


GET YOUR ENERGY,
SEX DRIVE, MEMORY
AND BODY BACK!

THE PERI MENO PAUSE PLAN



A GUIDE TO
SURVIVING
THE HORMONAL
CHANGES OF
PERIMENOPAUSE

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LEADING EXPERT IN BIOIDENTICAL
HORMONE REPLACEMENT THERAPY (BHRT)

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Dedication

This book is dedicated to all the clients and patients I have seen since starting out (especially “green”) in clinical practice in 2004. They are the teachers to have helped make this book possible.

Please get in touch

We want to hear your questions and concerns. We are here to help you fix your hormones. Send us an email at: help@progressyourhealth.com

About the Author



The book is written by Dr. Valorie Davidson. She is the co-founder of Progress Your Health, Inc, co-host of the Progress Your Health Podcast, and a graduate of Bastyr University. She has helped thousands of women since 2004 with hormonal issues including Hypothyroidism, Adrenal Dysfunction, PMS, PCOS, Perimenopause, and Menopause.

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Introduction

Perimenopause can start as early as your 30's and last until you reach menopause, which could be as late as your early 50's. That is a long time to deal with the unwanted symptoms or to be put on habit-forming, ineffective medications. In this book, you are going to learn options to help bring relief and navigate through Perimenopause.

The symptoms of Perimenopause are vastly different from menopause and can really affect a woman's life. Perimenopause is not often discussed in the healthcare system, leaving women suffering without effective or safe treatment options.

By the end of this book, you will learn effective and safe tools to make Perimenopause an easy transition.

In this book you are going to learn:

- What is it, and am I in Perimenopause?
- What are the symptoms of Perimenopause?
- What hormones are affected in Perimenopause?
- What are the best lab tests for Perimenopause?
- How do I read and understand lab testing for Perimenopause?
- What can I do safely to balance my hormones in Perimenopause?

In this book you will learn options to help you:

- Get back your energy
- Get rid of hormonal weight gain
- Manage irritability and moodiness
- Manage heavy, cramping, irregular periods
- Control Perimenopausal acne and hair loss
- Sleep issues such as staying asleep through the night
- Get your short term memory back

Who this book is for:

- This course is intended for women in their late 30s to early 50s.
- Any woman concerned about their hormones and health.
- Any woman looking to improve their energy, mood, sleep, and weight.



01

**Symptoms
Involved In
Perimenopause**

Perimenopause is a phase in a woman's life that can last months to years. Typically the age ranges from the late '30s to the early '50s. Some women can have relatively minimal symptoms. While others can experience a wide range of symptoms during Perimenopause. The symptoms can significantly impact a woman's quality of life, ranging from trouble sleeping to mood issues to memory issues. Below you are going to learn the main symptoms of Perimenopause.

Period Changes

Period changes are common in Perimenopause. Women will have heavier periods, more painful, longer periods, and even two periods in a month. The hormonal changes in Perimenopause can create a lot of spotting or even chronic bleeding for weeks. This unpredictable, chronic loss of blood can cause low iron levels (anemia). And this is the most common time that women will get hysterectomies (removal of the uterus).

Night Sweats

Night sweats are often mistaken for symptoms of menopause during this time. But it is very common to have night sweats in Perimenopause. One distinction between menopause and Perimenopause is that you do not see daytime hot flashes in Perimenopause. Also, night sweats in Perimenopause are not nightly. Usually, they occur up to 10 days before a period, and once the period starts, the night sweats dissipate.

Irritability

Irritability is very common in Perimenopause. The hormonal changes can cause mood swings and anger. One distinction is the mood is more angry and irritable than

sad in Perimenopause. Later you will learn what hormonal changes are creating this effect on the mood in Perimenopause.

Stressed Out

Women in Perimenopause will tell me that they are really stressed out. They cannot understand how it could be that they are older, and life is a little more sane, yet they are more stressed out and anxious than ever before. Many women will tell me how they raised their kids as a single mom with two jobs and feel more wound up and stressed now when life is calmer. The hormonal changes in Perimenopause can cause one to feel very edgy, highly anxious, and wound up.

Sleep

In Perimenopause, most women have no trouble falling asleep. Within minutes of lying down, they are out. Staying asleep is the trouble. They either wake up multiple times in the night or will sleep hard for 2-4 hours, only to find themselves awake for hours.

Weight Gain

Weight gain, regardless of a change in diet or exercise, is one of the top concerns with Perimenopausal women. In Perimenopause, it seems like you instantly put on 10-15 pounds for no reason. The common theme is that it is easy to gain weight but difficult to lose it, no matter what you do.

Short Term Memory Has Disappeared

Many women will complain that they have a hard time remembering anything. Their kids will laugh because they've asked the same question more than once. They need to make lists and take notes, so they don't forget. I promise, this is not dementia, it's your hormones.

Acne

Even if you have never gotten a pimple in your life, it is common to break out in Perimenopause. The chin and jawline are the most common areas to have a breakout.

Hair Loss and/or Thinning

In Perimenopause, women will notice their hair is not the same. It doesn't seem as thick and will shed more than it used to. The hair will still grow as fast as it usually does, but it just seems the thickness is less. The most common areas to notice this change is at the temples, hairline, and top of the head.

Sex Drive Is Low

Libido can be nonexistent in Perimenopause. Women will say sex is just not on their brains. Or once the day is over, and they are so tired, the thought of “more work” seems exhausting. There might be a thousand things on your mind, but sex is not one of them. And your partner is frustrated because you are not initiating like you used to. But this loss in sex drive seems more mental than physical. Because once things get “rockin and rollin,” it's fine. In Perimenopause, there is no dryness or lack of sensitivity as there is in menopause. It's like I said, sex is not on your mind.

Skin Texture and Muscle Mass

In Perimenopause, it seems that your skin texture and elasticity has changed almost overnight. Suddenly you find yourself on Youtube looking up makeup tricks for “mature-skin” (maybe that is just me). And your muscle mass has dropped dramatically. Is it a trick of the eye? Maybe, because we are way too self-critical with ourselves. But with the hormonal change, there can be slight changes to the tonicity of your muscles and the elasticity of your skin.

Tired Mentally and Physically

In Perimenopause, women are tired. I would have to say this is one of the top three complaints. But it is not just physically fatigued. Women in Perimenopause are mentally tired with a lack of motivation.



The Perfect 28-Day Cycle

To understand the symptoms of Perimenopause, you need to understand the 28-day hormonal cycle or the way your hormones are being secreted during your menstrual cycle.

A Perfect 28- Day Cycle

Unless you have had your uterus removed (hysterectomy), you will still have a period in Perimenopause. But your period can change and become quite different from what you normally experience. Let me explain a few details about the menstrual cycle. I promise to keep it short, but I think you need to understand the menstrual cycle to know what is happening in Perimenopause. This is written in a “perfect 28-day cycle.” Not everyone has a 28-day cycle. Some have 25-day cycles, others 35-day cycles, and everywhere in between, which is completely normal. But for the sake of physiology, I am going to describe a 28-day cycle.

DAY 1 TO 5

This is when you have bleeding during your period. The estrogen and progesterone levels are basically nonexistent. The low hormone levels cause the lining of your uterus to shed (hence, a period). That is why if you test your hormones on a blood test at this time, the levels are low. I have had patients tell me they are menopausal because their doctor tested their blood, and they had no hormones at all. I then asked them, ‘were you on your period when you had the blood tested?’ Of course, they were, and that is why blood testing might not be a great way to check for Perimenopause. But I will explain in detail about labs and hormone testing soon in this book.

DAY 6 TO 11

Estrogen levels are rising. No/very low progesterone levels.

DAY 12 AND 13

Estrogen levels spike through the roof. This fast, immediate rise in estrogen is what stimulates ovulation.

DAY 14

The egg leaves the ovary and is set to travel down the fallopian tube. The egg will then hang out at the top of the uterus waiting for fertilization, this is ovulation. Ovulation marks a pivotal point in the menstrual cycle. Once the egg leaves the ovary, it leaves a spot on the ovary called the corpus luteum. The corpus luteum will start to secrete progesterone. Progesterone doesn't get produced until this time. This is also why if a woman does a blood test for her progesterone before Day 14, it will show low.

DAY 14 TO 20

Progesterone is rising. Estrogen levels are slowly reducing and leveling out.

DAY 21

This marks the highest level of progesterone in your body.

DAY 22 TO 28

Your level of progesterone and estrogen are declining. Once they have dropped (because there was no fertilization/pregnancy), then you will get your period. Now you are back to Day 1.



03

**Why Are These
Perimenopausal
Symptoms Happening?**

Period Changes

There can be missed periods, longer periods, heavier periods, lighter periods, multiple periods in a month, spotting. Basically, your periods have changed, or they seem to change every month.

This is caused by the reduction of progesterone during the second half of the cycle (Day 14-28). Estrogen loves to “grow things,” especially the lining of the uterus. Progesterone prevents estrogen from growing the uterine lining too thick. And progesterone helps solidify the architecture of the uterine lining.

The drop in progesterone causes the uterus lining to become thick and “sloppy.” This, in turn, can cause heavier periods, exacerbate fibroids, spotting, multiple periods in a month, and increased intensity of cramping. Because of the reduction of progesterone, every month can be different from the next.

Night Sweats

While the progesterone levels drop dramatically, the estrogen levels during Perimenopause will reduce slightly. The drop of estrogen prior to a period will cause night sweats up to 10 days before your period. Also, during Perimenopause, the adrenal glands take a real beating. The adrenal glands are your “stress organs.” In Perimenopause, it is common for the cortisol production from the adrenal glands to become disrupted.

Cortisol is secreted from the adrenal glands in a diurnal fashion. Meaning cortisol is highest in the morning, so we are bright-eyed and bushy-tailed, ready for the day. It then reduces over the afternoon and is lowest in the evening, so we can fall and stay asleep. In Perimenopause, the diurnal curve of released cortisol from the adrenals is degraded. The cortisol is low in the morning, making you tired. And will rise at night, causing sleep issues and night sweats.

