Progress Your Health Podcast - Episode 086

What Biest Dosage is Best for Menopause?

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

Dr. Davidson: I'm Dr. Davidson.

Dr. Maki: Let's dive right back in. We have another listener question to do. This one is from, actually, her name is Natalie. Dr. Davidson, this one's fairly similar to what we did recently for Monica's, we've kind of thought this would be appropriate. I want you to go ahead and read the question.

Dr. Davidson: Sure, sure. So, this is from Natalie. Hello, Dr. Maki. I am 45 years old, full menopause, and currently on 80/20 ratio, biased 0.5 mg, and 200 mg of progesterone since July of 2018. At that time, I was given a testosterone injection. By October of 2018, I was losing hair, so we stopped that. I no longer take the testosterone injection. Since then, I have been gaining weight steadily, and even though we try to increase my estrogen slowly, I get too many side effects such as constipation, the weight gain, horrible bloating, hair loss, diagnosed as androgenic alopecia. My thyroid is in normal range. Is it possible that a different ratio of bias, like 90/10, would be more beneficial for me? I like having my brain in the dryness cured but hate the bloating and the weight gain from the estrogen. When I stop the hormones completely, I feel better. My belly fat goes away. I have no more bloating, and the weight loss happens. I did try DIM, but my weight just keep increasing. Thank you, Natalie.

Dr. Maki: Yes, right. This is a challenging one, right. I can understand where she might be frustrated. Even her doctor might be frustrated. She's on a very low dose, 80/20 at 0.5 mg. Maybe, she talks of bloating quite a few times in that question. I'm thinking maybe it might be more related to the progesterone than it actually is to the bias. What do you think?

Dr. Davidson: Exactly, that's why we wanted to do this question. We did another question earlier, kind of similar. This is why it's so important that what's going to work for Natalie is going to be completely different for somebody else that's right around the same age. That is why in everybody's so sensitive and so unique in their bodies that with BHRT or hormone replacement, there really is no one size fits all or a cookie cutter approach. You're right. With somebody else, 200 mg of progesterone would be great, but I really think that bloating is coming from the progesterone, even though in a perfect world, in the literature, and the research, theory is progesterone helps with that. I find when someone's taking- a female's taking too much progesterone for themselves, no matter what the blood work says, that it can cause bloating and puffiness and water weight.

Dr. Maki: Yes, right. Now, what we don't know, she doesn't specify. She says 200 mg of progesterone, but she hasn't specify if it's prometrium or not. We've talked about that in another podcast too, that 200 mg of prometrium could easily cause all those symptoms, even more so than 200 mg of bioidentical progesterone, 0.5 mg of bias, she might able not even be taking it. That is such a low dose that I can't imagine that that's going to be causing her much of either any relief or causing her any problems because it's such a small amount.

Dr. Davidson: She could be extra sensitive. There are some patients we have that are so sensitive to the littlest things that it could be that 0.5, really is too high for her. Now granted, she does say when she reduces the estrogen, that her constipation, her weight, or when she increases the estrogen, she gets more weight gain, more bloating, more constipation. While we're saying that the progesterone might have a factor in this, definitely, from her input here, the estrogen's having some kind of effect on her.

Dr. Maki: Yes, sure. Yes, right. She asked what a 90/10, a 90/10 ratio at 0.5 mg isn't really much of a change. Even going to a straight estriol cream, not even bias, just straight estriol, still isn't really that much of a change because the overall dosage, to begin with, is so low. Now, the thing I'm curious about, she's 45 and full menopause. Is that from a hysterectomy? Why would she be in full menopause at 45? Now granted, that's possible, but she's about six and a half, almost seven years too early for menopause. There's something that led up to that, that makes me question. Granted, we're not getting all the information, all the backstories, so we're trying to speculate on a couple of ideas. A woman, 45 and full menopause, that's not necessarily very common.

Dr. Davidson: Exactly. That was kind of my first thought, too. Maybe she had a hysterectomy, but I think she probably would have written that in there, that I had a hysterectomy. It could be that she's technically perimenopausal because like we've always said in the past, the blood work for checking for whether you're in perimenopause or menopause is so misleading when you look at the reference ranges. A lot of doctors just go by an FSH, Follicle Stimulating Hormone, and anything over 25, says you're menopausal and that's just not true.

Dr. Maki: Yes, right. Like you said, one of our last ones, we talked about Monica. You watched the FSH on purpose. You see it kind of bounce all over the place, that's where perimenopause and the menopause, it's not so black and white. There's a lot of gray area there and that transition from perimenopause into menopause can take you 10 to 15 years in some cases. It can be a very long period of time for women from their early 40's to their mid 50's, that whole time frame could be a woman being in perimenopause, then finally, she transitions into full-blown menopause.

Dr. Davidson: Exactly. Maybe she did have a hysterectomy where they took the uterus out but left the ovaries in, and that can be producing hormones as well. what you said, we don't have a whole lot of backstory to this, but she is having symptoms. When she raises up that estrogen slowly, she still gets negative side effects. Something you would mention earlier that might not- might actually be a good idea is taking the estradiol out completely.

