Episode 604: Dr. Michelle Sands on Myths and Truths About Hormone Replacement Therapy

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This episode is brought to you by Timeline Nutrition. We've all heard of probiotics and probably also prebiotics but have you heard of postbiotics? There are several major reasons these are important and thanks to emerging research, I've been experimenting with them. We know that maintaining muscle mass as we get older is critically important to longevity and enduring good health. In fact, it is one of the biggest predictors of longevity and one of the reasons I lift weights regularly and keep an eye on metrics like grip strength. Postbiotics are the active nutrients your body makes during digestion, and they are an emerging driver of this for a couple of reasons. One major reason is that certain postbiotics support mitophagy or the flushing out of old damaged mitochondria, which is really critical in the aging equation. The best compound I've found to support this is called Urolithin A and I was super intrigued when I found it. It's derived from pomegranate but it's very hard, practically impossible, to eat or drink enough pomegranate to get the scientifically proven therapeutic dose.

Urolithin A is one of the first postbiotics shown to have major health benefits and has become available to all of us. It upgrades your body's cellular power grid - giving your body the energy it needs to optimize. And clinical studies have shown that 500mg of Urolithin A alone significantly increases muscle strength and endurance with no other change in lifestyle. This is where a product called Mitopure from Timeline Nutrition comes in. They've created 3 ways to get your daily 500mg dose of Urolithin A in their product called Mitopure. They've got a delicious vanilla protein powder that combines muscle building protein with the cellular energy of Mitopure. They have a berry powder that easily mixes into smoothies or just about any drink. And finally soft gels for travel or you can use them everyday if you prefer. Personally, I love the starter pack that lets you try all three forms and see which one you like the most. Mitopure is the first product to offer a precise dose of Urolithin A to upgrade mitochondria function, increase cellular energy and improve muscle strength and

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Katie: Hello, and welcome to the "Wellness Mama Podcast." I'm Katie from wellnessmama.com. And this episode is all about hormone health, hormone replacement therapy, and specifically, as women enter the times of perimenopause and menopause. We go deep on what the data actually says. There's been a lot of misconceptions and myths in the research and data here, and this episode really goes deep on helping dispel some of those myths. I'm here with Dr. Michelle Sands, who is an absolute encyclopedia of knowledge on this topic, and she's the co-founder of Glow Natural Wellness and the Healthy Hormone Club. And she's a double board certified naturopathic physician and international bestselling author of "Hormone Harmony Over 35." She was the producer of the Perimenopause Summit and she's been featured all over the media for her work on this. And she herself has struggled with autoimmunity, digestive issues, and all kinds of other things.

So, she has personal experience here as well as she was diagnosed with primary ovarian failure at the age of 20, which thrust her into premature menopause early in life. And so she has experienced these symptoms way before her time. She went on to reverse it and have a child naturally, and she now works with so many women all over the world in the country on helping resolve these issues. And in this episode, she walks us through a lot of the myths and truths about hormone replacement therapy. She talks about the different types available and the differences in why this is really important to understand. She talks about why hormone levels are shifting earlier for women and men, and how to navigate this. And how to navigate the natural hormone decline with age and the best time to actually test and consider replacement therapy. We talk about (what makes bioidentical hormone replacement different and why dose matters.

We delve into where bioidentical hormones and synthetic hormones come from, including a surprising practice in China that was the first use of biological hormones. She talks about why hormone replacement therapy does not raise cancer, heart disease, or stroke risk if done correctly and can actually be protective. We talk about the real story about estrogen and cancer, a lot of new information on hormones from the Woman's Health Initiative in 2019 and so much more. So, like I said, she's an absolute wealth of knowledge and we'll do more episodes with her on other hormone-related topics in the future. But this one goes deep on hormone replacement therapy and menopause. And I know I learned a lot. I know you will too. So, let's join Dr. Sands. Dr. Michelle, welcome. Thanks so much for being here.

Dr. Michelle: Thank you so much for having me, super excited. I'm a fan of the show. So, it's just so great to be here.

Katie: Well, I'm excited to chat. And it's crazy that we live very close by and are yet to actually meet in person, but hopefully that will happen sooner than later. And we're gonna get to deep on hormones and hormone replacement therapy and so many things today, and I'm really excited to dive into that.

But before we do, as a background, I have notes that you were a kickboxing champion, which I want to hear a little bit about, and also that you have delayed sleep phase syndrome, which I would be really curious about because I suspect one of my kids might also have this. I recently found out that I am an inverse modulator of all things like magnesium, GABA, etc., which is why they affect me differently. So, I would love to hear how you found that out and what that's impacted your life.

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Dr. Michelle: Yeah, sure. So, with kickboxing, I don't know how I got into it. I used to hang around a gym, and one of my friends used to, actually, college roommates used to do some kickboxing. So, I would hang around there and wait for him to get out and do my schoolwork.

And then, one day, I just decided to jump in and give it a try, and I was actually pretty decent at it. And I would practice with him. I'd go. And then there was one time there was a kickboxing meet locally in Orange County, where I was going to school at the time, and one of the girls who was normally fighting was sick. So, they're like, "Hey, Michelle, can you jump in and do the meet?" So, I was scared, but it was amateur, so you wore total headgear, and so I wasn't gonna get totally hurt.