Irritability

The drop in progesterone during Perimenopause can cause irritability. Progesterone is very relaxing and can help reduce cortisol and raise GABA. When progesterone is reduced, it can cause mood swings, and more specifically, irritability. Even if the situation is not warranted, women will comment on having a very short fuse, going from feeling normal to very angry. In Perimenopause, the testosterone and DHEA (androgens) levels stay fairly consistent. Meaning the androgens are not being buffered by the estrogen and progesterone, making you feel easily... “testy.”

Stressed Out

Again, that darn drop in progesterone can really wreck a mood. Not only can it cause one to feel more irritable, with a shorter threshold for patience, but it can also cause one to feel really edgy, highly anxious, and wound up.

Sleep

The drop in progesterone levels in Perimenopause can cause trouble staying asleep. A common scenario is that there is no trouble falling asleep, but staying asleep is another story. Many women say they fall asleep within minutes. But after 2-4 hours, they will wake up and stay up for 1-2 hours or wake up multiple times until it is time to wake up for the morning. At that time, they are exhausted and not ready to start the day.

Weight Gain

Remember above, where I said estrogen likes to “grow things?” Well, estrogen likes to grow the waistline too. Estrogen is the best, most amazing hormone in the world. But without restraint, she can be like a runaway train. Without progesterone to rein her (estrogen) in, she will cause weight gain no matter what. Also, coupled with the adrenals pumping out cortisol inappropriately, that is a sure way to gain belly fat.

Short Term Memory Has Disappeared

It is really common to feel like your short term memory has run off in Perimenopause. Many women will comment that they feel forgetful and unfocused. They have notes and lists, and their families tease them about asking the same question repeatedly. This is really due to the adrenal glands. When the progesterone drops, this can cause a burden on the adrenal glands. Your adrenal glands are your “flight or fight” organs and help you deal with stress. When the progesterone level drops, your adrenal glands have to work harder. Pregnenolone is a hormone that is secreted from the adrenal glands. During Perimenopause, pregnenolone levels can drop dramatically. Pregnenolone is helpful in short term memory, learning, memorization, and mental “energy.” Later, you will learn more about pregnenolone testing and dosing.

Acne

When progesterone plummets and estrogen dips during Perimenopause, who is left? Testosterone. Testosterone rises to the top of the “hormone chain” because the progesterone and estrogen cannot buffer the androgen effects. Hence, testosterone can cause acne and pimples.

Hair Loss/Thinning

As mentioned, in Perimenopause, the testosterone is not balanced by progesterone and estrogen. Testosterone ends up leading the hormonal pack. Androgen/testosterone derived hair thinning, and loss is very common. Most specifically, hair loss/thinning will be seen in the temples, hairline, and top of the head.

Sex Drive Low

I wish in Perimenopause with the testosterone not being buffered by the estrogen and progesterone would at least spike the libido. Alas, it does not. For us ladies, sex drive is about the balance of hormones. In Perimenopause, many women will complain that their sex drive has run away. They are not having any pain with intercourse. But libido is just not on the brain. The slight drop in estrogen, a rapid

drop of progesterone, and changes in the adrenal hormones can completely take sex off the mind.

Skin Texture and Muscle Mass

With age, we all know it is inevitable that we are going to have skin changes. But in Perimenopause, many women feel like they have “aged overnight.” When the hormones change in Perimenopause, the cells lose hydration. This makes the skin look like there are more fine lines and a bit of sagging. As mentioned above, when the estrogen drops slightly, and the progesterone plummets, the testosterone can lead the show. This can also cause the skin not to feel as soft and supple. You would think the unopposed testosterone would cause muscle gain. But because the skin loses hydration and elasticity, it feels like the muscles shrink as well.

Tired Mentally and Physically

One of the most common complaints in Perimenopause is feeling tired all the time. In Perimenopause, the sleep pattern is disrupted, which in part, causes fatigue from poor sleep. Because we have so many receptors in the brain for estrogen, when the estrogen drops slightly in Perimenopause that can cause women to feel mentally tired and unmotivated.



04

What Hormones Are Affected in Perimenopause?

Before we get into lab testing hormones and interpreting the results, I want to touch on what hormones are affected in Perimenopause. I am going to go over the reproductive hormones and stimulating hormones, as well as the adrenal gland hormones and thyroid hormones. I do think it is important to teach you about insulin, which comes from the pancreas. And testosterone, which actually comes from both the ovaries and adrenal glands (although a small amount occurs in peripheral tissue conversion). Now don't get glossy-eyed on me, this is really interesting. And it is important to know when interpreting the results of your own hormone tests.

Stimulating Hormones FSH & LH:

FSH stands for Follicle Stimulating Hormone, and LH stands for Luteinizing Hormone. They are not really hormones but are releasing factors or stimulating hormones that come from your brain, specifically the pituitary. Your brain monitors the levels of hormones in your body and will respond depending on whether those hormones are too high or too low.

For example, if your ovaries are working in perfect function, your FSH and LH levels will be fairly low, somewhere between 2 to 9. But let's say your ovaries have been removed, resulting in low to no circulating estrogen or progesterone, then the FSH and LH levels will be very high, well over 70 to 100. This system works in what is called a "negative feedback loop." If the levels are low, then the brain raises the stimulating hormones trying to get the glands to make more hormones.

For example, if you were to ask your daughter to clean up her room, and she doesn't do it and ignores you. You might start raising your voice to get her attention so that she gets up and cleans her room. This is the same with the stimulating hormones from the pituitary. The brain will raise its "voice" to get the appropriate endocrine/hormone gland to do its job.

This works the same way if the hormones are “too high.” If someone is taking too much hormone therapy, the stimulating hormone drops very low in consequence of the hormones being too high. For example, if someone were pregnant or taking a strong form of birth control, then the FSH and LH would be nonexistent, less than 1.0, due to the high levels of hormones.

Hormones Secreted From the Ovaries, Adrenal Glands, and Thyroid

Below you will learn about the hormones that are affected in Perimenopause. We have many hormones that are secreted in our bodies, but I am going to focus on the main ones that are impacted in Perimenopause.

Estrogen

We have three main circulating estrogens: Estrone (E₁), Estradiol(E₂), and Estriol(E₃). Estradiol is the strongest of the three, meaning it has effects on the heart/ cardiovascular system, brain, bones, and pretty much every system in your body. It even has an effect on hair, skin, and nails. Estriol is very gentle. It has a beautiful effect on skin and hair, and it can help balance the strong effects of Estradiol. Estrone is made by the ovaries but also made by the fat cells (adipose). Estrone is necessary for the body but not at high levels as that can cause some unwanted symptoms. For example, it is perfectly normal for young women/teens who have just started cycling to have higher levels of Estrone. This is normal as the body is learning how to cycle. But having these higher levels of Estrone can cause some of the common symptoms teens display like moodiness, grumpiness, weight gain, and carb cravings.

Progesterone

Progesterone increases after ovulation, which is commonly around Day 14 of the menstrual cycle. It is very relaxing and calming. Progesterone also helps balance estrogen. This is why the drop in progesterone during Perimenopause can cause a lot of those unwanted symptoms we talked about, which you will learn more about as you read on.

DHEA

DHEA (dehydroepiandrosterone) is mainly made from the adrenal glands. It is commonly referred to as a “hormone precursor,” meaning it can convert to other hormones. The best way to describe DHEA is that it is an androgen and, in some ways, similar to testosterone. DHEA is characterized as a “male hormone” creating male characteristics, but we ladies need DHEA in our bodies as well, just not at the levels that a male might have it.

Cortisol

Cortisol is made from the adrenal glands and is part of our “stress management system.” Cortisol is essential to life, but when out of balance can cause many unwanted symptoms. Cortisol is supposed to be released in a diurnal fashion, meaning it is high in the morning, slowly falls throughout the day, and is low at night. This diurnal release of cortisol helps us get going in the morning, and then because it is low at night, it helps us sleep. Cortisol is also released when there is a stressful event.

Cortisol and Insulin Interaction

Let’s look at the interaction between cortisol and insulin. Insulin comes from the pancreas in response to glucose in the blood. You eat something, such as a cookie. The cookie will be converted into glucose/sugar in your blood. In response to the rise in blood sugar, the pancreas will release insulin to allow sugar to enter the cell for fuel. This is where it gets interesting. Insulin is the only fat-storing hormone. If you do not have any insulin then you have diabetes type 1 (sometimes with DT1.5) with super high levels of blood sugar and can be very slender. Diabetes is a very large topic itself as there are DT1, DT2, and DT1.5, and even more, will be uncovered/labeled with time. But for this book on Perimenopause, just know that if insulin is elevated, then you store fat very easily.

Back to where it gets interesting. Recall that cortisol is released in response to stress. When cortisol is released, it will cause an immediate rise in glucose, even if you didn’t

eat anything. That rise in glucose will then trigger the pancreas to release insulin to facilitate glucose into the cell. This really is a beautiful system. If a bear were going to attack you, your adrenaline and cortisol would rapidly rise, which would then pull glucose from your large muscles to help you run like the wind.

This is a potentially life-saving system at work here. I don't know where you live, but there are not a lot of bloodthirsty predators where I live. Here is the catch, you are sitting at your desk, and you get an awful, horrible email from a client or your boss. Your cortisol immediately spikes. This sends a signal to cause a rise in glucose (even though you didn't eat anything). But you are not running from a bear, you're sitting in your chair in front of the computer. That rise in glucose will cause the pancreas to release insulin.

Because you didn't burn that excess glucose in your "fight or flight" reaction, the end result is the glucose enters the cell and is stored as fat.

