Progress Your Health Podcast - Episode 073

What Is A Low Dose of Bioidentical Hormones?

Dr. Maki: Hello everyone. Thank you for joining us for another episode of the progression health podcast. I'm Dr. Maki.

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

Dr. Maki: So just as a warning before we get jumping into the episode, we are in our home office recording this. Our dog is with us as well. He's always with us. We can't really go anywhere without him, but he's laying on the floor with a bone. So, if you hear any strange noises or any banging around, he's just either repositioning or trying to find another bone. We can't really go anywhere without him. And he's happy as long as we're close by.

Dr. Davidson: In some ways. He's kind of our first dog, 'cause our other one was a poodle, which they always say once you have a poodle, all the other ones are just dogs. So, he was completely different from this one. He follows us everywhere so if you hear him chewing, he's chewing on a bone. Thank goodness he doesn't chew on other things. It's just his bones.

Dr. Maki: No shoes, no clothes, no furniture. Just bones. So, we're good, we're lucky about that. All right, so, now this episode and the next few, we know enough to be dangerous when it comes to SEO and Google and all that kind of stuff. But there was some kind of conspiracy thing about alternative health websites not getting the traffic. We're not really sure if that was real or not there are some other prominent websites in this space that was kind of commenting on that. There was a recent Google update just a few weeks ago and we've noticed that there was a significant drop in our traffic based on what they called Google analytics. For those of you that run websites, you know what Google analytics is. But without doing really anything different, just our normal, we've seen a nice little uptick in our traffic and as a result of that, we've got a mini flood of questions as of late. As we're just kinda wrapping up the end of 2019 would be to

answer some of those questions we feel some of these questions are very good and as the adage goes, if you have that question, especially on a podcast, there are probably hundreds if not thousands of other people that have a similar question. And because this one and a few of the other ones that we're going to be doing, we feel like there's a lot that can be pulled from that. Everybody else can benefit from that question as well. So, Dr. Davidson, once you read the question and we'll go from there.

Dr. Davidson: Okay, so this question is from Michelle. Her comment is I am fifty-two years old going through menopause since forty-eight. I had a hysterectomy at age thirty-six and kept my ovaries for the hormones. My ovaries are nonfunctional now. I was on Premarin, but when I sought out a specialist for hormone therapy, I was prescribed Estradiol 0.5 Estriol one milligram, which is technically Bios. It's the combination of estriol and Estradiol. Estradiol was 0.5 milligrams, Estriol is one milligram. And she's also taking a hundred milligrams of Progesterone. I take this at night. I've had a weight gain of forty pounds and suffer from anxiety at night since starting menopause, I was prescribed Propranolol, which is technically a blood pressure medication, but it does help with reducing anxiety. But she has prescribed the propranolol for this and it seems to take the edge off. I have poor sleep as well, where I used to sleep very well. What am I missing? Am I on the right track? I feel deconditioned fatigue and brain fog to mention a few. I feel poorly when I used to be a happy, healthy person. Please help with recommendations. Would testosterone help? My levels were not terrible enough to prescribe.

Dr. Maki: Yes. She's asking kind of a couple of straight forward questions. I mean am I missing something? We think that she is, we'll get to that in a second.

Dr. Davidson: Of course. Disclaimer, disclaimer.

Dr. Maki: Yes. And we can't really give medical advice, but we can certainly offer our opinion. Michelle is certainly not our patient, but we see some issues with this and the testosterone question. Interestingly enough, that's something that comes up, women are asking about testosterone quite often. And it's a trend that we see a lot of women come to us after having been on testosterone and we're not necessarily quite in the same agreement as what other practitioners do. So first and foremost, this issue in general, she's doing all the right things. At least she thinks she's doing all the right things. She's asking, well what else can she be doing cause she's not feeling any better? And Dr. Davidson, I'm sure you would agree. For the most part, it comes down to a dosing issue.

Dr. Davidson: Exactly. So first off, we want to work with that Estrogen and the Progesterone. The dose is right for her, for her goals, for her symptoms, but she's wondering, maybe testosterone would be it. And really testosterone, a lot of women do take testosterone, but that's not the first thing we want to jump into 'cause we always think of when you're doing the BHRT, the hormone replacement, we want to create a good foundation. Or as I kinda call it, you know, we want to build the cake and then then the testosterone would be like the frosting on the cake. You wouldn't want to start with that, we want to build it first with that Estrogen and that Progesterone. So, definitely we would change up that dose for that Bios.