So I went in and I actually won the meet, and so I ended up going and actually competing. And I became a junior champion and college kickboxer. And when you meet me, I'm so nonconfrontational and kind of timid so no one would actually think that, but it's kind of like something in my past that people would never believe. But it's true.

Yeah. And then the delayed sleep phase syndrome, that is really interesting. So as a child, I always had a hard time getting up for school. And I was always wanting to stay up at night. I was the kid that would have my flashlight under my blanket, reading comic books and magazines. And my mom would be like, "You gotta go to bed," and I always kind of fought it.

And then, when I got to college, my classes, the early classes, I'd never be able to make it to. So, I'd go in my jammies, to like the 10:00, 11:00 classes, and that was the first class I can make it to. And then, out of college, I got a job, and jobs start at 9 a.m., and most jobs 9 to 5.

And I really struggled. During that time, I can do it, I can force myself to do anything. So, I'd get up, I'd go, and I just would be struggling, my digestion would be off, my hormones would be off, my moods would be off, and I would not be able to concentrate really before noon.

So, it wasn't really until, gosh, much later in my life until I finished naturopathic medical school and I started getting into genetics that I ran my own genetics on myself. And I realized that I'm part of the 1% of the population that has a variation in their clock genes, which is called delayed sleep phase syndrome. And what that means is that my genetic clock is actually pushed forward by, it can be anywhere from two to four hours.

So, if you think about normal and natural medicine, holistic medicine, we always say, "Aim to go to sleep around 10 p.m. for optimal health." For me, that is actually around 2 p.m. So it's just switched forward. So for me, like my focus time, the time when I'm in my flow, when I can get my creative stuff done, when I actually think clearly, it's really after midnight.

And so, for me to force myself into the standard of waking up at 6 go to bed at 10, I'm not in my optimal. And I miss out on that time when I can actually be most creative. So, I've been honoring that now. And I've shifted my work schedule to be later. I shifted my bedtime later. And everything seems to work better, my digestion is better.

So, you know, if you don't have a good night's sleep, I don't know if you guys realize this, but if you don't have a good night's sleep, you don't digest your food as well because that's when your body kind of cleans itself out. I get sick less often. And I just feel much better. It's easier to maintain my weight. My cravings are better.

So, it's really interesting. So, yes, 1% of the population has delayed sleep phase syndrome. And then there's another 1% of the population that has advanced sleep phase syndrome, which is the opposite. So, you need to go to bed earlier, and you would be better waking up earlier. And the only really way to know is to run

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genetics. We have our own genetic tests in our practice, but you can easily do 23andMe, and there's certain snips to look for.

Katie: That's so fascinating and definitely different than people who would just consider themselves night owls but who can, for instance, train their circadian rhythm based on the light and other factors more easily.

Dr. Michelle: Exactly. Yeah, I mean, you can train. There's some genes that it would make you more of a night owl and more of an early morning person and that you can train yourself either way. But with the specific genetic variation that I have, it's really hard to train yourself. You can still do it. You can still combat it, but you're really going against your natural rhythms.

Katie: That's so fascinating. I love the more we learn about genes, it just opens up whole new worlds of understanding, I feel like. And another area that I think is really relevant right now and that you are definitely an expert in is the world of hormones. And I hear from a lot of listeners and readers who are trying to figure out different pieces of this puzzle for themselves. And so, I'm really excited, we're gonna get to sort of delve into some of the myths and misconceptions related to hormones and hormone replacement therapy.

I think for a lot of women, especially, this sometimes feels like a really overwhelming topic or that there are so many things that come into play. And so, I'm really excited to learn from you on this.

To start broad, maybe just give us a walk-through, an overview, of when we're talking about hormone replacement therapy, especially for women, what hormones are we talking about, just so we have a kind of base understanding.

Dr. Michelle: Yeah, so there's over 100 hormones in the human body. But when we're talking about hormone replacement therapy for women, we're generally most of the time talking about estrogen and progesterone. In our practice, we also encompass testosterone and DHEA also, because those are your sex hormones, as long as we're talking about hormone replacement therapy.

There's also interplay between the thyroid and interplay between the adrenals. But those are technically not included in the hormone replacement therapy conversation. What we're really talking about is the hormones that decline as a result of perimenopause and menopause, when the ovaries stop working, and our ovaries make primarily estrogen and progesterone, and some testosterone. Men, in their testes, make a lot of testosterone and a little bit of progesterone and estrogen.

So, and then in menopause, once our ovaries stopped working, we don't have zero hormones. Our adrenal glands still kind of can make some hormones. They will make DHEA. And then DHEA can convert to testosterone. And testosterone can convert to estrogen.

And we still have a little, tiny bit of progesterone just from our peripheral tissues, but it's not really enough to do all the things that we want it to do as far as bone health, the brain health, heart health, weight maintenance, blood pressure, and blood sugar regulation. So, there's so many things that our sex hormones do besides reproduction. And that's really where the conversation about hormone replacement comes into play.