Yes, stress can make you fat. This is one of the main reasons why women gain weight in Perimenopause and menopause. Estrogen and progesterone help to buffer this cortisol and insulin reaction. This is why when you are 20 years old, you can eat burgers and fries and chase it down with a milkshake, yet do not gain weight. It is also the same reason that you can lose weight so easily when you are younger. Fast forward to when you are 46 years old, and on Sunday night, you have some Mexican food, skipping the chips and salsa (maybe one glass of wine). Come the next day, and you have slept terribly and wake up 3-5 pounds heavier.

Pregnenolone

Pregnenolone comes from the adrenal glands and is (like DHEA) considered a prohormone because it can convert to other hormones. Pregnenolone is important in learning, memory, focus, and mental energy. While it is mainly made from the adrenal glands, we do produce a small amount in the brain and spinal cord, making pregnenolone neuroprotective. Pregnenolone is very sensitive to stress and will decline in states of acute and chronic stress. It also declines with age. For example, when we are young, our pregnenolone levels are really high. That is why when you

are 25 years old, and you can sit in a meeting, not take notes, look out the window, and still remember everything. When pregnenolone levels are low, you can't even remember where you parked your car. During Perimenopause, you will often see very low levels of pregnenolone.

Testosterone

Testosterone is not a reproductive hormone for women like it is for men. We ladies make most of our testosterone from the adrenals (by way of DHEA), and a slight amount is converted in the peripheral tissues and made in the ovaries. But the point here is the majority of testosterone is converted from DHEA that is made from the adrenal glands. Which is why I consider testosterone to be an adrenal-hormone for women. When I see blood work of a woman and her testosterone levels have changed, I will ask them, "what stressor happened to you?" But testosterone does not drop much in Perimenopause or menopause. The drop happens more so because of stressors and adrenal insufficiency.

Thyroid

It is important to test the thyroid in Perimenopause. Low thyroid function can make Perimenopausal symptoms worse. And low thyroid function can push a woman into early Perimenopause and menopause. Thyroid function itself can decrease with time and age. In Perimenopause, the progesterone has dropped, and the estrogen is present but slightly lower, which can cause a lot of pressure on the thyroid, making it common in Perimenopause to see the thyroid function drop. A little background about thyroid function: the main thyroid tests I like are a TSH, FreeT₄, FreeT₃, and Reverse T₃.

TSH (Thyroid Stimulating Hormone)

TSH is similar to FSH and LH. It comes from your brain (the pituitary) and monitors overall thyroid levels in your blood. Like the FSH and LH, it too works in a negative feedback loop. If thyroid function is low, then the TSH is high. If thyroid function is high, then the TSH is low.

FreeT4, FreeT3, and Reverse T3 (RT3)

You never want to rely on a TSH test alone to evaluate thyroid levels, making it important to also test the FreeT4 and FreeT3. “Free” hormones mean they are unbound and active. Your thyroid gland mainly makes T4, and it will travel in your bloodstream. Mainly your liver and some peripheral tissues will convert T4 to T3.

T4 has a very long half-life (up to 7 days), but it is not as active as T3. Free T3 has a very short half-life (less than 24 hours), but it is the main active component to the thyroid. You want to make sure the T4 is converting to T3 properly to assess thyroid function. In some cases, T4 can convert to ReverseT3 (RT3) instead. RT3 is an inactive metabolite meaning it has no thyroid activity.

Antibodies for Hashimoto's

When the female reproductive hormones decline, the pressure on the thyroid can cause an activation of Hashimoto's. I always make sure to test the antibodies for Hashimoto's as well. These antibodies are TPO (thyroid peroxidase antibodies) and TGab (thyroglobulin antibodies).



05

**Testing Your
Hormones and
Interpretation**

I have heard from many frustrated women that their doctors will not test their hormones because they assume that hormone testing is not necessary. Or women have had hormone tests, and there is not a clear interpretation or reading. I am going to show you some common lab tests for hormones and how to read them.

Blood Testing

I have used blood testing more than any other test for hormones since 2004. It can be cost-effective because insurance can cover some or most of the blood testing. And if someone is paying out of pocket, it is fairly inexpensive using a physician's private account. But doing a blood test is looking at one day of your cycle. So timing is the most important part here when doing a blood test for Perimenopause.

Remember the "Perfect 28-Day Cycle?" During Days 1 to 5 (your period), both progesterone and estrogen levels are low. You do not want to do a blood test for hormones during Days 1 to 5. Also, do you remember progesterone does not rise until ovulation (Day 14), with its peak at Day 21? That means if you are doing a blood test for hormones, you want to have your blood drawn between Day 16 and Day 25 for the best accuracy.

To make hormone blood testing more clear, I want to clarify what tests I order when checking hormones for Perimenopause. And I am going to explain the reference ranges as that can be extremely misleading.

Follicle Stimulating Hormone & Luteinizing Hormone

FSH:

Common lab reference ranges for FSH:

- Follicular Phase 2.5 - 10.2 mIU/mL

- Mid-Cycle Peak 3.1 - 17.7 mIU/mL
- Luteal Phase 1.5 - 9.1 mIU/mL
- Postmenopausal 23.0 - 116.3 mIU/mL

LH:

Common lab reference ranges for LH:

- Follicular Phase 1.9 - 12.5 mIU/mL
- Mid-Cycle Peak 8.7 - 76.3 mIU/mL
- Luteal Phase 0.5 - 16.9 mIU/mL
- Postmenopausal 10.0 - 54.7 mIU/mL

You might be thinking, “what is follicular, mid-cycle, luteal peaks, and phases?” And the reference ranges for all of them are vast. Well, ignore all those phases, peaks, and numbers.

My Interpretations of FSH and LH Levels

If the FSH is under 9, you can generally say they are in very good ovarian function and not in menopause or Perimenopause.

If the FSH is 12-20, then that is just entering Perimenopause. They are not quite in the thick of Perimenopause, but they are on their way. These women might have some of the perimenopausal symptoms, but not many.

If the FSH is 25 to 45 they are in Perimenopause.

If the FSH is over 50-80, that is menopause. Menopause, like Perimenopause, is a phase in life. It can last years. An FSH level of 50 -90 usually means a woman can be having a lot of menopausal symptoms.

If the FSH is over 100, then the woman is post-menopausal, meaning she has gotten through menopause. An FSH over 100 usually means she can have some menopausal symptoms such as hot flashes or night sweats, but they are diminishing and most

likely won't have the cascade of other symptoms of menopause that a woman with an FSH of 50-90 will be having.

I usually use the FSH as my marker for Perimenopause and menopause more so than LH, as the LH level can surge pretty high before ovulation. Also, LH can be elevated in PCOS (polycystic ovarian syndrome). But on average, if you see an LH higher than 25, then you know that woman is in Perimenopause. And if the LH is over 35, then that is pointing to menopause.

An exception to FSH and LH: if a woman had her blood work done just before ovulation (day 11-13), then sometimes the FSH and LH are higher trying to encourage ovulation. Then you look at the estradiol and progesterone levels. In a woman that is not Perimenopausal, you will see the estradiol levels are fairly high, over 150 mg/mL, and the progesterone nonexistent less than one, usually at .3ng/mL.

Estradiol

Estradiol is the best test for estrogen. We have three circulating estrogens: Estrone, Estradiol, and Estriol. Doing a Total-Estrogens blood level does not have the accuracy that doing an Estradiol-only does. Like FSH and LH, the reference ranges for Estradiol are hard to understand.

Common lab reference ranges for Estradiol:

- Follicular Phase 19 - 144 pg/mL
- Mid-Cycle 64 - 357 pg/mL
- Luteal Phase 56 - 214 pg/mL
- Postmenopausal <less than 31

Ignore these reference ranges because if you are perimenopausal and still cycling, then every day is different. When I described the "Perfect 28-Day Cycle," estrogen was low to nonexistent during your period, spiking prior to ovulation. That is why I like to have the blood tests run on Day 16-24. During that time, the estrogen will start declining.

Blood Test for Estradiol between Days 16 to 24

- If the Estradiol is over 150 during this time, that is estrogen dominance.
- If the Estradiol is under 50, that is too low for estrogen.

Progesterone

I am going to say it again, we do not make progesterone until after ovulation. Just like with Estradiol, I like to have the blood test between Day 16 and Day 24. Again ignore the typical lab reference ranges, which are hard to understand.

Common lab reference ranges for Progesterone:

- Follicular Phase <1.0 ng/mL
- Luteal Phase 2.6 - 21.5 ng/mL
- Postmenopausal <0.5 ng/mL

I have to say that at least the typical reference values are trying to follow the idea that progesterone is only made after ovulation or near Day 14. But the reference ranges are so wide that anyone can fall into these ranges.

Blood Test for Progesterone Between Days 16 to 24

- If the progesterone is less than 3, then that woman is in Perimenopause.
- If the progesterone is less than 3, the Estradiol is under 50, and her FSH level is close to 50, then she may even be entering menopause.
- If the progesterone is 4 to 8, then that means that woman is just entering Perimenopause.
- If the progesterone is over 8 and even in the teens, that is the perfect range and the woman is not in Perimenopause.

Hysterectomy or Irregular Periods

What happens if you have had a hysterectomy and don't have periods? If you don't have a uterus (hysterectomy) but still have your ovaries, you're obviously not going

to be having a period. But at the same time, your ovaries might be making hormones, we just do not know where you are in your cycle.

Similarly, if you are in your late 30s to mid-40s and are missing periods occasionally, or getting two in a month, making it impossible to determine days 16 to 24 in your cycle. You might be wondering when to do a blood test.

For a woman who is unsure of where she is in her cycle, has had a hysterectomy or a history of irregular periods, this is what I look at:

- The FSH is 12-20, Estradiol is 50 or above, and progesterone is less than 3, then that woman is just entering Perimenopause.
- If the FSH is 25-45, Estradiol is over 50, but the progesterone is less than 1.0, then you are in Perimenopause.
- If the FSH is under 10, Estradiol over 50, and progesterone over 8, then we caught you in the perfect testing range between Day 16-25, and you are not in Perimenopause.