Dr. Maki: Yes. And when would you go from a commercial conjugated [inaudible] and the Premarin, an oral hormone and then you switched to Bios. Now granted we love bioidentical hormones. We use it with all of our patients, but going from Premarin to that is kind of taking a step down in dosage or efficacy. Granted other some fewer side effects. And we encourage, we never prescribed Premarin, we never would, never will, never have. However, knowing the transition and like we are talking about as we are preparing for this episode, there's no really good conversion going from that to that, a common dose of Premarin is like .65 milligrams. You can't give a woman .65 milligrams of Bios and expect her to feel the same. She's going to feel probably a lot worse.

Dr. Davidson: I've had lots of women, especially maybe about ten years ago, around 2009-2010 when really a lot of people were converting over because of those studies. Showing that Premarin is not healthy for females. I would have women that would come in and of course, their doctors would try to transition into something or nothing. They felt awful. I've had women say they, their whole lives have been changed because they're, they were taken off their Premarin. Now we know that's not safe. So, that's the thing is when someone's on even any other kind of conventional, like even an Estradiol patch, because the Bios or the Estriol and the Estradiol for the BHRT are so gentle is you actually have to start off high on those doses and then work your way down. So, with Michelle coming off of Premarin, we would probably do a much higher dose of the Bios, the Estradiol and the Estriol combination that she's on, do much higher dose and then over time titrate it down till her body. Cause a lot of times, like Dr. Maki was saying, when you're taking these oral hormones, they go through your liver and they just eat it up that you can't convert into something so gentle, so low. So, definitely we would do a higher dose of the Bios and we would for sure do it twice a day.

Dr. Maki: Yeah. Right now we don't need to get into too much of the liver detoxification pathways, but there's what they call the cytochrome P450 system, which is this huge crazy kind of network, so to speak, of enzymes that are upregulated when you take Premarin and then when you stop that, those enzymes are still up-regulated. So, your body will, like you say, chew through the BHRT dose relatively quickly. So it's the simplest solution, they just need more. And 1.5 milligrams of Bios is for you and I is really not even basically a starting dose. That's a very, very conservative dose. So, the practitioner that prescribed it should know if you're going from Premarin to Bios, you need to increase that quite significant. Now that increase or the significant increase that you'd go is really based on the person. It's based on their symptom picture and it's a little bit of kind of, I wouldn't call it guesswork on the practitioner side, more based on experience to know that that transition is going to make them feel worse. So, you're kind of overshooting the mark because let's be honest, what makes a woman a woman is an estrogen. In a lot of cases, especially in menopause, the more she has, the better she's gonna feel. And I think that's what's going on in this case for sure.

Dr. Davidson: And then like I had mentioned about doing it twice a day cause the BHRT, the bioidentical hormones are so awesome. I mean they're great, they're very gentle and they don't have a very long half-life. So if Michelle is putting on her Bios cream at night, say ten o'clock at night, by the time ten in the morning, noon, one o'clock in the afternoon, it's pretty much gone. So, that's why you want to take it twice a day. So, definitely I have people take it at night. So, it helps with the hot flashes, helps with night sweats, helps with cellular turnover, helps them sleep and then you take it during the day. That would probably help a lot with her brain fog. 'Cause one classic symptom and menopause is, and I've had women patients tell me they think they're having dementia or they want to get checked for Alzheimer's because they lose their memory and it's not, and they don't have dementia, they don't have Alzheimer's. Once that estrogen drops in menopause, the recall is hard. They'll say, "I can't remember the name of that book. What was that author's name? Ask me in five minutes, I'll remember then." They just feel like they just lost that sharpness. So that's why doing the Bios, doing the bioidentical hormone estrogen component in the morning. So, morning and evening really help with that brain function.

Dr. Maki: Yes, right. So, from a Bios dosing perspective, what we call a half a gram twice a day. So two clicks twice a day. So, they apply two clicks means that there are more than likely going to be given a toppy click from the pharmacy.

Dr. Davidson: There are so many [inaudible]. There are pumps, there's so many. There's jars[?].

Dr. Maki: Yes. I mean there's a lot of different ways, but typically what we like to use is a simple topic click, two clicks on the bottom of the dispenser. The low cream comes out, they apply it in the morning to their thighs only. We don't recommend putting it on your forearms or your wrists, anything like that. So, two clicks or half a gram in the morning and then two clicks or half a gram in the evening and whenever you apply in the mornings, going to get you through the day where you apply in the evening is going to get you through the night. And then over time, those blood levels should tend to rise a little bit. They're not going to surge, they're not going to go crazy, they're not gonna go super high. But you should start to see each dose is building on the previous dose. So, now you can hopefully get a sustainable level and now symptoms will start to resolve.