It's a quality of life. It's a longevity issue. It's about not getting on the pill mill, the treadmill of prescriptions, one after the other, as we hit a certain age in our 50s and 60s. And the truth is that we're living a lot longer than we used to. It used to be, when I was a little girl, and my grandparents lived to 60, 65, that was considered normal for them to die in that age range. But now, people are living 80, 90, 100 is considered normal.

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And if the average woman is going into perimenopause at age 40, that's more than half her life that she can be in a state of hormone decline. And that is just not fair. And it's really an impact on her quality of life and her ability to really enjoy her life.

Katie: And I think to that point, you know, the conversation around healthspan versus just lifespan and having to address these in ways we haven't in the past. So, I'm curious who you think is good candidates for these hormone replacement therapies, before we start going to some of the myths and misconceptions.

Like, is this something that, in general, is a helpful recommendation for most women? Because you talked about some of these hormones that can still be created in the adrenals. But I would guess that puts more of a load on the adrenals, which also impacts other hormones and stress and cortisol and everything else. So, when you have people come into you, how are you evaluating who may be a good candidate for hormones and who isn't?

Dr. Michelle: So, we look at their health history. We look at their symptoms. We look at their goals. And nearly everybody, almost everybody is a candidate for some form of hormone replacement therapy. And there's different forms that are available. You can do vaginal hormone replacement therapy, which stays local to the vaginal tissues, which then will help with all the urogenital symptoms, the vaginal dryness, the vaginal atrophy, painful sex, increased UTIs, and all that, and a lot of different issues that can go on down there. And that's even available to women who have had breast cancer or currently have breast cancer.

Whereas other therapies, like topical hormones, those have pretty much the least side effects, so there's no worry about increased risk of stroke or clotting. With topical hormones, there's no increased risk of toxicity to the liver. And so, these topical hormones can really be at a dose that's appropriate for that woman available to most women. And I would say there's very few women who are not candidates for hormone replacement.

And for men, testosterone replacement, in some respect, progesterone for men also. It's not really talked about a lot, but it helps to reduce prostate cancer. It's also important for their bone health and some other issues. They do need that sometimes as well, in addition to testosterone. But there's very few people that cannot use any hormone replacement therapy.

Now, of course, it's a choice. So, in our practice, we believe in freedom of choice and the importance of knowing your choices. So, some women may choose not to use hormone replacement therapy, and I fully support them in that. But, definitely, no one should make that choice for them. They should know their options and then make that choice themselves.

Katie: Yeah, I think that's a huge piece of it. And I've worked in the birth world some, as a student midwife and a doula. And same thing, like, I fully respect any woman's right to choose whatever birth she wants, whether it be a scheduled C section, but she should get full informed consent of that choice and get to make it.

And it seems like there's a very relevant conversation at this phase of hormone change as well. I think the difference in the types and applications is also may be misunderstood or just not commonly known for a lot of women between, you mentioned, like topical, I know there's also injectable, there's pellets, there's all kinds of different ones hitting the market. And I've seen stats that, for men, for example, is it that their testosterone is a third of what it was for their grandfather's generation or something, some really drastic stat. Are we seeing the same type of hormone decline in women as well?

Dr. Michelle: Yeah, so, what we're seeing is the benchmarks of reproduction are actually moving up. So, we see young girls as young as 8 starting to develop breasts and, by age 9, starting their periods. And then we're

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seeing women in their 20s, 30s going into hormone decline, and the beginnings of perimenopause, starting to have symptoms like anxiety, trouble sleeping, lack of libido and sex drive, vaginal dryness, all types of things that we might attribute to women who should be in their late 40s, early 50s.

We're seeing that come on a lot earlier for a variety of reasons, from environmental toxins, you know, estrogen in the environment. We're seeing people are heavier than they used to be, so additional weight that they're carrying can influence the ability of the reproductive system to work properly. So, there's a lot of different factors that we are seeing a lot of advanced age and symptoms of having earlier cases of menopause.

I'm calling it the "millennialpause" now because the millennial generation is seeing the menopause coming on in their 30s and 40s. And they're shocked that they don't know what to do. They're thinking they need antidepressants. They're thinking that they're slacking off or they're just not pushing hard enough because they're tired. And they're blaming themselves a lot of times. And women lose confidence because they think there's something wrong with them because this conversation that we're having today is not happening.

And so, I think the more that we're able to talk about what to expect and what might be happening, and why it might be happening, then women will benefit. And unfortunately, many doctors...only 20% of doctors in the United States have any training on the natural decline of hormones due to perimenopause and menopause and hormone replacement therapy when it comes to women replacing their hormones after that natural decline.

Less than 20%, that's scary. That means that you go to 8 out of 10 doctors, and they have no clue. So what they're doing is they're just giving you a band-aid for each symptom. You're depressed, you get an antidepressant. You know, some women are being told to suck it up when they don't... If they don't have a sex drive, they're being told... I actually had a woman today who, she went to her doctor having painful sex, vaginal dryness, low libido, and her doctor told her to take one for the team that she should just drink some wine and take one for the team.