Testosterone

Testosterone levels do not drop that much in Perimenopause. Often I want to make sure the testosterone levels are not low but also not too high. The typical testosterone reference ranges are way too broad. Some labs say the reference range should be 3 to 41 ng/dL and others 2 to 45 ng/dL. Trust me, a woman with a testosterone level of 2 is going to feel much different than a woman at 45 versus a woman at 25.

Testosterone levels are more subjective. Meaning I have had women who felt terrible at a level of 40 and were breaking out and losing hair. But there have been other women who felt amazing at higher levels of 65. As with all hormones, you need to get the subjective information about symptoms and how a woman is feeling because it is just as important as the objective data of lab testing.

These are the levels that I consider when working with a woman who is in Perimenopause. If the testosterone level is higher than 45, and she is not taking testosterone, we need to actively reduce those levels. If the testosterone levels are

under 15, then we want to consider some testosterone replacement in low doses if she is having symptoms that warrant it.

DHEA-Sulfate

The best way to test for DHEA (dehydroepiandrosterone) is to do the DHEA-sulfate. It is much more accurate and specific than a total DHEA level. Lab reference ranges are very hard to interpret for DHEA and DHEA-sulfate. That is because the labs are trying to account for the fact that DHEA levels decline with age. It is important to keep DHEA levels in the optimal range for anti-aging, health, and general wellbeing.

Common lab reference ranges for DHEA-Sulfate:

- 18 to 21 yo: 51 - 321 mcg/dL
- 22 to 30 yo: 18 - 391 mcg/dL
- 31 to 40 yo: 23 - 266 mcg/dL
- 41 to 50 yo: 19 - 231 mcg/dL
- 51 to 60 yo: 8 - 188 mcg/dL
- 61 to 70 yo: 12 - 133 mcg/dL
- >71 yo: 7 - 177 mcg/dL

You want to be careful supplementing too much DHEA with women. Some women are sensitive to the androgen effects and will have acne and hair loss with too high a level.

Typically in a Perimenopausal woman aged late 30s to late 40s, I like the DHEA at 150 to 250 mcg/dL depending on symptoms such as energy, weight loss, mood, and libido. But monitor skin for breakouts and hair loss as we are all unique individuals.

Pregnenolone

Pregnenolone is often very low during Perimenopause. This leads to more short term memory loss, lack of motivation, forgetfulness, and low motivation/mental energy. At the time of writing this book the usual lab reference ranges are way too

broad. Some labs state pregnenolone should be anywhere under 150 ng/dL, and other labs say 22 to 237 ng/dL. I have seen pregnenolone levels so low that the blood test couldn't even find a value. Ideally, I would like to see the pregnenolone levels at around 80-100 ng/dl for women in Perimenopause.

Thyroid

The thyroid is very much affected when the female reproductive hormones decline. Often you will see a drop in thyroid function during Perimenopause. Most doctors only test the TSH. While the TSH is important, I always also test the FreeT₄ and the FreeT₃ along with the antibodies for Hashimoto's. Remember, TSH is just a signal from the brain monitoring overall thyroid levels in the blood. I always test thyroid function and Hashimoto's antibodies with blood. I feel blood work is more accurate for thyroid function than saliva and urine.

Common lab reference range for TSH:

- 0.40 - 4.5 mIU/L.

I always want to pair the TSH with the FreeT₄ and FreeT₃. Again, the typical lab reference for FreeT₄ and FreeT₃ is vast:

- FreeT₄ reference range is 0.8 - 1.8 ng/dL
- FreeT₃ reference range is 2.0 - 4.4 pg/mL

What I consider when looking at lab work for low thyroid function is

- Anytime I see a TSH over 2.0, then I know that person's thyroid function might be compromised.
- FreeT₄ under 0.8 or over 1.6 ng/dl is a flag that needs to be addressed. If the FreeT₄ is less than 0.8, then you know that the thyroid function is low and it may be converting to Reverse T₃. If you see a high normal T₄ over 1.6, then that means the T₄ is pooling and not converting to T₃.
- If the Free T₃ is under 3.0, then that is lowered thyroid function. My ideal level of Free T₃ is 3.5 to 4.4.

A quick note about Reverse T₃ (RT₃): I don't always test the Reverse T₃. But I realize it can be important to test the RT₃. In the cases that it looks like the T₄ is converting to Reverse T₃ instead of Free T₃, I will include a RT₃ on the blood work. The reference range for RT₃ is 8 to 25ngdL. If I see the RT₃ over 20, then that means the T₄ is not converting well to the FreeT₃.

A common scenario in Perimenopause is a normal TSH, normal T₄, but a low T₃ (in the low 2s).

When the female reproductive hormones decline, that can also cause the Hashimoto's to be activated. If I am considering hormone imbalance or Perimenopause, I always test Hashimoto's antibodies: TPO (thyroid peroxidase antibodies), TGab (thyroglobulin antibodies). If one or both of these antibodies are out of range, then we want to treat Hashimoto's as well as Perimenopause. This is one time that I stick to the usual lab reference ranges:

- TPO: <9 IU/ml
- Thyroglobulin antibodies: less than or equal to 1.0 IU/mL

CBC (Complete Blood Count) and Ferritin

Commonly in Perimenopause, there can be heavy periods. In this case, I really like to do a CBC test, which stands for Complete Blood Count. I also include testing the ferritin level.

A CBC will have a total number of red blood cells (RBCs). If a woman is losing a lot of blood every month from her period, then her number of red blood cells could be too low. Also, with heavy periods, the hemoglobin and hematocrit can be low.

Iron has an affinity for oxygen, which is why it is necessary to have enough red blood cells, hemoglobin, and hematocrit. Often, testing the ferritin level is missed. Ferritin is not iron itself. It is a protein that binds to iron, which gives us an idea of what your stored iron is. Often in Perimenopausal women, periods are so heavy that they will have low stores of ferritin.

Imagine that hemoglobin and hematocrit are like your checking account, and your ferritin is like your savings account. We all know it is a bad idea to have an adequate checking account but no savings. The typical lab cites female reference ranges for ferritin at 15 to 150 ng/mL. And even some labs will have normal ranges up to 232 ng/mL. These are vast reference ranges. My perfect range for ferritin in a menstruating woman is 70. But if a female's ferritin is under 20, then it is absolutely necessary to address adding in a safe form of iron supplementation.

What I Don't Usually Test with Blood Work

I don't normally test cortisol levels with blood. Blood cortisol levels are not as accurate when looking for adrenal insufficiency. And because cortisol is secreted in a diurnal curve, you want multiple cortisol samples in a 24-hour period or at least a morning and an early evening value.

If you just have a random blood test for cortisol in the morning, you have no idea if the cortisol is high or low in the afternoon or evening. Also, cortisol blood testing is not quite as accurate for evaluating adrenal fatigue or adrenal insufficiency. I find saliva has more accuracy in evaluating cortisol levels, which you will read more about later in this book.

Urine Testing

Urine testing for hormone evaluation has been around for a long time. But recently, dried urine testing has gotten quite popular of late and with good reason, as urine testing can be very accurate in reflecting hormone levels. In fact, urine testing can be incredibly comprehensive compared to a blood test. Although, once having done the urine test, understanding or interpreting the results can be difficult, which makes it difficult to provide recommendations.

Dried urine will test all the estrogens and estrogen metabolites, as well as all the androgens and androgen metabolites. Urine doesn't test pregnenolone. And technically, urine testing is not testing progesterone. This is because progesterone is not released in great enough amounts in the urine to be tested. But urine testing

can check for progesterone metabolites, which gives us a good idea of what the progesterone levels are.

Estrogen Metabolites

One aspect of urine testing that I love that you cannot get with blood is the estrogen metabolites.

Three estrogen metabolites that are important to know:

- 2-OH-estrone
- 4-OH-estrone
- 16-OH-estrone

You do not want high levels of 4-OH-estrone, which can lead to DNA damage, and possibly an increased risk of cancer. Having higher levels of 2-OH-estrone is beneficial as it decreases risk. And the 16-OH-estrone does not increase or decrease risk. To sum up, you want a higher ratio of 2-OH-estrone and moderate levels of 16-OH-estrone and low levels of 4-OH-estrone. In Perimenopause, because the progesterone levels have dropped, but the estrogen levels have not, it puts most Perimenopausal women in an estrogen “dominance” category. Without progesterone to buffer estrogen, this can lead to higher levels of 16-OH-estrone and 4-OH-estrone.

The other great aspect to most urine hormone tests is that you can add on cortisol saliva test with it, which would include your cortisol patterns.

Saliva Hormone Testing

There are many companies that do saliva hormone testing. And the technology with saliva testing has come leaps and bounds. Even some insurance companies will cover saliva testing. In my experience, I have found insurance coverage limited, making it a private, out-of-pocket expense. With that said, saliva testing can be reasonably priced.

Saliva testing can test your estrogen and progesterone over an entire menstrual cycle. This is one of the advantages of saliva tests over blood testing. Blood testing will only look at one day of your cycle. Saliva tests can give you a look at how the hormones are cycling over an entire month. That means you have to save saliva samples during an entire 28-day cycle. But it is interesting to see how the hormones are secreted in a full cycle. In most cases, in Perimenopause, the estrogen levels are fairly normally cycled, but the progesterone will be low from Day 14 to your period.

Cortisol Saliva Testing

Remember how I said, I don't normally test for blood cortisol? That is because it is a one time draw and our cortisol levels fluctuate in a 24-hour diurnal pattern. Cortisol is supposed to be high in the morning, so you bounce out of bed. It will then slowly decline over the course of the day, ending with low levels of cortisol at night so you can fall and stay asleep. A saliva test can include your waking, afternoon, and nighttime cortisol levels.

