Progress Your Health Podcast - Episode 088

Is Prometrium Safer Than Progesterone?

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

Dr. Davidson: I'm Dr. Davidson.

Dr. Maki: How you doing this morning?

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

Dr. Maki: Pretty good. Pretty good. You were surprised by that question?

Dr. Davidson: Yes, a little bit [laughter].

Dr. Maki: Why are you surprised?

Dr. Davidson: Because we've been hanging out all morning. [chuckle] Now you're asking me how I'm doing.

Dr. Maki: Well, we had to start over on this podcast a couple of times, so that's okay. That's...

Dr. Davidson: I felt like I had rocks in my mouth. So I'm like, "Just stop it. Let's start it over." So I think this one will be the one [chuckle].

Dr. Maki: Yes, yes. So this one is a question we have from Donna. So why don't you go ahead and read it?

Dr. Davidson: Oh, okay. So yes, this is a listener question from Donna, it says, "Hello. I'm 62 years old with a uterus. Recently my nurse practitioner switched me from 6% progesterone cream to Prometrium capsules. The amount of cream I was using was 1/4 teaspoon two weeks out of the month." So it looks like they were trying to cycle the progesterone or cycle the hormones. "She also added in the INTRAROSA vaginal inserts instead of the estradiol cream for vaginal discomfort. I do not have many symptoms other than occasional sleepless nights and occasional hot flashes. My question is are the Prometrium capsules safe?" So the safety of the Prometrium capsules. "And is the cream safer than the capsules? Thank you, Donna."

Dr. Maki: So this Prometrium question comes up quite often. Very, very common from a from a conventional perspective to be prescribed Prometrium. The 6% that she talks about, that's basically 60 milligrams of a progesterone cream. Pharmacies just always seem to use the percentages like that, so what are your thoughts? What do you think?

Dr. Davidson: Well, I love the question. There's limited amount of information here, so I'm just going to extrapolate based on what I'm reading here. So it looks like she was using estradiol cream for vaginal discomfort. Now as we've always talked about, there's three different estrogens that our body makes: estrone, which we don't really make a lot of maybe when you're young, or fat cells make a lot of estrone, but typically we don't make much estrone; there's estradiol, as in the estradiol that she's using, which is estradiol, E2, is the strongest form of estrogen; and then there's estriol, which is the weakest, maybe you could call it, more gentle form of estrogen.

So I'm imagining that she was doing the estradiol cream and that she was also doing 60 milligrams of progesterone cream or the 6%, which honestly is a very low amount of progesterone, and she has a uterus. So what I'm thinking on why her nurse practitioner switched her to the INTRAROSA vaginal inserts, which is basically estradiol, so switched her to, I apologize, the INTRAROSA vaginal inserts is DHEA. So she switched her from the estradiol to the DHEA inserts, and switched her from the progesterone cream to a Prometrium capsule, is I'm thinking she was probably bleeding.

Dr. Maki: Yes. So it's interesting, now we're getting these questions and as they're coming in they're giving us the age and whether they have their uterus or not. We're training people whether she did that on purpose or not. But that that does make a difference - how old you are when we answer these questions, and whether or not you have a uterus makes a big difference in the eventual determination of what's going on. So we appreciate the fact that she-- granted there's still some of their other information

that we don't know, but I would agree. Now it's possible that it could be an estriol cream or an estradiol cream, that part we don't really know.

Dr. Davidson: It says estradiol cream for vaginal discomfort. So, that is...

Dr. Maki: I know we were talking about this beforehand and I know that it wasn't spelled exactly quite right, so you weren't really sure what it is. I assumed based the way it was written because it has the 'd' in there, estradiol, that it was E2 and not the E3. If it was estriol, we would never use estradiol as a vaginal cream. That's just not something that we would typically do.

Dr. Davidson: There are a lot of estradiol gels available that people use vaginally for vaginal dryness, to help with intercourse, with lubrication, with pain with intercourse, so it is common. So I could imagine she was doing the estradiol cream, but the six percent of the progesterone cream only, and even only doing it half of the month makes me think that she may have had a little thickening of that uterus lining, maybe she had some spotting, or maybe they did a transvaginal ultrasound and the lining of her uterus was a little thick, which is why this was switched to the Prometrium capsules. Now, the difference is Prometrium is progesterone, it is a bioidentical form of progesterone. There's some fillers in there that not a lot of people like: it's instant release, the doses on their only come as 100 or 200 milligrams. So switching dirt from you know, a tiny, tiny, tiny amount of progesterone cream to a pretty good amount of a progesterone capsule is kind of a change there, but I'm thinking it was probably maybe to protect that uterus.

Dr. Maki: Right. So using the progesterone cream with the estradiol cream. So she wasn't using the progesterone cream vaginally. She's more than likely applying that to her inner thigh or something. That wasn't giving her really any protection. The estradiol cream could easily cause some spotting or bleeding. But you're right, that's why we don't like to use Prometrium because what a lot of women, whether it's the dosing or the instant release, women just don't seem to tolerate it very well. I don't think that there's any inherent harm or danger to Prometrium, I think it's fin, and it is commercially available. So your insurance will cover it. But women just don't seem to do well on it. We've had many a women that wanted to try it because their insurance will cover it or something, and they just they just can't tolerate it. They have to go back to bioidentical sustained-release progesterone.