Dr. Maki: Right, yes. Even though such a small amount, like you said, she might be one of those ones because of where she is in her life. She might just be extra sensitive, a little bit in her case, a little bit goes a long way. That's why like you said, you can have some starting points for women, just in general, but when you have a situation like this, again, taking all the factors into consideration, it is always a custom prescription, a custom treatment plan for that particular person and situation. You might have 10 women with the same dosage, but how you got to that dosage is very specific to that person.

Dr. Davidson: Exactly. Just from experience and working with a lot of different women with the hormone replacement, I do find if a female is going to be sensitive to estrogen, they're going to be sensitive to the estradiol. That's usually the thing that's causing whether it's breast tenderness, fibrocystic density, weight gain, bloating. Like we said, the progesterone might have a little hand in this. It might be a little bit too high or their prometrium isn't the right thing for her. If she is going to be sensitive to something, it's most likely the estradiol if we're looking at that bias. Estriol is very gentle, but not that

we want to give medical advice, just for educational purposes, I would say even taking that estradiol completely out, but raising up the estriol.

Dr. Maki: Explain that.

Dr. Davidson: She's on 0.5 mg of a biased 80/20, that's really, really low. I have to pull my iPhone out and do the calculations to tell you exactly how much estradiol and exactly how much estriol is there. Honestly, if we took the estradiol out and just did an estriol only, but really bumped it up to like 3 mg per gram, where she does maybe 1.5 mg in the morning, 1.5 mg in the evening, even going up higher to like 5 mg of estriol E3 because estrogen- there's three different estrogens. Estrone, we make that a lot when we were younger, our fat cells make a lot of estrone. We don't want it, we don't want estrone. Estradiol is the strongest form of estrogen, E2 estradiol and estriol E3 is very, very gentle. What Natalie's saying here, is she really likes having her brain back and also probably the vaginal dryness, I'm assuming. Estriol is great for your brain, and it's great for vaginal dryness. We could use estriol instead, take out the estradiol, and maybe dial back the progesterone a touch, and then she wouldn't have to deal with the bloating and the weight gain. Trust me, no gal wants to gain weight if she didn't get to earn it.

Dr. Maki: Yes, right. Another idea too is if you're using just a straight estriol cream and if she's applying that vaginally because she's having some dryness issues, in some of these situations, again, if they're a non-menopausal age, so to speak, or in that perimenopausal window where their menstrual history is fairly recent, you could do a little bit vaginally. That sometimes gives them enough estrogen to solve some of their problems.

Dr. Davidson: Yes, she could do it vaginally for the vaginal dryness. Then maybe, once or twice a day, she could do it just topically, like on the inner thigh to go systemically. It does help with the brain, that might be an option for Natalie because it looks like she's darned if she does and darned if she doesn't. I can understand wanting to try the DIM because that does help reduce down estrogen metabolites, but I don't usually find that really helps with estrogen dominance, weight gain.

Dr. Maki: Yes, right. DIM, Diindolylmethane comes from cruciferous vegetables. It might be very good in situations like full-blown estrogen dominance, but a woman that is in perimenopause, or in this case, if she says she's a full menopause, you're not really estrogen-dominant when you're in that transition because your body's estrogen threshold or your estrogen burden, so to speak, is declining anyways. You're right, I can understand her wanting to try something like that because she's not handling the estrogen very well. Taking the DIM, in some ways, that's kind of the opposite of what

she really needs, by using DIM as opposed to the estrogen but she just haven't had any success. I just looked at the question again, and it doesn't specify whether the progesterone is a capsule or a cream, either. What if you notice with women's tolerance from her symptoms, the cream versus capsule, which one's worse?

Dr. Davidson: Cream, I wouldn't say worse, but cream, being bypassing the digestion, going in, applying it to her inner thigh or something like that. At 200 mg as a cream is really high because when you test somebody with the cream, the levels do go up. You do see it go up. It doesn't have that protection for the uterus. I find that progesterone cream doesn't do a whole lot for helping you sleep at night like the capsules do. She's using a cream, the 200 is just way too much. If she's using a capsule, I'm thinking the 200 might be too high that she'd want to reduce that down to a hundred. If she's using prometrium, which is bioidentical progesterone, but it still tends to have a lot of side effects, especially with bloating and water weight, I'm thinking probably more the capsule. Just real quick, just to jump back to that DIM comment that you made, I do find that when I test women in their 40's and their estrogen is really high, that means their metabolites are high. It does tend to help when it's really high, when their estradiol level's up at 400 to 800. Doing the DIM is a nice piece of the puzzle when you're working with that, but looking at Natalie here, I bet her estradiol, if you tested her blood, is not anywhere near 400 or 800. It's probably like 32.

Dr. Maki: Yes, right. Just to clarify that, you're totally right on that. In perimenopause, you have kind of a pseudo-estrogen dominance because you have relatively a lot of estrogen with no progesterone. That is in some ways kind of what our definition of perimenopause is, your body just stops making progesterone, but now you have collectively all of this estrogen floating around. That's going to leave a woman very unbalanced in some respects. The DIM, in that context, would help to kind of tone down the estrogen a little bit in the absence of the progesterone. In that context, you could use DIM with progesterone. DIM with progesterone would actually be a fairly good combination.