In Perimenopause, you will typically see a normal to low-normal cortisol level in the morning but very low levels in the afternoon, hence, the afternoon drowsiness. I have many perimenopausal women as patients who plan their day so that everything gets done before noon, which is the time they typically "crash." Then you see the cortisol levels come up higher than normal or high levels in the evening, which means that the cortisol is bouncing up and down all night long. This is why Perimenopausal women have such a hard time staying asleep. Progesterone is very calming and helps balance the cortisol. The drop in progesterone during Perimenopause can cause the cortisol to rise at night, leading to trouble staying asleep.

If you have any questions about hormone testing or where you can obtain hormone testing, please reach out to us. For your purchase of The Perimenopause Plan, you have access to the PDF document that has all the lab testing panels at: progressyourhealth.com/perimenopauseplanresources



06

Perimenopause Solution

You've gotten this far. Now comes the fun part.

- You're in Perimenopause—how do you begin to feel better?
- How do you alleviate Perimenopausal symptoms?

There are limited treatment options in the conventional healthcare field. Your primary care doctor, endocrinologist, or gynecologist typically will not offer effective treatments to help you. If they don't blow you off, they'll try to give you meds that are not effective, possibly unsafe, and/or a business card of a psychiatrist or therapist. I know from my patients that birth control pills, antidepressants, and anti-anxiety medications are not an option. And a woman in her 40s should not be on birth control pills.

Why are there limited treatment options? That is because Perimenopause is not a disease. That doesn't mean it can't be a huge burden on your quality of life.

In Perimenopause, there is no one "pill" to fix it all. It is a combination of lifestyle, nutrition, supplementation, and possible bioidentical hormone replacement, all of which I will cover in-depth throughout the rest of this book.

By the end of this book, you will walk away with a clear understanding of what steps you can take to feel better. For the supplement recommendations, I will provide you with the actual constituents and dosing suggestions. If you would like actual product brand recommendations, there is a downloadable list at: progressyourhealth.com/perimenopauseplanresources

Case Study - Michelle

To better understand what options can help alleviate your Perimenopausal symptoms, I want to tell you about Michelle. She represents a real patient, but

personal details and her name have been changed for privacy. Michelle is a 44-year-old woman. She is married and has a 13-year-old daughter in middle school. Michelle is a realtor specializing mainly in selling residential properties.

Michelle came to me, complaining that there was something wrong with her, and no one could find it. She was irritable with a short temper, which she said was never her nature. Her periods had gotten so heavy and painful that she often had to work from home on the first two days of her period.

Michelle could not sleep through the night. She would fall asleep quickly and wake up after four hours only to find herself wide awake for at least 1-2 hours, which made her very tired the next day. She also complained of being forgetful. Michelle used to be able to memorize anything and now had to write everything down. Michelle also gained 15 pounds seemingly overnight. This rapid weight gain made her frustrated and distressed because she was already exercising at least 3-4 times a week and following a strict eating plan.

Michelle had been to her gynecologist, pleading with him to help. She just knew it was her hormones causing her problems. But all her gynecologist did was offer her birth control pills or an IUD.

Michelle is a 44, almost 45-year-old woman. At that age, to be on birth control pills, there are many risk factors. Michelle did not want an IUD. An IUD may help the periods, but it would do nothing for the other symptoms she was experiencing, such as weight gain, sleep issues, and irritability.

Michelle then went to her primary care physician, who told her she was fine and offered her antidepressants. She kept saying, “I am not depressed. I might feel off, but I am not depressed.” Michelle was right, it was her hormones.

Michelle’s Testing and Interpretation

Michelle is very healthy and has taken good care of herself for her entire life. She does not have a “disease.” Michelle has a hormonal imbalance based on being in Perimenopause. Some people coast through Perimenopause and menopause without

missing a beat. And others do not. Everyone is unique and responds differently when hormones change. But Michelle did not need to take risky medications or a “just deal with it” approach.

Every year, Michelle would get her annual blood work done from her primary care doctor, and it’s always been excellent. But she’d never had her hormones tested. It was essential to get some objective data for Michelle. Michelle’s symptoms were significant, and I am certainly not minimizing what she had been feeling and experiencing. To get more details, I always want to test the hormones and pair that with the woman’s symptoms to get the bigger picture.

I ran my typical Perimenopause blood tests for Michelle on Day 18 of her cycle:

- FSH: 34 mIU/mL
- LH: 30 mIU/mL
- Estradiol: 89 pg/mL
- Progesterone: 1.7 ng/mL
- Testosterone: 17 ng/dL
- Pregnenolone: <5 ng/dL
- DHEA-Sulfate: 155 mcg/dL
- CBC: RBC, hemoglobin, hematocrit: within normal ranges
- Ferritin: 2 ng/mL
- TSH: 1.4 mIU/L
- FreeT₄: 1.2 ng/dL
- FreeT₃: 2.5 pg/mL
- Thyroid Peroxidase Antibodies TPO: negative for Hashimoto’s
- Thyroglobulin Antibodies TgAb: negative for Hashimoto’s

Michelle was not in menopause, even though her FSH and LH were in the lab's reference ranges of "menopause." Remember when I talked about testing FSH and LH levels in Perimenopause? If a woman's FSH is between 12-20, she is just entering Perimenopause and might have some of the symptoms, but not many. If the FSH is 20-45, the woman is in Perimenopause, and if the FSH is over 50-80, that is menopause.

Michelle's FSH was 34, and she still had a monthly period. Her Estradiol was at 89, which means she was making estrogen. This means that Michelle was in the heart of Perimenopause. Her progesterone levels were very low on Day 18, which is the time that progesterone should be starting to peak. Her periods were pretty heavy, resulting in low ferritin levels. Her DHEA and testosterone were fine, but her pregnenolone was nonexistent in her bloodstream.

Remember when you learned about the perfect 28-day cycle and how it relates to symptoms? Michelle's low progesterone levels were causing irritability, waking in the night, easy weight gain, and heavy periods. The heavy periods dropped her stored iron (the ferritin). And without treatment to address the ferritin levels, then eventually her hemoglobin and hematocrit would drop too. The low pregnenolone made Michelle have trouble with her short-term memory and mental energy.

Reviewing Michelle's thyroid labs, she did not have Hashimoto's, because the thyroid peroxidase and thyroglobulin antibodies were in the normal range. While Michelle's TSH and Free T4 was in range, her Free T3 levels were too low. Low T3 levels can reduce metabolism, causing weight gain. Michelle had been complaining about weight gain. She recalled feeling like she gained 15 pounds overnight, especially noticing it in her stomach and waistline. Because of this, Michelle started to restrict her caloric intake to 1000-1200 calories a day, coupled with intense cardio exercise at least 3-4 times a week. When you eat less and exercise more, the body will try to protect itself against "starvation." The body will automatically drop T4 conversion to Free T3. Michelle's Free T3 level was low, but she did not have a thyroid problem or low thyroid. It was the lifestyle steps she took that inhibited her thyroid function.

Michelle's Treatment Plan

Next, I am going to go over what helped Michelle's Perimenopausal symptoms. Remember, one pill will not fix all. Michelle's treatment plan was multifactorial, looking at supplementation, diet, lifestyle, and prescription bioidentical hormone replacement.

Michelle's Ferritin

Michelle had extremely heavy periods that were so bad that she had to work from home on the first two days of her period. On her complete blood count, Michelle's hemoglobin, hematocrit, and total red blood cells were in the normal range. But her ferritin was a 2. Having low ferritin means that you have low stores of iron in your system. Eventually, with low ferritin, the hemoglobin, and hematocrit, and even the red blood cell number will soon drop.

There are two issues with having low ferritin:

- If you were in an accident and lost blood rapidly, you would want to get to the hospital quickly because you have low stores of iron to protect you from a heavy, rapid loss of blood.
- Low ferritin levels can present the same symptoms as anemia (as in low RBC, hemoglobin, and hematocrit). There can be fatigue, heart racing, lightheadedness when rising to stand, hair loss, headaches, and falling asleep as soon as you sit down.

It was essential to get Michelle's ferritin levels up by giving her iron.

Ferrous Bisglycinate Chelate (Ferrochel)

I like to use a type of iron called Ferrochel, which is ferrous bisglycinate chelate. It has none of the adverse side effects that over-the-counter iron supplements cause. It will not cause constipation, nausea, bloating, or dark sticky stools.

Dose Suggestion

Usually, supplementing with 25-60mg a day works well while monitoring your complete blood count (CBC) and ferritin.

Michelle's Pregnenolone

Michelle's pregnenolone was <5, meaning it was not even found in her bloodstream. It is common to see low pregnenolone in Perimenopause. This can account for the reduction in short-term memory and brain fog. If the pregnenolone is low, a great way to raise it and get your short-term memory back is to supplement it.

The catch is that you do not want to take too much pregnenolone. As with all hormones, too much of a good thing is not a good thing. I find that using low doses of pregnenolone such as 10mg to 30 mg stimulates your own production of pregnenolone.

Again, pregnenolone is great for short term memory and mental energy. Michelle started with 10 mg, and over time she worked up to 20mg in the morning. While 20mg was perfect for Michelle, I find that 30mg of pregnenolone is the most common dose for women in Perimenopause. I have very few patients on 60mg, but sometimes higher doses are needed. This is why I like to monitor the blood values of pregnenolone to make sure the dosage is correct.

Michelle's Sleep Plan

Michelle, like most perimenopausal women, had no problem falling asleep but could not stay asleep. She would wake up in the middle of the night and would be up for hours, feeling like her mind was racing, and she was thinking about anything and everything. One of the reasons that Perimenopausal women wake up in the middle of the night is elevated levels of nighttime cortisol.