Dr. Davidson: Which is why I always say hormones are very based on the individual. Everybody is so unique and what's going to work for one person is not going to work for another person. So on a whole, there are a few people that do well on the Prometrium, but mostly, they really do much better on a sustained-release progesterone. And what I'm thinking here is the capsule that her nurse practitioner, because a lot of times the capsules work much better for sleeping than creams. Creams don't have as much an effect on helping you stay asleep through the night than the capsule. So the promethium capsule may be looking at protecting that uterus, and then at the same time, helping her sleep better.

Dr. Maki: Right, yes, And if she was using before she's using the estradiol cream, then some uterus protection, especially if you're applying an estrodial cream vaginally, that's exactly why we wouldn't do that because it's just a matter of time before she starts having some bleeding or spotting because of the strength of the estradiol. Now we don't know what the dosage of it is, one milligram, two milligrams, half a milligram. But the proximity to the uterine lining, the likelihood of that causing some issues, is pretty high.

Dr. Davidson: I'm thinking because there's this 'd' in the in here that she's doing the estradiol. I'm thinking that that, like Dr. Maki had mentioned earlier, is actually doing an doing an estriol, E3, I think would be a better bet for the vaginal discomfort because I know the new INTRAROSA, or they also call it the Pasterone, is basically a man-made DHEA, and DHEA has been very hot, like the new kid on the block in the last year and a half, two years, using that vaginally to help with vaginal dryness because the concept is it's not estrogen, it's not testosterone, it's a prohormone that can convert into estrogen, it can convert into testosterone, and can help with the vaginal dryness. So we'll see as things move on because I do know some people really like it, it does help with their vaginal lubrication, it helps with their sex drive. But a lot of times what I find is sometimes, it doesn't work.

Dr. Maki: Right, right. Now, and again, some of that same research that the DHA is supposed to help those things, helps increase libido. I've had a few patients where I've added DHEA into the estriol cream. So now you can even add testosterone into that. For example, if you have some major issues, a way to complement that is for us to-- Let's say for example a starting dose of an estriol cream would be four milligrams per gram. You apply a half a gram or you would use a half a gram few times a week, and then you would add in a little bit of DHEA, something like 10 milligrams of the DHEA into the same cream. So now you're getting the additional benefit of having that DHEA there.

So it's interesting, like you say, now that there's INTRA- I don't even know how long the INTRAROSA has been around. But it's interesting that now it comes in a commercial form.

Dr. Davidson: And I've had patients that are on it. The nice thing about it is it doesn't-- if you test somebody's blood if they're using this DHEA vaginally is that their estrogen and testosterone are still very low. So it's a way of being able to bring some relief to female without raising up their hormone levels. But at the same time, DHEA is, technically, a hormone. It's a steroid hormone. It's not estrogen or progesterone or testosterone, but it's still a hormone.

What I find is if you're going to be using the any kind of DHEA vaginally or even orally, you know, lots of people take DHEA orally, is you've got to test the blood work for it because on these DHEA inserts, is there 6.5 milligrams, is that can be a lot of of DHEA taking orally, but doing it transvaginally isn't quite as much. But I have found when I do the blood work on the DHEA sulfate, which is the best way to test for DHEA in the blood, is DHEA sulfate, which is a metabolite, is the levels are a little elevated for their age. And I have found people say that they do have some irritability.

In fact, I had a patient yesterday that was telling me that her husband said make sure that you talk to her about your hormonal rages. Then I had found out since I had talked to her last, her gynecologist had put her on the DHEA inserts, and I'm like, "Your DHEA is higher than it was when I've tested it before." Anybody on higher levels of DHA is going to get a little testy.

Dr. Maki: Yes, right. And for a woman, DHEA is basically their form of testosterone. It is kind of the predominant androgen - DHEA and testosterone are both considered androgens. The amount of DHEA that a woman produces is quite a bit more than testosterone, so it does have a significant impact on how a woman's going to feel in that respect.

Dr. Davidson: Exactly. So, with Donna, like I said, everybody is an individual. It depends on what works for you. So I'd say monitoring that vaginal discomfort or dryness, if it starts coming back, then the DHEA inserts might not be for her. If she notices she's getting a little irritable, the DHEA vaginal inserts might not be for her. The Prometrium, like I said, progesterone is very safe. Progesterone can be incredibly safe and very protective of the breast tissue, the uterine lining, so I know she's worried about the safety between that and the cream, but if she were on any kind of estrogen - she's not at the moment, because her doctor switched her from the estradiol to the DHA

inserts - but if she were on estradiol, then safety-wise, she needs to be on a stronger form of progesterone than the cream.

Dr. Maki: Yes, right. From that respect, going from the cream to the Prometrium capsule was kind of the right move to make if she stayed on the estradiol. And if she's tolerating the, I'm assuming 100, does it say 100 milligrams?