And I'm just like, "That's not what a licensed medical professional should be telling them." But the thing is, they don't have any education when it comes to hormone replacement.

There is now a big movement within the Harvard Medical School and a lot of prestigious universities where they are starting to do some menopause training and some more education, more than just the one hour where they might learn, "Okay, when a woman hits 55, her hormones decline." And that's it.

The problem with hormone replacement came out, although, in 2002. We'll talk about the Women's Health Initiative study, which really was the biggest disservice to women in the menopause, perimenopause age range could ever happen. And it was a very erroneous study. It was debunked many times since it has been published.

But the actual study itself does have the true information. But the headlines that the media took from the study back in 2002, that's what scared everybody to think that all hormone replacement was dangerous. And all hormone replacements can cause cancer. And so, that is the thing that doctors, a lot of doctors who are not educated in hormones, will immediately go back to what they heard in those headlines, and they'll tell their patients, "No, you can't have hormones because hormones cause cancer."

And, really, it's a shame because that...I will talk about the study in a minute. I can go into it right now if you want. But I want to answer your question about the different types of hormones before I go down a rabbit hole. The different types of hormones, there are a lot. And there's different types when you talk about

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synthetic versus bioidentical. There's different types when it comes to delivery methods. And then there's dosing.

So, all three matter, so the type of hormone, the delivery method of the hormone, and the dosing of the hormone are all important when it comes to the safety and whether it's going to actually help you or hurt you because hormones are very Goldilocks. So, too much of a hormone can cause problems, too little of a hormone can cause problems, but just the right amount of hormone is what we're looking for. So we always test, we always individualize. I mean, we always give women the safest and most effective dose.

So with synthetic hormones, synthetic hormones, all it means is it's manmade. And with synthetic sex hormones, they're slightly different than what our body makes because they're patented by the pharmaceutical industry. And the most popular estrogen is called Premarin. It's a conjugated equine estrogen. And what that means is the horse estrogen is made from the urine of pregnant horses, which is where they get Premarin from.

And that was the very popular hormone that was used at around the time of the Women's Health Initiative study. So that's the one that they have in the study. It's oral hormone derived from horse urine.

Now, horses have like 17 different types of estrogens. None of those are identical to what is in a female human estrogen. And we have three types of estrogens. And we have estrone, estradiol, and estriol. And horses have 17 different ones, 10 of which are in the Premarin. So that's the estrogen.

And for the progesterone, there's a synthetic progestin called medroxyprogesterone acetate, that is what was in Provera, which was what was used in the Women's Health Initiative study too. And that's pretty commonly prescribed even today and also what's in birth control pills. So synthetic progestin is what we see in most birth control pills.

The birth control pills are synthetic hormones and they are endocrine disruptors. They're not actually giving you hormones to balance your hormones. Actually, the reason why we take birth control pills is to disrupt our ability to get pregnant.

And so, when you think about that, giving women for menopause these endocrine disruptors, it's not really doing the same thing as giving you back or replacing the hormones that you've lost, which is what we do at bioidentical hormone replacement.

Now, it's important to note that unlike in 2002, today, there are pharmaceutical brands that do make bioidentical estrogens and bioidentical progesterone. So, it's not just the compounding pharmacies, where you can get these things. You can get a prescription for bioidentical estrogen and bioidentical progesterone.

The problem is most doctors don't know the difference. And the reason why is if you look on studies on PubMed or any of the medical journals, when they're talking about synthetic progestin and when they're talking about conjugated equine estrogen, in that study, they will interchange the words conjugated equine estrogen with estrogen, and they'll interchange progestin with progesterone as if it's the same thing. But it's not the same thing. It's very, very different. So, this is why doctors, a lot of times, don't know the difference.

Bioidentical hormones, however, are biologically identical to what our body makes. So, we're replacing exactly the chemical structure of what a hormone that our body would make is. And there's a lot of doctors that will say bioidentical is a marketing term or there's no such thing as bioidentical. It's not a marketing term. It's actually biochemistry. So, if I was to extract estrogen from my body that I've made and put it in a petri dish, I

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was looking at the chemical structure, it will look exactly the chemical structure of your bioidentical hormones.

Now, where are they made from? A lot of women are like, "Well, where are you getting me the bioidentical hormones?" Because that can be important to know. We know that the conjugated equine estrogen was from horses, and those horses were treated very badly. And there is a huge deal with PETA on how horrible they are treated. So, where are the bioidentical hormones coming from?

Well, those are actually plant-based. So, they can come from the wild yams and the Mexican wild yam or from soy. There is a compound called diosgenin. So, it's a chemical compound that's within those plants that has to be extracted and then taken into the lab. And different little parts of that chemical structure are removed to make it...what's left over is an identical to the estrogen molecule or estradiol, identical to progesterone, identical to testosterone.

So, what's left is the molecule that is that hormone. And there's no yam left in that hormone. There's no soy left in that hormone. It's only the chemical structure that's been extracted. And so, a lot of women ask me, "Well, can I just eat yams? Or can I just eat soy and get the same effect?" Absolutely not. It's not the same. It's kind of like if you're drinking water or you're just taking hydrogen. Well, it's not the same. You're not gonna hydrate yourself with this hydrogen, you actually need that H2O. And it's the same thing like taking it out.