As mentioned, there is no one-pill-fixes-all. I implemented a sleep supplement protocol with Michelle. But the goal with the sleep protocol is to help get rested sleep and not feel groggy the next morning. Sleeping pills are habit-forming and notorious for causing brain fog and morning grogginess. Michelle's sleep protocol

was intended to be non-habit forming, helping her stay asleep, and waking up refreshed. Our goal with Michelle was to reduce her nighttime cortisol levels and increase her GABA.

Reduce Nighttime Cortisol and Increase GABA

Magnolia (*Magnolia Officinalis*) can help reduce cortisol levels at night to help with sleep. The key here is using the magnolia bark extract standardized to about 2% of the active constituent honokiol.

Ashwagandha is very calming and can help with sleep. It helps by calming the brain so that you can actually fall asleep and stay asleep. For a sleep dose, Michelle took 500mg of ashwagandha (extract root and leaf) before bedtime.

Phosphatidylserine is a phospholipid that is great for the brain. It can help reduce cortisol levels for healthy sleep. The suggested dose is 50 mg to 300 mg before bed. Because phosphatidylserine is fat-soluble, it is better to take it with a fat-snack such as a little nut butter.

GABA is great for helping to stay asleep. But as a supplement, it is a very large molecule and hard to digest and absorb. But using PharmaGABA is much easier to digest and absorb. And it is great for relaxing and reducing cortisol. Michelle would take 200mg before bed. Other suggested doses of PharmaGABA are anywhere from 100mg to 500mg before bed. If Michelle woke up in the middle of the night, she could also take 100mg of a chewable PharmaGABA and the glycine together to get back to sleep quickly without feeling groggy the next day.

Glycine powder is great to turn off your brain and racing thoughts. Michelle would mix one teaspoon of glycine powder in a small water bottle, which equaled 4000mg. She would drink half of it before bed. If she woke up in the middle of the night with racing thoughts, she would drink the rest of the glycine water to help her fall back asleep quickly.

If Michelle woke up in the middle of the night, whether it was because she had a lot on her mind or there was an event the next day that she was anxious about. She

could also take 100mg of a chewable PharmaGABA and the glycine together to be able to get back to sleep quickly without feeling groggy the next day.

Are you interested in the product brands that Michelle took for her Perimenopause treatment plan? For your purchase of The Perimenopause Plan, you have access to all the product brand recommendations at: progressyourhealth.com/perimenopauseplanresources

Michelle's Bioidentical Hormone Plan

Michelle's progesterone was very low. Michelle was an excellent candidate with her personal and family history to take prescription bioidentical progesterone. There are many forms of progesterone, which we will detail in other books. For Michelle, she took 100mg of sustained-release bioidentical progesterone orally as a capsule before bed. Oral progesterone is great for sleep, making it is perfect for taking at night. The progesterone, along with her sleep supplement protocol, helped her sleep through the night.

Oral progesterone also helps balance estrogen and thin the lining of the uterus. After three cycles of being on the progesterone, Michelle's periods lightened up, so she could leave the house on the first two days of her period. Oral progesterone can also be great for helping with irritability. The 100 mg progesterone capsule immediately helped Michelle's mood and patience.

We originally started with Michelle taking the progesterone on Day 14 up to her period. Remember, progesterone is only made in the body for the last half of the cycle. Michelle noticed that she felt great when taking the progesterone. But she didn't feel as well when she wasn't on the progesterone Days 1-13. In this scenario, I had Michelle take her progesterone nightly from Day 5 up to her period. You do not want to take hormones such as estrogen or progesterone when you are on your period because you want the entire uterine lining to slough off during your period, and estrogen and progesterone can inhibit that. Taking the progesterone from Day 5 to the start of her next period worked perfectly for Michelle.

Michelle's Diet and Exercise Plan

Michelle was eating less and exercising more. To her shock, not only did she not shed a pound, she kept gaining weight. When I first saw her, she was 165 pounds at 5 feet 5 inches. She had gained 15 pounds in what she described as “overnight.” And even before that, when she was 150, she had wanted to lose 10 pounds to get to 140.

Michelle was worried that she would just keep gaining and gaining and didn't know what to do. By restricting her calories so low, her body thought it was in starvation. When the body thinks it's starving, it will reduce the conversion of thyroid hormone T₄ to Free T₃. This was why Michelle's Free T₃ level was so low on her blood work.

She also started doing intense cardio exercise at least 3-4 times a week. Intense cardio exercise will cause cortisol to rise. Remember when you learned about the cortisol and insulin interaction?

A rise in cortisol will cause an increase in glucose and then a surge in insulin. Both the low Free T₃ and the elevated cortisol and insulin made Michelle's metabolism come to a screeching halt and increased her ability to gain weight.

For Michelle, we created a plan that focused on her caloric intake and exercise routine. To get her metabolism in high gear, she needed to increase her calories to a target of 1,800 and never drop below 1500. This initially freaked Michelle out, worrying that 1800 calories would cause rapid weight gain. But she noticed it did not.

We also set up a work-week caloric and eating plan that she would eat 1500 to 1800 calories a day. And on her two days off, she would refeed and increase calories to 1800 to 2300. The calories were also based on her macros as a 40/40/20, meaning 40% protein, 40% fats, and 20% carbs.

Also, just as important as her diet and nutrition was Michelle's crazy cardio regime.

She had to stop the cardio and focus on resistance strength training. Doing weights or strength training increases your metabolic hormones, especially testosterone and growth hormone. Michelle switched her workout to weight training 2 to 4 days per week. At the end of this, Michelle lost 20 pounds. And at a weight of 145, she felt great and didn't want or need to lose anymore.

Synopsis of Michelle's Exercise, Calories, and Macros

- Michelle: 44 yo Height: 5' 5" Weight: 165 lbs
- Exercise - Focus on resistance training (strength) 2 to 4 days per week. High-intensity cardio is not necessary and can be counterproductive to the fat loss process.
- Weekly Calorie Average (WCA) - This is very important for fat loss.

Michelle's WCA should be roughly about 1,500 to 2,000 calories, with 1,800 being the target per day. Dropping calories too low will reduce thyroid function, lower metabolic rate, and stop the fat loss process. Michelle's daily calorie minimum is 1,500. During her fat loss process, she was not allowed to drop calories below 1,500 calories. Maintenance calories for Michelle once she achieved her goal was 2,300 calories with moderate activity (3-5 days per week).

We ended up cycling her calories throughout the week. During Michelle's work-week, she would eat 1,500 to 1,800 calories (5 days per week). Then she would have two "refeeding" days where she would eat 1,800 to 2,300 calories per day. In Perimenopause, most women respond to a lower carbohydrate diet, not a ketogenic diet, as chronic ketosis in women can reduce thyroid function and further disrupt hormones. For Michelle and many Perimenopausal women, basing the macronutrients as 40/40/20 works well.

- 40/40/20 means 40% protein, 40% fats, 20% carbs
- Macros based on 1,800 calories: (work-week macros)

Macronutrient Breakdown

- Protein = 180 grams x 4 calories per gram = 720 calories from protein
- Fats = 80 grams x 9 calories per gram = 720 calories from fat
- Carbs = 90 grams x 4 calories per gram = 360 calories from carbs

Again, Michelle did very well eating a lower carbohydrate diet and increasing her calories. Initially, she was afraid to increase her calories and reduce her cardio exercise,

but she found she felt better, and she was able to achieve her weight loss goals. The take-home message here is to swap out cardio for weight resistance exercise and do not reduce your calories. For Perimenopause, keeping your macros with a lower percentage of carbs to fats and proteins will help with weight loss.

Based on Michelle's treatment plan, she felt much better. She was thrilled to lose the weight she had gained from the imbalance in her hormones from Perimenopause. But she was most happy about the extra energy she achieved. Fatigue or lack of energy is a multifactorial process to work on. By helping Michelle sleep better improved her physical energy tremendously. Also, changing her diet, adding more calories, promoting weight resistance training over intense cardio, and raising her ferritin levels also contributed to her physical energy. By addressing and raising her pregnenolone levels improved her mental energy and clarity. Michelle's moods were improved, and she felt more like herself. She knew the irritability, short temper was not her normal self. By addressing the imbalance of estrogen to progesterone, she was able to get her easy-going patient nature back.

Michelle is a classic case of Perimenopause, but I realize that her symptoms didn't include all the features that can happen in Perimenopause. And you might notice that there are more symptoms that she wasn't experiencing that you might be. Below you will find supplements that can help with the other symptoms of Perimenopause. I have described the main constituents and supplementations. But if you are looking for brand product recommendations, that is available as a downloadable PDF at: progressyourhealth.com/perimenopauseplanresources

Supplements for Balancing Estrogen and Progesterone

Below you will find Perimenopause supplementation that can help to balance the drop in progesterone and balance the estrogen metabolites.

Remember, for your purchase of The Perimenopause Plan, you have access to all the product brand recommendations at: progressyourhealth.com/perimenopauseplanresources

Vitex agnus-castus (Chaste Tree Berry)

Vitex is an herb that will help to increase and stimulate LH (luteinizing hormone). Luteinizing hormone has a direct effect on stimulating progesterone. Vitex can help to balance progesterone without having to give the actual hormone, progesterone. To be effective, a good dose is 450mg once to twice a day. If your symptoms are related to night sweats, then I would suggest 450mg at night. If you are having more irritability, then 225 to 450mg in the morning.

Wild Yam Root Extract and Dong Quai Root Extract

These helpful herbs can buffer the progesterone drop and balance the estrogen. I usually have perimenopausal women take these twice a day. A suggested dose for both of these herbs would be 125mg to 250mg twice a day. In Perimenopause, there are more symptoms 7 to 10 days before a period. Such as increased craving for sweets and carbohydrates, night sweats, brain fog, irritability, and acne, to name a few. I will usually have women increase the dose of these herbs 10 days before their period.