Dr. Davidson: Well we know Prometrium's either 100 or 200, probably 100, I would imagine.

Dr. Maki: Yes, probably 100. So if she's tolerating it, then that's fine. There's no real issue there as long as she's able to handle it. Now, what are the side effects? I think we've done a, like I said, we've done-- the Prometrium thing has come up a few different times. You might get anxiety, you might gain some weight. What are some other side effects that you've seen from Prometrium?

Dr. Davidson: For certain individuals, if the progesterone is too high for them, they will be sometimes a little lethargic during the day and cause a little depression because it does relax you. Too much relaxed means you have no motivation, so I do see some depression. And like you said, the weight gain, and I think that has more to do with like water weight. So you'll see a lot of puffiness.

Dr. Maki: Yes, sure. Right. And those are things that would happen kind of in that premenstrual window, the seven to 10 days before your cycle.

Dr. Davidson: No, she's not cycling because she's 62 years old. Right?

Dr. Maki: Right, right. She's not but I'm just saying in general, the same thing. So the interesting part that we didn't really touch on, she was taking the progesterone cream for half the month, which in some ways, when a woman is menstruating still, her body really only produces progesterone from ovulation until her period starts again, so her nurse practitioner, she's trying to mimic that whole idea. But when a woman is taking estrogen, pretty much all month long, you can't really cycle or should not cycle the progesterone. They need to be taken in tandem. Again, the rule is you never give a woman unopposed estrogen.

Now granted we do rhythmic dosing, which we're going to talk about fairly soon, rhythmic dosing, you use our estradiol cream and a progesterone cream, that's an exception. But in that context, the progesterone cream is only used for half of the month

because you're encouraging the woman to actually have-- if she has her uterus, like in this case, if she is using rhythmic dosing because she has a uterus even at 62, she would have a period again. Now, she may not want that. That's more of an elaborate conversation that has to align with what the woman's trying to accomplish as far as where her goals are, but in this context we would we would recommend for Donna to be taking progesterone all month.

Dr. Davidson: Yes, you're right. I mean, rhythmic dosing is great, but it is a little bit, I wouldn't say complicated, but you have to follow the patient. You can't just give them a prescription and see them next year. You have to follow up with them, see how their cycles are, do their blood work, they get their screenings and all that. So it is a bit of a process if somebody's going to undertake that, and we do that with a lot of patients because rhythmic dosing works great with some and of course not great with others. It depends on the person.

I would say for Donna, the Prometrium, there are some side effects to Prometrium that, if she's not on the estradiol at all and she's just on the DHEA inserts, she might not even need to take the Prometrium.

Dr. Maki: Yes, right, because the DHEA is not going to have an effect on the uterine lining, she just might need the one - she could go from having two prescriptions down to just one. Just use the insert if that-- she says she's not really having a lot of symptoms anyways. A few sleepless nights here or there. Prometrium doesn't really help too well with the sleep that much.

Dr. Davidson: It might help her sleep throughout the night, but if it's just a few sleepless nights, I mean we all get a few sleepless nights. I'd say if she was having three or four sleepless nights out of a week, then yes, then she needs to take something to help, that progesterone would definitely be a great way to help her sleep. But if it's just a couple of times a month, I mean, I think I get a couple of sleepless nights if I watch a scary movie or watch the news before bed [laughter].

Dr. Maki: Yes, I think you get it more than that.

Dr. Davidson: Well, I do take my progesterone.

Dr. Maki: And you're not allowed to watch scary movies, you can't watch scary movies. So I think that we covered the bases on Donna, do you have anything else to add for Donna?

Dr. Davidson: No, I appreciate all of you listeners and readers, especially with your questions. We welcome that, we like to have the conversation, and it's actually really awesome. So thank you Donna, thank you everybody.

Dr. Maki: Sorry we can't get two more of them. There's so many questions that come in. We do try to keep up, and we're trying--

Dr. Davidson: And I promise we keep them in a vault. We always have them if we need-- We'll try to get to all of them at some point [chuckle].

Dr. Maki: Yes, but as we do these more will keep coming in and we just try to pick out the ones that are you somewhat the most the easiest for us to understand what's going on, what their question actually is, and the easiest ones that are for all of you to understand as well, and that we can relate to the most amount of people. So that way we, like you say continue the conversation, and then we have really an unlimited amount of content to produce because now we are answering everybody's questions. It's kind of like a new modern version of Dear Abby or something. It's just not in the newspaper, it's actually in a digital format, and now people are able to get the answers they want.

Dr. Davidson: And know that if we didn't get to your question, we still write them down and try to put together other podcasts that might coalesce with that because really when it comes to hormones like, like I say, we're all unique, but we all have a lot of common themes. So if you if you don't hear us answering your questions, know that we do have it and we try to take it and put it into some form or some kind of content so that other people can have use of it.

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

Dr. Davidson: I'm dr. Davidson.

Dr. Maki: Take care. Bye bye.