They are plant-based with no horses or pigs or humans involved in that situation. Although the first bioidentical hormones were actually extracted from the urine of women, and in China, I don't know if this practice is still in place, but I do know 50 to 70 years ago, the elders used to drink the urine of the younger women to get those estrogens back. So, it's actually a known practice in China.

And the first bioidentical hormones were from female urine. And then, you know, I don't know where it happened, but some marketing team was together sitting around the boardroom and said, "Hey, you know, let's use horse estrogens instead." And that became really popular and so that's what got used. And so that's what was in the Women's Health Initiative study.

So back in 2002, there was actually a really, really good reason for the study. Because up until this time, there hadn't been any large studies on hormone replacement. They were just, you know, basing it off of the benefits and how women were feeling. And it was really common in the '70s, '80s, '90s for women to walk into their doctor's office, tell them about their symptoms, and get a prescription for hormone replacement. It was just what got done.

And then the Women's Health Initiative study came out and they were just going to prove, finally, that hormone replacement was protective against heart disease and protective against osteoporosis and how it was healthy for women. And so, it was really a good reason to do the study.

And so, they had two different arms of the study. One arm of the study was with a woman who had had a hysterectomy, so they no longer had a uterus. So, they only got the Premarin, the estrogen only. And this was because it was thought back then, and it still thought in some circles now that if you don't have a uterus, you have no reason to take progesterone, which we can talk about why that's not true in a little bit. But those women just got the conjugated equine estrogen.

And then, the other group are women that still have a uterus. So, they got the conjugated equine estrogen, and the medroxyprogesterone acetate, which was Provera, Provera and Premarin put together. And so those

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women still have their uterus. And these are all oral hormones. So, these are all oral synthetic hormones that were taken.

And they follow these women along. And after a few years, they actually stopped the study because they actually realized that the women in the group that was taking a bit combined progestin and equine estrogen were starting to get more incidences of heart disease. They were starting to get more incidences of stroke. And they had an increased rate in breast cancer.

Now, the increased rate in breast cancer was one additional person per 1000, but that was still an increase. And so the study was stopped, the headlines came out. Hormone replacement therapy causes breast cancer. Hormone replacement therapy causes heart disease. Hormone replacement therapy causes stroke.

And so, immediately, women were yanked off their hormones. They are told, "No more hormones." No matter what they were taking, hormones were done. And a lot of lawsuits came out. So, the companies that made these hormones, high-class action lawsuits against them.

And doctors were afraid they would lose their license. Even the doctors that read the study, which we'll talk about what the study actually said that actually that read the study and believe that hormones are safe, they still are afraid to lose their license. They don't want to get sued.

So, women went from about 6 million women on hormone replacement to less than 2 million women on hormone replacement. That's a lot. So, women got all their symptoms back. They started getting put on antidepressants. And that kind of led us to where we are now. We still have a lot of doctors who are still believing that hormones cause cancer, hormones cause heart disease.

And the studies haven't looked back on several times. First, the group that were getting that equine estrogen only, they actually had a decrease in cancer rates in breast cancer and heart disease. So, that part of the study was never recorded.

And then, when we looked at the group that had the increase in cancer, this was versus the control group. So, the control group wasn't on any hormones. So, when they measured against the control, there seemed to be an increase in cancer in the combined group. But when they really looked at the study, and they really looked at all the women, the women in the control group, a large portion of them had previously been on hormone replacement therapy, which protected them against cancer. So, that kind of go went wacky.

But in 2019, so about 20 years later, there was a symposium, a Breast Cancer Symposium, in San Antonio. So, this 2019 San Antonio Breast Cancer Symposium, where 12 prestigious cancer universities all reported their findings. And they reported that estrogen replacement is actually protective against cancer. And they actually cited a lot of different studies and a lot of different research, including the fact that when women have pregnancies, it's actually protective against breast cancer because the increase in hormones, during that time when you're pregnant, actually has a protective effect.

Even women with the BRCA mutation...so, you know, Angelina Jolie made it popular. The genetic mutation that makes you more susceptible that breast cancer. What that mutation actually does is actually...our body has natural ways to inhibit the replication of cancer cells. And people who have that genetic mutation can't inhibit it as well. So, they have a more easier time having their cancer cells mutate. So, that puts them at a higher risk of cancer to begin with.

But there's actually research done showing that women who have had estrogen replacement with this gene defect actually had a 44% reduction in breast cancer rates. That's huge.

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So, there's a great book actually by an oncologist who is actually an investigator for the American Cancer Institute, his name is Dr. Bluming, he wrote a book called "Estrogen Matters." It's really well researched, and it talks about all of the benefits of estrogen and how it is actually beneficial protection against heart disease and cancer, especially breast cancer.