DIM (diindolylmethane) and Indole-3-Carbinol

Using DIM (diindolylmethane) and indole-3-carbinol can help balance excess estrogen metabolites to help with estrogen dominance. It doesn't raise progesterone levels. By balancing and reducing the estrogen metabolites, it can help with weight gain, especially water weight. It also helps with cravings and moodiness by balancing the estrogen metabolites. A good starting dose is 100mg DIM and 200mg indole-3-carbinol.

Supplements to Help with Sleep

While Michelle's issues with sleep were helped immensely with her sleep protocol, there are other supplements that can be helpful for falling and staying asleep.

Using neurotransmitter precursors can help with sleep, specifically 5HTP and Mucuna pruriens. Having a balance of neurotransmitters is important for sleep but also can help appetite craving control, happiness/mood, and focus.

5HTP (5-hydroxytryptophan)

5HTP is a precursor to serotonin, meaning that taking 5HTP can convert to higher levels of serotonin in the body. Serotonin is the happy-neurohormone. It can help with mood and falling and staying asleep in Perimenopause.

Mucuna pruriens Extract

Mucuna Pruriens Extract contains L-Dopa, which is a precursor to dopamine and is also a neurohormone that helps with mood. I find that raising dopamine and serotonin levels can help with mood thereby helping with sleep.

But both Mucuna and 5HTP are contraindicated with certain medications, particularly antidepressants meds. Check with your doctor before taking.

Suggested doses:

- 5HTP for sleep suggestion: 50mg to 150mg in the evening
- Ideally, the Mucuna pruriens should be standardized to contain at least 10% L-Dopa: 200 to 400mg in the evening.

Melatonin

Melatonin can be helpful for falling asleep. I don't find that melatonin can help you stay asleep, which is the main issue for Perimenopausal women. There are sustained-release forms of melatonin that work for some. While it is worth a try, melatonin is just one of those supplements that work great for some and for others, not at all. For Perimenopausal women, I usually suggest starting with 1mg before bed and an increase up to 5mg. I find more than 5mg at night can cause morning grogginess in a lot of women.

Supplements to Help with Low DHEA Levels

As mentioned before, Michelle did very well on pregnenolone. Pregnenolone is a dietary supplement available over the counter. But DHEA is also a dietary supplement that is available over the counter. While Michelle did not need DHEA supplementation, there are many women in Perimenopause who need DHEA supplementation.

DHEA is considered as a prohormone. Meaning it can convert into other hormones; in particular, it is a precursor to testosterone. DHEA can help with motivation, muscle mass, and energy. If your blood test shows low DHEA-sulfate, then you can supplement with oral DHEA. Remember above, when I talked about DHEA lab testing? DHEA-sulfate under 150 could be warranted for supplementation. Make sure to pair the symptoms with DHEA.

Symptoms of low DHEA would be low motivation, low libido, weight gain, low energy, and lowered immune function, to name a few. Now, there are a lot of doses of DHEA on the market as a dietary supplement, but for us ladies, you want to start with 5mg. Make sure to monitor blood work and possibly raise to 10mg or at the highest, 15mg. I have met very few women who can tolerate more than 15mg of DHEA. Because DHEA is an androgen, taking too much DHEA can cause hair loss and acne.

Supplements for Perimenopause Acne, Skin, and Hair

Michelle was not having acne, skin, or hair issues. But having breakouts and changes in skin and hair is common in Perimenopause.

Acne

Saw palmetto is commonly known as an herb that is a healthy supplement for men and their prostate. It can help with BPH (benign prostatic hyperplasia) or enlargement of the prostate. It helps by blocking testosterone metabolites, particularly DHT (dihydrotestosterone).

The same process that causes saw palmetto to work for men can work for women with acne. In Perimenopause, the progesterone plummets, and the estrogen can, in some cases, drop slightly. These hormones can no longer buffer the testosterone. The testosterone metabolites will exacerbate and cause breakouts and acne. Blocking the metabolites with saw palmetto can help with acne. A good dose for saw palmetto is about 300mg of *Serenoa repens* fruit extract containing standardized to at least 45% or higher total fatty acids.

Skin and Hair

As we talked about, in Perimenopause, women can see changes to their skin and hair. Skin is not as elastic as it used to be. Hair seems less thick or shedding more than it used to. Blood work to check for preexisting conditions such as thyroid and anemia are the first steps. But there are safe, natural supplements that can help with skin and hair.

As mentioned above, if your testosterone is elevated, taking saw palmetto is great for acne, but it is also good for hair thinning seen around the temples, hairline, and top of the head.

Evening Primrose Oil (EPO) is great for hair thickness. It is also great for women in general, as it has a hormone- balancing effect without being an actual hormone. It is great for PMS and breast tenderness. But I do find that it can help with improving hair thickness in premenopausal women. The dose is very important here—1000 to 2000 mg is the ideal dose for hair.

Using a good ‘hair, skin, and nails formula’ can be especially helpful in Perimenopause. There are many products out there. Again, if you are looking for product brand recommendations, download the PDF at: progressyourhealth.com/perimenopauseplanresources

For a hair/skin/nails formula, look for one that has minerals such as zinc, copper, silica, and manganese as well as biotin, which is commonly known for hair and skin. Also important is a hydrolyzed type II collagen in the formula, which is very helpful for hair, skin, and nails.

Supplements for Perimenopausal Anxiety / High Stress/Overwhelmed Easily

It is common to experience varying levels of anxiety during Perimenopause. Honestly, I don't really like the word “anxiety” because it has such a negative connotation. But it is common in Perimenopause to feel overwhelmed and stressed. As you all know, there are not a lot of conventional treatments to help with Perimenopause.

Often women are given antidepressants and anti-anxiety medications. I want you to know that there are natural, safe supplements that can help with angst and feeling overwhelmed.

Methyl Folate

I like using high doses of Methyl folate. Not folic acid. It is better to take folate than it is to take folic acid. It has been found that higher doses of methyl folate can help with anxiety. Taking anywhere from 10mg, which is 10,000mcg, to 15mg (15,000mcg) can be helpful in Perimenopause for mood. It is great because methyl folate is not habit-forming and will not make you sleepy or foggy-brained.

L-Theanine

While methyl folate can act as a more general supplement to help with angst and feeling overwhelmed, L-theanine is great for “in the moment acute stressors.” For example, getting some bad news which makes you anxious or having to give a speech or performance and which makes you feel especially nervous.

Taking L-theanine in the moment of a stressor or shortly before can help calm you without reducing performance or making you tired. L-theanine is an amino acid that is found in green tea. I have women use this whenever they get triggered and start to feel anxious. It does not make you tired, but a lot of women will take this before bed if they are feeling overwhelmed.

A dose recommendation would be 200mg in the moment of an acute stressor or feeling of angst. L-theanine is easily tolerated and can be taken frequently throughout the day if needed.

Improving Energy in Perimenopause

As mentioned in Michelle’s treatment plan, fatigue is approached as a multifactorial process. There are no one-pill-fixes all in Perimenopause. The goal is to rebalance the hormones to make Perimenopause a gentle transition into menopause. Which menopause will be its own book.

Goals for improving energy in Perimenopause involve focusing on physical energy and mental energy. Many people don't realize that physical energy is different from mental energy. I will have patients that complain that they are so tired. But I find that they are doing hours of exercise daily. If you can go running 3 miles or take a pilates class, you are not necessarily physically tired.

When a patient tells me they are tired. I ask them, "If I begged you to help me pack up this entire office, furniture, books and all, could you do it?" If they say, "yes, I could." Then I would respond, "you are not physically tired, you have the physical energy, you just lack your mental energy." Low mental energy is just not having the motivation, the mental focus to want to exercise, be physical, focus on future goals, or get your projects fully accomplished.

Of course, there are plenty of patients that tell me that by 2:00 pm in the afternoon, they want to crawl under their desk and sleep. I have plenty of fatigued patients that have taken 2-3 hours naps in the afternoon. And there are many women in Perimenopause that are indeed physically and mentally tired. But I do want to pick the two apart and treat each independently.

Goals for mental energy is to address the adrenal gland function. This is where the pregnenolone is important to test and treat for. Low pregnenolone is a big cause of lack of mental energy.

Common Supplementation I Use for Mental Energy

Pregnenolone

Refer to Chapter 5 on Testing Your Hormones and Interpretation regarding pregnenolone. You will find in Chapter 5 that pregnenolone is very important in memory and mental motivation. The most common dosages I find for perimenopausal women is 30mg in the morning. But I have used as low as 10mg and as high as 60mg. If someone is taking 60mg or more and the pregnenolone levels are still low, then they are not absorbing it. At this point I would look at the brand and/or the excipients and fillers in the pregnenolone supplement.

Rhodiola

Rhodiola is a great adaptogen herb for the adrenal glands. An adaptogen is a herb that balances highs and lows. For example, with mental energy, Rhodiola can help increase mental awareness but also help with calming excess hyper-energy for focus.

Goals for physical energy is to make sure to address sleep. As mentioned, many perimenopausal women cannot stay asleep through the night. If they are only getting a few short hours that are broken up all night, they are going to be tired in the day. As you read above, taking supplements for sleep would be a great step in helping with physical energy.

Common Supplementation I Use for Physical Energy

Supplements to Help with Sleep: See above for the supplements used for healthy sleep. Because just getting a good night's rest can help with physical energy tremendously.

Michelle's Sleep Plan: Michelle had the typical Perimenopausal sleep trouble. She would fall asleep within minutes. But find herself wide awake four hours later. By the time she fell back to sleep, it was close to waking for the day. Needless to say, this made for a terrible night's sleep and created a lack of physical energy for the day. Refer above in Michelle's Sleep Plan for supplementation that helped her sleep through the night.

Adrenal Glandulars

I find that adrenal glandulars can be helpful for physical energy in the daytime. Adrenal glandulars are made from either bovine or porcine adrenal glands. Taking an adrenal glandular can help with physical energy, and it is best to take in the morning. Some patients that are very tired in the afternoon, I will have them also take in the early afternoon around lunchtime. Of course, taking too late in the day can disrupt sleep. And if you are vegan or vegetarian, you would not want to take a glandular because it is made from animals.