Dr. Davidson: And then like Michelle had mentioned on her comment is she's taking progesterone a hundred milligrams. I'm assuming that that's probably separate from the Bios and as a capsule cause that's pretty common as an oral Progesterone 100 milligrams. Now that in itself we do have women just take once a day. So, taking that at night is great cause Progesterone is very relaxing that if you took it during the day, it could make you sleepy, it can make you tired, feeling a little foggy. I've had patients on accident take their Progesterone in the morning and they're calling me saying they felt like they drink wine or something. That's cause it's a little relaxing so, I definitely always taking that progesterone at night. But the progesterone, typically we do it once a day.

Dr. Maki: Yes, right. And as you're raising the Bios dose or the amount of estrogen, the progesterone capsule, in this situation, we definitely recommend a capsule versus a cream. The Progesterone, not only does it provide some of those other benefits, as you said, it's fairly relaxing, it can reduce her anxiety at night and we may often go up to even up to 200 milligrams in a situation like this because her sleep isn't great and she's still having some nighttime anxiety. So, playing around with that, you have a 100-milligram capsule, it's easy enough to just to add on a second capsule just to see if you feel any better.

Dr. Davidson: Yes, just like Dr. Maki said, this really is based on the person. You can't just look at a chart and everybody gets the same cookie-cutter dose. So, looking at what works for her. And we do labs, I do think doing labs are important, checking her estrogen dose, checking her Progesterone dose and then comparing that objective data with her subjective data is perfect, it kind of pulling that together. So, I'd say definitely for Michelle as a start and if she's worried about raising up her estrogen or her practitioner

is unsure, doing a simple blood test to check to see where her levels are at and then you could raise it up, see how she feels, and then do another blood test to see where her levels are at. So, I definitely think coming back to Michelle and her main concern is it really boils down to probably that Bios dose.

Dr. Maki: Yes, I think it needs to be doubled, tripled or, even more, to help her not feel like she's tired all the time, all this anxiety. She doesn't mention too much about having any hot flashes or anything like that, but her symptom picture is like super common. These are the complaints that everyone feels. And once you start bumping up that estrogen, we'll maybe talk about this on another episode, but this is where you also talk about the two types of hormone replacement. You're doing static dosing, which is what she's doing, which is what we do most of the time. And the other option is rhythmic dosing, which we do a lot of as well because again, for women and how they feel, it's really about that estrogen dose in a way to keep them safe but yet give them the amount of estrogen that their body really wants is the difference between static dosing, rhythmic dose. We'll compare those two on another episode because that is becoming a little more popular, even in the past, static dosing still is by far the most popular because unfortunately, the rhythmic dosing you get your period. But Michelle, she had a hysterectomy at thirty-six. In my opinion, she's kind of a really good candidate for it because she's had her hysterectomy already, so, now you don't have to worry about the bleeding part, which is really the deterrent for most women. They don't really want to consider rhythmic dosing 'cause the last thing a woman wants in her mid-50s is to get her period back.

Dr. Davidson: Most of the time, yes. I have a handful of women that do want to get a period, but as you said, rhythmic dosing is you do have to change the dose, every several days. So, you have to keep like your calendar and your track and that's not a hard thing to do. But the static dose, cause you're doing the same thing every day is a little bit more user friendly. So, that would depend on the person. If I have somebody that's a little bit more particular on how they like to do things, they were like, oh they're perfect for the rhythmic and have some that are like, you know what, I'm going to be a little flaky and forgetful. Then we do the static dosing. So, it all really boils down to the individual. And like I said with Michelle, I am actually surprised she didn't write on here that she wasn't having night sweats at night 'cause looking at her dose and that she was on Premarin and she's now 52 and her ovaries aren't definitely are menopausal. I'm surprised she's not having hot flashes and night sweats all night.

Dr. Maki: What I hear a lot from women, they say that they're like hot and cold. The hot covers are coming on and off and on and off and on and off, which is what is waking them up and now their sleep is completely disrupted. I would assume based on what you just said, I would assume that that's probably happening, but she didn't write it there, so then, of course, the next day you're going to be exhausted because every night you try to go to bed, there's no restoration. It's just this battle with your body and so, you're right, I'm surprised that she didn't mention that, but I would assume that some of those things are probably present. And then, of course, the weight gain, the weight gain, forty pounds. I mean, how many women have we talked to over the years that no matter what they do, their lifestyles really don't change that much. All of a sudden they just put on a ton of weight like that, which of course is very frustrating because the weight goes on really easy. But getting that weight to come off is sometimes very challenging, very difficult as well.