And then there's another researcher who I love. She actually is a breast cancer survivor. Her name is Devaki Lindsey Berkson. And she wrote a wonderful, really easy to read for the layperson, whole paper on, it's called "Estrogen Vindication." And you can Google that, if you google "Estrogen Vindication," And she really was actually at the San Antonio Breast Cancer Symposium in 2019 when they found all these findings. And she really lists out, it's very well researched, easy to read, and also has all the citations in it.

So, that's a resource I share a lot with my patients because, sometimes when you read the studies, they can be confusing, even for doctors. And so, when it's a nicely kind of mapped out for you with the commentary, I really think that that is really good for people to read and even bring to their doctors because, you know, a lot of doctors don't have this education.

But it's sad because estrogen is the one that gets the bad rap all the time. But estrogen is actually protective against breast cancer until 1974 was when Tamoxifen came out. So, if you're familiar with breast cancer therapies, when women have breast cancer, they're given hormone-suppressing medication, one of them is called to Tamoxifen. And before Tamoxifen was put on the market, the medication that was given to women to help them heal from metastatic breast cancer was actually estrogen.

So, it was only 1974 when that pharmaceutical came out and they stopped giving women estrogen as a prevention or actually a treatment for breast cancer. So, it's really funny to think that now we're blaming estrogen for breast cancer when that's not actually the case.

Then a few might say, "Well, my doctor said I had estrogen receptor positive breast cancer or progesterone receptor positive breast cancer." What does that mean? Or how can you say the estrogen doesn't cause it? Well, the fact is that all of the cells in our breast tissue actually have estrogen receptors and progesterone receptors. So, when your cell becomes cancerous, it still has these estrogen receptors and these progesterone receptors until it mutates enough that they're no longer detectable.

And so when you have estrogen receptor cancer or progesterone receptor positive cancer, that actually means that your cancer hasn't actually progressed enough to make those receptors no longer there. It doesn't mean that those hormones are causing the cancer. In fact, stem cells are actually what cause cancer, cancer stem cells, not estrogen. Because if that was the case, then every woman who gets pregnant who has their estrogen skyrocket will be at ultimate risk for breast cancer, and we'll be seeing women who are pregnant have the highest rates of cancer of all women.

And the truth is the highest rates of breast cancer, actually, the women who are in perimenopause and menopause and when their estrogen going to declining. And it even makes common sense when you think about it, I mean, look at who's getting breast cancer and who's not. And it's really kind of counter to what we've been told.

And also, the other research that is really promising now as well is that women who do end up getting breast cancer, if they have had estrogen replacement in the past or if they're currently on estrogen replacement, they actually have a better outcome. They have better chances of survival, and they have less of a hard time conquering that cancers, but we'd beat it even faster. So, there's really no reason, especially if you have a

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family history of breast cancer, that does not preclude you from taking hormone replacement therapy, actually, I would actually recommend it as a protective aspect.

Katie: Well, that's so fascinating. I feel like I just learned a ton. And there's so much to go deeper on in this. I remember reading a while back actually that the stat you mentioned about pregnancy actually being protective against that. And that even realizing, I had my first child at 19, having a child before age 20 is actually a pretty significant cancer-inverse risk.

Dr. Michelle: Yes.

Katie: And pregnancy is somewhat protective. But also I'm glad that you brought up sort of this medical gaslighting and women's symptoms being ignored. I'm glad this is entering the conversation and I'm glad there are practitioners like you who are actively working against this, because I've seen that in the birth world. I've seen that in the thyroid world with my own thyroid issues. And you hear this from...you know, we know that women aren't listened to as much as men when they are having a heart attack. We know women weren't even studied until 1993. So, I feel like we have so much catching up to do that.

Dr. Michelle: Yes, a lot of people don't know that. That's exactly right. So, women were not included in any studies before 1993. And so, everything you see about medication safety and efficacy stuff, how supplements work, even like how fat-burning medications work, these are most of the time done in healthy young men.

And so, how things work in women is way different. And so that's a huge distinction to bring up. But the gaslighting, that's been going on forever. And I was just doing some research for a talk. And I was kind of going back to the history of how women's feelings and women's emotions and how our ability to stand up for herself how that's been suppressed for such a long time.

And in the early 1900s, it was really common for women to be given lobotomies, like up until the 1940s. And they would actually, if women were uncontrollable or if they were not easily to be controlled by their husbands or they like to speak out, it was common to put them in an insane asylum, which they would do sometimes for some women, if they were... Today's women, we talk a lot. We stand up for ourselves. But back in the early '20s and '30s, that was not tolerated. We didn't really have the voice that we have.

And so, women were put in insane asylums or they were given lobotomies to make them more docile and easier to deal with. Then they ended up killing some people with the lobotomies because, if you guys don't know what a lobotomy is, they literally take a sharp needle and they put it through your eye socket, and they actually puncture your frontal lobe and that makes you kind of like not yourself anymore. And it can make you like a vegetable, but what they're going for is the childlike kind of docile, agreeable, gleeful, kind of putting women into that place.

And once that was kind of taken out of the common medical procedures, then women were given valium, it just kind of make us docile again. And now, you know, as when women go in and they are talking about their sex drive, are talking about they're not able to think clearly, they feel like they're losing their edge at work, they're having brain fog, they're feeling tired, they're given antidepressants, again, to make us docile. And I think that's not fair.