Doses for adrenal glandulars are quite different from person to person. I like to start with low doses and work up until the physical energy is improved. And from there, even reduce the doses down to see if less will work best. Starting with 50mg in the morning and can increase up to 160mg to 250mg. Like mentioned some people do well with taking an adrenal glandular at lunchtime to help with afternoon fatigue.

Improving Sex Drive in Perimenopause

Sex drive can be tricky with us ladies. We are complicated when it comes to libido. Because it comes down to the balance of hormones in our system to get the libido to increase. In Perimenopause, a lot of pressure is put on the adrenal glands. You will occasionally see a drop in DHEA and testosterone. Increasing DHEA and testosterone can help with sex drive. But these hormones are androgens and sometimes can have side effects like acne or hair loss.

That is why I like to test the DHEA-Sulfate, which is more accurate to assess for DHEA levels and test for testosterone. The adrenal glands will often secrete the cortisol at night, causing a lack of sleep. Thus creating fatigue in the day. And often, the thyroid function can drop in Perimenopause, causing even more fatigue. Couple that with the drop in progesterone that is the hallmark of Perimenopause.

In most cases, sex is an evening event. But by the end of the day, a perimenopausal woman is tired and cranky, and the last thing she wants to do is “more work.” As I said, we ladies are complicated when it comes to the sex drive.

Firstly, the main goals for improving libido are improving sleep, mood, and energy. You can refer back to Michelle’s Sleep Plan or the Sleep and Energy sections in this chapter.

Next, look at adding in DHEA supplementation if warranted. As mentioned, DHEA can convert to testosterone. By adding in DHEA, supplementation can, in itself, increase testosterone levels.

Oxytocin is another hormone that can help with sex drive. At the time of writing this book, oxytocin is a prescription medication, refer below to the section on Prescription Medication for Perimenopause.

Supplements to Help with Sex Drive

DHEA

If warranted, start with low doses of supplemental DHEA to avoid the androgen side effects. Usually, 5mg daily, orally is a good starting dose and, if needed, possibly raise to 10mg. I have few patients on 15mg or more orally because of the side effects of acne and hair loss. Using DHEA transvaginally can also help with sex drive. Inserting a suppository of DHEA can help with libido and also minimize the androgen side effects. Using a DHEA suppository 2 to 3 times a week can be useful for sex drive.

MACA Root

MACA, also called *Lepidium meyenii* can help with female sex drive. Start with 500 to 600mg of the MACA root once a day and can possibly increase to twice a day. This can be helpful for libido and putting sex back on the mind without having to give a woman hormones.

Improving Thyroid Function with Supplementation in Perimenopause

In Perimenopause, it is common to see thyroid function drop. Symptoms of lower thyroid function can be fatigue, weight gain, hair loss, low mood and constipation. But not everyone needs thyroid medication to help with thyroid function. Often I find using thyroid supplementation can help with the drop in thyroid function during Perimenopause.

Iodine

When people think about using thyroid supplementation, the first thing that usually comes to mind is iodine. I have to say that iodine can be quite tricky. If you use too much iodine, it can actually suppress and drop thyroid function. In fact, I often use iodine to help reduce a high thyroid or hyperthyroidism. On the other hand, iodine is essential for the synthesis of thyroid hormones. Now with that said,

I only use very low doses of iodine for low thyroid function in combination with other minerals, amino acids, vitamins, and glandulars. For subclinical low thyroid function in Perimenopause, there are a few supplements that I use depending on the situation. If you are interested in brand recommendations, those can be found at: progressyourhealth.com/perimenopauseplanresources

A dosing recommendation for iodine in the form of potassium iodide would be to keep it fairly low. I usually like to test for iodine as a blood test before starting iodine and then again after being on iodine. I begin at 225 mcg, and I rarely go any higher than 3.75mg of potassium iodide and may combine with up to 2.5mg of free-iodine USP. As I said, be careful with dosing iodine too high as it could have the opposite effect and suppress thyroid function. Sea vegetables and kelp are packed with iodine. It is a good way to give the body iodine without overdoing it.

L-Tyrosine

L-Tyrosine is an amino acid that the thyroid gland uses in making thyroid hormone. Tyrosine is combined with iodine to make thyroxine (T₄) thyroid hormone. Supplementation with L-Tyrosine can be helpful for thyroid support. The recommended dosage for L-Tyrosine is 500mg.

Selenium

Selenium is a mineral that can be helpful for thyroid support. Selenium is used for the conversion of T₄ to T₃. Remember when we talked about thyroid hormones? T₄ is the stable form of thyroid hormone, while T₃ is the active form of thyroid hormones. It is necessary to make sure T₄ conversion to T₃ is optimal for thyroid function. A suggested dose for selenium is 200mcg. More than 200mcg is not usually necessary, and I find 200mcg works very well.

Thyroid Glandulars

If you are looking for a higher intervention for thyroid support, utilizing thyroid glandulars can be helpful. Thyroid glandulars are made from an animal's thyroid

gland. If you are going to use thyroid glandulars, make sure it is from a reputable source as it is derived from an animal's thyroid, usually bovine or porcine. Dosing for thyroid glandulars varies from individual to individual. But for a point of reference, a dosage for thyroid glandulars would be 65mg to 130mg. Because the thyroid glandulars are more potent than minerals, vitamins, and amino acids, if you are taking a thyroid glandular, make sure to test your thyroid levels. It is necessary to make sure they are in a proper range (see above about thyroid testing and optimal levels in Perimenopause).

Prescription Medications for Perimenopause

Sometimes women need bioidentical hormone prescriptions to help with the symptoms of Perimenopause in addition to lifestyle changes and supplements. Bioidentical hormone replacement therapy is used to help restore or replace your own hormones that are not being produced. BHRT means that the hormones are exactly identical to your own. BHRT can be confused with HRT (hormone replacement therapy), but as HRT encompasses both synthetic and bioidentical hormones. I have been treating women with BHRT since 2004 and find it much safer, and women respond much better to it than they do to the synthetic.

Progesterone

In Perimenopause, taking bioidentical forms of progesterone can help with symptoms. Progesterone can come in many forms, such as a topical cream, capsule, or sublingual troche. Progesterone can help with hair thinning, sleep, and mood. It can help chronic spotting or frequent periods. I find the oral capsules seem to help more with staying asleep at night and reducing heavy periods. Progesterone cream bypasses the digestion and goes right into the system. Troches are sublingual but can sometimes take a while to dissolve, and there is a taste to them that some women dislike.

Estriol

Estriol is the gentlest and weakest of estrogens. Taking estriol topically can sometimes blunt the strong effect of Estradiol. This can help with heavy periods and chronic spotting. It is also very good for skin tonicity and texture when used topically.

Testosterone

Some women respond to testosterone very well. It can help with sex drive, muscle mass, and mental and physical energy. Testosterone is better absorbed as a cream. Oral testosterone can put a burden on the liver and is not readily absorbed. But like DHEA, less is best. As too much testosterone can cause hair loss, acne, and feeling “testy.”

Oxytocin

Oxytocin is a hormone that I have found to be helpful for female libido and mood. You cannot test your oxytocin levels (at the time of writing this book). But I have found using a prescription of oxytocin with women can increase sex drive and mood. Oxytocin is the “love hormone.” It is commonly known that oxytocin skyrockets after a woman has a baby. This helps her bond with the baby, wanting to protect and stay with baby. But oxytocin also increases when you hug your best friend or cuddle with your kids or pets, making it great for improving mood. Also, oxytocin rises after an orgasm, helping you bond with your mate. This makes oxytocin helpful for increasing the sex drive. Oral oxytocin is not readily absorbed in the digestion. But I do have some patients that do very well with oral capsules of oxytocin. Better absorption paths for oxytocin are as a nasal spray or a sublingual tablet.

Thyroid

It is common to have lowered thyroid function in Perimenopause. In Michelle’s case, her Free T₃ level was low because of her caloric restriction and hardcore cardio exercise. Because of the drop in progesterone, the pressure on the adrenal glands during Perimenopause can cause thyroid function to drop.

There are many forms of thyroid replacement. If your doctor only recommends Synthroid/Levothyroxine or nothing at all, find a new doctor. Because there are so many forms of thyroid replacement, recommendations need to be based on the individual. There is porcine thyroid, which is made from a pig's thyroid gland. These are commonly known as Armour, Nature-Throid, Westhroid, NP Thyroid, WP Thyroid, or compounded porcine thyroid.

In most cases, I prefer a compounded bioidentical sustained-release T₄/T₃ combination. It is synthesized from plants to look exactly like what our own thyroid makes. Being sustained-release can reduce the side effects that instant-release can have, such as heart palpitations, increased heart rate, and anxiety.

I know there is so much more to thyroid function, thyroid health, and thyroid options, which is a whole other book itself. I understand you might have more questions regarding hormone replacement and thyroid prescriptions. This is an area where we get a lot of questions and concerns. Types of BHRT, types of thyroid prescriptions, and dosing based on blood work and symptoms can be quite complex. This was an overview, but if you would like to learn more about BHRT and thyroid medications, that information will be provided in other books and courses.

Congratulations, you have come to the end of this book on Perimenopause. Having completed this book, I can assure you that you now know more than your doctor knows. You not only know the physiology of why the symptoms of Perimenopause are occurring, you also know about the proper lab testing for Perimenopause and interpretation. Most importantly, you have the tools to successfully improve your perimenopausal symptoms.

To help you further, we have lab testing and the supplement support available. For your purchase of The Perimenopause Plan, you have access to all the product brand recommendations and lab testing at:

progressyourhealth.com/perimenopauseplanresources

Again, congratulations on the completion of this book on Perimenopause.

Thank you

Dr. Valorie Davidson &
Progress Your Health Team