, once after starting BHRT but not as Monica's having here three weeks straight. She started bleeding for 10, within 10 days. And then again three weeks straight heavy bleeding, that’s too much bleeding.

Dr. Maki: But I think this is also what gives BHRT kind of a bad rap and then kind of blame it on the BHRT and gynecologists get a little irritated by this kind of situation because they have to you know, fix it with the way they know how to fix it. But to begin with, I don't think that her prescription was enough variables weren't really taken into consideration granted. It's a really tough place to be when you're having hot flashes. But your menstrual history is still fairly either you're still having a period or you've had one within the last six months, right? Because the bleeding even though it's not serious. It's still really inconvenient. It can lead to some anemia. It’s just, not something that a woman wants to deal with because it's unpredictable, to give her practitioners that she's going to see now, you know some credence. Because of where she is in her life in the

transition that she's in it's a really difficult spot and to have all those hot flashes and night sweats and being miserable while you're trying to work or take care of the kids or whatever. Just trying to be functional. She made the right decision to look into BHRT, but the way the prescription was done, it could have been done a little bit differently, and hopefully, then it would have provided her with the relief that you wanted.

Dr. Davidson: Because she's an individual so this dose didn't really work well just like we said, as well and just like she did here which is great, taking the progesterone as a capsule, and then possibly after she's gotten this into her bloodstream after about a month is retesting those levels because she is perimenopause and that's the interesting thing about being perimenopause as opposed to post menopause is those ovaries are like little gremlins they want to work full time, they want to work part-time, they want to go vacation they don't want to work at all and then they come back full blast. Your kind of following them a little bit, as opposed to somebody that's postmenopausal in those ovaries are like we're retired were done then whatever you're giving them is actually that dose. So that's where I would definitely test her levels again after she's been on the new hormones for about a month.

Dr. Maki: And initially when she goes into see the practitioner of the first time looking at her FSH level because she's only 47 or period is three months ago, her FSH if you had to guess where her FSH is what would you say? What would you guess?

Dr Davidson: FSH was probably in the 50s. But this is really interesting is I'll test a females FSH or the follicle-stimulating hormone. It's a signal from the brain kind of monitoring the overall ovarian status and the higher the FSH the close to, the lower the ovarian functioning is her FSH was in the 50s where you think a fertile female menstruating cycling just fine and their 20s, they're FSH is usually around two and a half to five, you know, right around there.

Dr. Maki: Very low.

Dr. Davidson: I would definitely say that hers was in the 50s. But like I said, what's interesting is I do a lot of FSH is with females. I do it a lot more than I think you do is I'll see somebody; a perimenopausal female. I'll see their FSH in the 50s and then I check it again three months later and it's 19.

Dr. Maki: Right now. Is that after hormones or is that just a change that you notice?

Dr. Davidson: No. That's just they're feeling fine hear Monica's having some symptoms, but let's say their symptoms are minimal. We're working on some adrenal things. We're working on some thyroid levels. And I say okay, let's you know they might have had a period every other month. I'm like let's hold off before we throw you into that,

hormone soup is let's hold off for a second and then let's check it again and we check it again and sure enough. It's down at 19 and then we check to keep following it and hey, it's you know, 12, 19, 13 and then it popped back up to 40 and that's because the ovary sir, they're vacationing or they're working full-time or the working part-time. We're following that because I find that when I give a female hormone that they don't need right away. They don't feel that great. They get puffy. They get munchie. They gain a little bit of weight. You know when somebody needs a hormone is when they do feel good when they're sleeping better when they lose a little weight when their mind is working when their libido goes up. It does sound like Monica liked the overall wellness and her hot flashes went away. Definitely, BHRT is something that's really good for her. It's just finding the right dose.

Dr. Maki: You're right. That's the difficult part. That's the part. We have to take all these you could take our stress. You got it to take her age. You got to look at her menstrual history. You got to look at you even asking where mom went into menopause. How old was mom when she went into menopause, was she on the early side, was she a little bit later even grandma will be a similarity between a grandma mom and daughters of when they start to see because perimenopause 30 years ago no one even heard about anything like that. Now, this is the other thing too that happens around this age too because what you're talking about the FSH. FSH is a pituitary hormone in your brain that is released and that communicates with the ovaries to tell them to produce estrogen and now as a woman gets around this age to their late 40s to the early 50s as that signal as the ovaries like you said are on vacation and stopped responding that deaminated FSH levels keep going up eventually the ovaries kind of kick in and they do what they're supposed to do. Women very often start having heavy bleeding in their late 40s and now sudden doctors are kind of freaking out when there should be approaching menopause also in their periods heavier than it's ever been, scaring women a little bit, thinking like there's a major problem going on again. Going into the transvaginal ultrasound thinking you might have uterine cancer that that's a normal process that is not a cancer-producing process. It's just the way the body works, even though it doesn't seem really counterintuitive that you're going to have a heavier period right at the end but it's because of how that feedback loop works between the brain and the ovaries. And again, that's why you're probably seeing these FSH levels on lab test jump around so much because the brains doing what it's supposed to do. The ovaries are just being stubborn and eventually the signal kicks in and all of a sudden now that estrogen threshold is being met and they have excessive bleeding than they used to have.

Dr. Davidson: Exactly, because that is one thing we didn't mention is in perimenopause is the progesterone always drops, you hit 44, 43, 46 that progesterone plummets, but the estrogen doesn't always do that at my drop a little bit so that excess estrogen will cause a thicker lining just in general not even Monica or anybody being on BHRT it just that you see in that perimenopausal phase. It might have sort of had in doing this biased 50/50 ratio without oral progesterone might have just accelerated that process.

Dr. Maki: Sure. I think we hash something out pretty well. Do you have anything else to add?

Dr. Davidson: No, thank you, Monica, for sending in your question, and was this in response to a Blog article that she read?

Dr. Maki: This was a blog post. The blog post title is. How does biotechnical progesterone help which is exactly about this issue and we have a couple, other ones that are about cream versus capsule because of these kinds of questions they just keep coming up over and over and over and we look at these prescriptions which we see all the time and it's not that our way, is the best way there, that's the one thing when it comes to hormone replacement it is you talk to 10 doctors, you're going to get 10 different opinions, everyone has their style of how they do it. But at the same time, there are some glaring differences in this situation and all the other ones we talked about. That's why we talk about them because it's not that the other doctors are doing something wrong necessarily, it’s just we don't agree with how they're how the prescriptions are being delivered or constructed and we're just giving opinions and I think in this one, at least this one, the fact that there's something that we can discuss about it. Like there's something that we can say would have done this different, would have done that different and then that would have hopefully protected from the bleeding. That's why we talk about these questions because now everybody goes back to the practitioner, like wait a minute, you know, what about this? What about that? They can be informed and ask the right questions because we get a lot of people like Monica, they end up coming to see us as patients because they've been through this process and they're just not getting to where they want to go. They feel better in some ways, but other things come up in a lot of times practitioners don't necessarily know how to troubleshoot once there's a problem.

Dr. Davidson: Exactly. Thank you. Thank you, Monica, for reading and for all you, listeners. Thank you for listening. I hope this helps some people like you said help people, learn. We're all learning, right? We're always all learning,

Dr. Maki: I know online learning is online everything is going up these days with all the locked-down pockets that's going on. So hopefully everyone surviving through all of that, until next time. I'm Dr. Mackey.

Dr. Davidson: I'm Dr. Davidson.

Dr. Maki: Take care. Bye, bye.