As women, we have to talk about this. And we have to really stand up for ourselves and we can't let a doctor write our prescription for the rest of our life. We can't let them determine what we want for ourselves. We really have to keep searching if you don't like what a doctor tells you, or you kind of think, "Well, I've heard

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otherwise or I've done some research." There's other doctors out there. Find another doctor, talk to your friends.

I always say interview your doctor like you would someone you're gonna date. You know, definitely, you're not gonna like them all. They're not all going to be your cup of tea. And see, do they prescribe hormone replacement therapy for some women and not others? Are they open to it? And that's who I would actually talk to because they're gonna give you the most information and they're going to be most open-minded. Not to say you have to take hormone replacement therapy, that should be an option for you if you want to at least explore that route.

Katie: I've said on here many times, at the end of the day, we are each our own primary health care provider, and we can work with amazing practitioners, but the ownership of that starts with us. And that means we can hire and fire them if they aren't good partners in that.

And I love that you already sort of dispelled the myth about hormone replacement necessarily causing cancer, heart disease, stroke, etc. because, ironically, statistically, from my understanding, menopause actually increases risk of all of those things. And so, it makes sense that there could be a protective effect of these hormones, especially if done in the right dose.

But I hear from people who are, like, "Well, hormone replacement isn't good because hormones naturally decline with age, so that's what they're supposed to do." Or, like, of course, all these more glaring headlines, which I think is an even bigger problem in medicine, of people cherry-picking headlines, only reading the headlines of a news article that's misinterpreting a study to begin with and then running with it. At the end of the day, that's not where great medical information originates.

Dr. Michelle: Yes. It's really funny that you said that because we just talked about the reevaluation of that Women's Health Initiative study in 2019, where they actually found, oh, my God, like estrogen is protective, all these wonderful things. Well, guess what the headline was after that study? It was only about the fact that they actually determined that combined hormones with the synthetic progestin that actually did cause detrimental effects.

And so, the headline is still the same thing, combined hormones cause cancer. And even though the whole, like, nine hours is all about presenting the protective effects of estrogen, that was down in the article, like down low, where no one actually reads. Most people just read the headlines. Most reports are just about the headlines. That's really, really sad.

But yes, the protective effects of hormones go way beyond cancer. And we talk about heart disease, heart disease is the number one killer in women, and up until the time we hit menopause, women actually have the edge over men. Like men generally have a higher risk of heart disease than women when women have their hormones in place. But once women hit menopause, they're on equal playing ground with a man because now their risk is higher.

And so, replacing hormones is so protective for your heart. And one of the reasons why is because the inflammation. So, estrogen is anti-inflammatory. And so when we have less inflammation in our blood vessels, then we don't need to make as much cholesterol. And so, when we have inflammation in our blood vessels and they become rigid because estrogen helps them to have more expanding and contracting and be more flexible and more hydrated, when they become rigid and more inflamed, then we get a little damage inside our blood vessels.

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And that damage needs to be repaired. Think of like a band aid. Well, our body actually will make cholesterol and that band-aid will kind of cover up that damage inside the blood vessels. And then, if you have more damage, there'll be more patching put in. And if you think about it, you have a lot of patches inside your vessels that didn't have less blood flow.

And if you're vessels are more rigid, and they can't expand the contract as well and you have less blood flow because you have more cholesterol, then you're more likely to have a stroke or a blockage or a clot. And then just the heart itself, the ability for it to fire properly expand and contract properly, that is really important to have your hormones balanced.

A lot of women will notice that they go into perimenopause, that they start getting like little heart palpitations that a lot of times they think they're having a panic attack. But it's really the hormones kind of declining and then coming back up, because at perimenopause, you'll have this kind of...it's not a steady like steady slope going down. It's really up and down. And so, it can be really confusing for women, especially when their hormones start declining, because they can be low and then they can go back up. So, the symptoms will come and go. And you might think there's something wrong with you there. So the heart protective, they're very well documented.

And then the brain, we've really seen a lot with brain health. When our estrogen goes down for women, and for men, it's when testosterone goes down, our hippocampus in our brain, which is really where our sense of self is, actually shrinks. And the hippocampus is also where our temperature regulation system is. And so, that's why we start getting the hot flashes. Our body really can't control, doesn't know, are we hot or cold. And so, this misfire there because the hippocampus is actually shrinking and this causes the hot flashes and the cold flashes that women experience.

And then also, estrogen is really important for the brain to use glucose. So, it really helps the brain to be able to utilize the glucose that it needs for energy. And when it can't do that, we start to form amyloid plaques in our brain.

So, if you look at a brain scan from a woman who is in her reproductive years versus a woman in menopause, you'll see more amyloid plaques in the brain, some more areas that are not working quite as well for women in menopause. And this can lead to things like Alzheimer's and dementia. It starts out as brain fog, and then some mild cognitive impairment. And then, maybe we forget why we would walk into a room. And eventually it can lead to more severe cognitive impairment, and it can eventually lead to things like dementia and Alzheimer's.