She was kind of on the right track there. She does say that her thyroid is normal. I always like to push back on that a little bit. I would like to see the numbers, more than just the TSH number, because these is where these thyroid issues begin to come up when those female hormones are declining, your cortisol is through the roof. We don't know what her stress level is. The higher the stress level, the more cortisol that her body needs, the worst is transition is for women. This is an exact physiology with those female hormones tend to buffer some of that stress hormone. When those hormones are starting to leave, now you just have this cortisol all the time. That's where some of that weight gain comes from that they don't want. This cortisol freight train that makes

her weight just go in one direction. That's why this happens once women get into perimenopause. Whether that's their early to mid-40's and all of a sudden they're in perimenopause, the weight just seems to keep going up and up and up, no matter what they do.

Dr. Davidson: Exactly, because you're right. We look at thyroid a little bit different. We always combine the thyroid with some- looking at the adrenals and then the reproductive system. Think of it like a triad. You've got these female hormones, the estrogen and progesterone, then you've got your adrenal hormones, and you got your thyroid hormones. You want to look at them all. You want to work on them all to some extent. That way, you're not just compartmentalizing and looking at one thing. I completely agree with Dr. Maki as I would love to see those.

Dr. Maki: Yes, right. I had another woman the other day as a patient actually, and she was 45. Another doctor actually put her on a rhythmic dosing protocol. We'll talk about rhythmic dosing later. When I did her blood work, as an initial consultation, her estradiol at a 45 year old woman was still 240, meaning that she was still producing. Where usually when you're in menopause, on the lab sheet from either Quest or LabCorp, it'll give you either the number, but usually, a menopausal level will be less than 30. Sometimes, it'll be even in the teens or early even be below 10. Hers was still 240, and the doctor had her on estrogen. That's just not really going to go well for her and now it's possible, she's 45. How was that determined that she's in full menopause? If it's a hysterectomy, okay, I get it. But maybe her body is still producing some of, they left her ovaries there.

You said before, this is just how it works with hormones. When your body does not need a hormone because your body is still producing it, you're not going to feel very well. In that case, the woman told me, she goes, "I like the philosophy of the rhythmic dosing." It's called the Wily protocol. She loves the philosophy of it, but she didn't do very well with it. My opinion was at the time, I said, "Well, to be honest, you're not really a candidate for it. You should never been on that in the first place, because your body is still producing." When I saw her, she'd been up on all hormones for two weeks, her level was still 240. So, that's a woman who does not need any hormones. There's a few things here that we would just need to ask more questions, so we could clarify. Certainly, it doesn't mean that the estrogen like you said, switching it. There's a lot of things we've just thrown out about four different options that could be done, that we would easily know what to do if we had some of that backstory.

Dr. Davidson: Exactly, you're right. We always say it, the hormones are not a cookie cutter approach. For the right candidate, hormones can be great. Like you said, the rhythmic dosing is amazing for the right candidate. For the wrong candidate, it's not good. It doesn't mean thatprotocol is bad. It just wasn't right for that individual. With Natalie, working with her doctor in finding the right protocol that works for her and then constantly updating and keeping an eye on it.

Dr. Maki: Yes. We didn't talk much about the progesterone or the testosterone injection. She kind of came to that conclusion on her own. We never would give a woman testosterone injection, it's just too strong, too powerful, and it's not the place to start. You do that, like you always say, it's the frosting on the cake. You do that later, once you have a good solid foundation of estrogen and progesterone. Estrogen is what makes a woman a woman. That is the number one hormone or the main hormone for a woman to focus on in whatever context or situation that is, giving them that strong of a variable right off the bat. That's why you don't do too much too quickly because the skin and the hair issues will show up immediately, and then you're trying to backpedal and undo some of that.

Dr. Davidson: Exactly.

Dr. Maki: Now, I will say one more thing about that, about the hair loss is. Hair loss can also be kind of exacerbated by stress level. As your cortisol is through the roof, in some ways, that's where that hair loss comes from. Sometimes, especially now with the lock-down and COVID-19, everything that's going on, everybody's stress levels is a little bit higher than it needs to be. That is just not a good thing for preserving hair. Lack of sleep, too much job or family stress, too much exercise, aggressive cardiovascular exercise, are all things that can kind of make that hair issue worse, which is a really challenging thing to solve and calm down for women.

Dr. Davidson: Not to keep beating the horse hair, but she does mention that her hair loss was diagnosed as androgenic alopecia. That means androgenic is androgens. That would be too much DHEA, too much testosterone. In some regards, somebody is diagnosing her, saying her androgens are too high, creating the hair loss, which would be in the top of the head and the temples, mainly, when you have androgen-derived hair loss. In some respects, trying to dampen some of that androgenic response, and they're probably trying to do that a little bit with the progesterone.

[end] - we apologize because some of the transcription is missing. We will update shortly.