Dr. Davidson: And that's definitely a product of the menopause 'cause it's kind of unusual, if the estrogen is too high, you can gain weight and if the estrogen is too low, you can gain weight. So, you have to really try to get it right in the middle.

Dr. Maki: Yes, we're trying to recreate what the body normally does when a woman is menstruating. Now she had a hysterectomy. So, more than likely there were either some fibroids in her past or maybe an estrogen dominant kind of a situation, especially at the age of thirty-six. We don't really have that backstory, but we could probably make some assumptions as to why she had that. So, her cycle might've been a little bit more than likely her cycle was a little bit abnormal for a while anyway. So, the one last little comment about the testosterone, once the sleep is better, the estrogen dose has been increased and she has some resolution then would be when you and I would probably consider doing some testosterone once she's already feeling better, for the most part, significantly feeling better, then it would be a good opportunity to add in some testosterone. Would you agree with that?

Dr. Davidson: Oh absolutely. Like right now, you'd say her estrogen is definitely way low and then you throw in some testosterone who ends up at the top of the hormonal chain, it's the testosterone. So, the testosterone ends up being dominant. So, then you get these negative side effects 'cause testosterone is a great hormone. All humans have it. Women have less of it than men. But if that testosterone is the dominant hormone running the show, that's what you'll see. And women will get irritable, they'll have hair growth on their face, hair loss on their head, they'll have acne. And of course, all hormones are steroid. Having too much steroid or steroid testosterone can also cause weight gain.

Dr. Maki: Yes, especially for a woman. Just because that's not the dominant hormone. So, we like to be a little bit conservative. If she came to us as a new patient, we know we would not put her on testosterone probably for at least a few months, probably ninety days or so, just to make sure that those other bases are covered and then contemplate. And honestly at that point when she's feeling better, she might not even need or want the testosterone.

Dr. Davidson: She might not even need it.

Dr. Maki: Especially she said her levels were good on a blood test. I would assume that her levels are probably in the mid-twenties the low to mid-twenties something like that.

Dr. Davidson: Well, that's another issue, right, 'cause the reference ranges for testosterone are huge, on Quest, they're like two to forty-five, LabCorp, it's six to fifty-five, so, she could be anywhere on that continuum. But like you said, they weren't terrible enough to prescribe, hey probably were around twenty.

Dr. Maki: Yes, and honestly, when it comes to a lot of these hormones, especially when a woman is already in menopause when you're starting the hormones, the levels don't really mean as much, right? It's more about once you're on the hormones and then testing after the fact because if they're in menopause, you know their hormones are going to be low. Of course, across the board, there's going to be dysfunction across there because they're in menopause. It makes more sense to have that objective value or the objective value or objective levels make more sense once they're already taken hormones. So, you have kind of a baseline and then you have the aftereffects once they're on them. Because if they stop the hormones, then everything goes right back to basically zero or at least suboptimal because, and then that in conjunction with how they feel, the numbers make more sense once they're actually doing something or taking something.

Dr. Davidson: Yes, I agree. I mean really with Michelle, she says, "I used to be a happy, healthy person." She still is a happy, healthy person. It's just a few little tweaks here and everything would probably feel really good for her because I do love the fact that she stopped the Premarin. That is wonderful. It's just having that transition, changing up that estrogen a little bit, getting her sleeping better, even just sleeping better will make her metabolism go up and then help her lose weight, just in that regard.

Dr. Maki: And more estrogen plays a big role in helping the sleep. And once that sleep is improved, as I said, then everything kind of trickles off the sleep, her energy comes back or mood comes back or happiness comes back, her weight will start to go down or at least the potential of you can't sleep or not sleeping well, that's the number one thing that we try to focus on. If weight loss is your goal, you have to sleep well at night. Otherwise, the weight is almost impossible for that to lose. Your cortisol goes up, your insulin sensitivity goes down, all these things happen when you're not getting a good night's rest and then your body is just exposed to all this cortisol all the time. And that's why a lot of these things are going on. The brain fog, the weight gain, all those things just kind of become a runaway freight train. So, Dr. Davidson, do you have anything else to add about Michelle or do you think that we can call this one a wrap?

Dr. Davidson: No, this is great. And thank you, Michelle, for sending your question. You wouldn't believe how many women are in the exact same situation that you're in and they have the same exact question. So, I hope that this helps Michelle, which will also help probably other females out there that have some of the same symptoms or questions.

Dr. Maki: Yes, so, until next time, I'm Dr. Maki.

Dr. Davidson: I'm Dr. Davidson.

Dr. Maki: Take care. Buh-bye.

Dr. Davidson: Bye.