So, replacing hormones can really encompass so many different things, including our heart health, or our brain health, and then, of course, our bone health. Osteoporosis, the primary reason for osteoporosis is estrogen decline. There are other ancillary causes of osteoporosis, of course, improper nutrition. So, if you're not getting enough protein, if you're not getting your minerals, although estrogen does help us to be able to utilize calcium from our diet, and so that does compound into it.

And then progesterone, testosterone are also important for the rebuilding of the bones. So, estrogen helps us to not lose as much bone, and then progesterone and testosterone help us with the building of the bone. So, it's really all the hormones that go into the bone health importance.

And the really scary thing about osteoporosis, which really shocked me when I first heard it, was, if a woman breaks a bone, especially a hip, she's likely to die within a year of doing that. It's a very high chance, it's like over 60% of how likely she is to die within a year. And it seems so crazy. But it's really because the quality of

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life goes down, the hopelessness. And it really is like the beginning of a compound effect of a snowball of other symptoms happening.

That one thing alone, for preserving your bone health, that just might be one of the primary reasons why women decide to go on hormone replacement therapy, because they might get a scan, it might show they have osteopenia, and then they might get another scan and now they have osteoporosis. And replacing hormones is like one of the best things you can do to rebuild that bone along with a healthy diet and lifestyle, doing some resistance training or some weight-bearing exercise.

So, hormones alone...a lot of women love to just use hormones and just like not doing anything else. But we are very holistic in our practice. And if you're gonna use hormones, you might as well get the best benefit out of them. And that's gonna be with a healthy diet, anti-inflammatory foods, optimizing your gut health because our gut is where our hormones actually are able to be packaged up and excreted out of our system. We have a part of our gut called the extrabellum, which there's an enzyme called beta-glucuronidase, and after estrogens are used in the body, they're actually packaged up into a nice little package, and then they're able to be excreted through our bowels.

And if we don't have that ability to do that, we can recirculate the estrogens, and then that can cause estrogen-dominance-type issues and it can just mess up our balance. And now, all the hard work we're doing replacing our hormones and living that healthy lifestyle can be inhibited. So, you can definitely get better results from hormone replacement with a healthy lifestyle.

Katie: Yeah, I feel like that's true of anything. It's like if you're going to do anything, these more advanced interventions, it's like always, it makes sense to have a quality diet and lift some heavy things and get morning sunlight and hydrate and get good sleep. Those are going to make everything better.

This episode is brought to you by Sleep.me, formerly ChiliSleep**.** You've heard me talk about them before and with good reason. Science tells us that the best way to achieve and maintain consistent, deep sleep is by lowering core body temperature. Temperature-controlled sleep repairs muscle after a hard day's work and improves cognitive function so you always start your day feeling sharp and alert. In fact, cooling my sleep environment has been the single most impactful change I've made for my sleep and I desperately miss my cooler sleep environment so much when I travel. ChiliSleep makes the coldest and most comfortable sleep systems available. They create the environment that meets the body's natural need for lower core temperatures, promoting deeper, restorative sleep. ChiliSleep makes the OOLER, the Cube and Dock Pro Sleep Systems, which are all water-based, temperature-controlled mattress toppers that fit over your existing mattress to provide your ideal sleep temperature. These mattress pads keep your bed at the perfect temperature for deep, cold sleep. These sleep systems are designed to help you fall asleep, stay asleep and give you the confidence and energy to power through your day.

They also just launched the NEW Dock Pro Sleep System, which has two times more cold power than other models, is whisper-quiet and has a tubeless mattress pad design that allows for five times more cooling contact. Pair it with the new Sleep.me app for enhanced device control and sleep scheduling. I love all of these because they cool your bed and not your room. Head over to Sleep.me/wellnessmama to learn more and save 25% off the purchase of any new Cube, OOLER or NEW DOCK PRO Sleep Systems. This offer is available exclusively for Wellness Mama listeners -- and only for a limited time!

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This episode is brought to you by Timeline Nutrition. We've all heard of probiotics and probably also prebiotics but have you heard of postbiotics? There are several major reasons these are important and thanks to emerging research, I've been experimenting with them. We know that maintaining muscle mass as we get older is critically important to longevity and enduring good health. In fact, it is one of the biggest predictors of longevity and one of the reasons I lift weights regularly and keep an eye on metrics like grip strength. Postbiotics are the active nutrients your body makes during digestion, and they are an emerging driver of this for a couple of reasons. One major reason is that certain postbiotics support mitophagy or the flushing out of old damaged mitochondria, which is really critical in the aging equation. The best compound I've found to support this is called Urolithin A and I was super intrigued when I found it. It's derived from pomegranate but it's very hard, practically impossible, to eat or drink enough pomegranate to get the scientifically proven therapeutic dose.

Urolithin A is one of the first postbiotics shown to have major health benefits and has become available to all of us. It upgrades your body's cellular power grid - giving your body the energy it needs to optimize. And clinical studies have shown that 500mg of Urolithin A alone significantly increases muscle strength and endurance with no other change in lifestyle. This is where a product called Mitopure from Timeline Nutrition comes in. They've created 3 ways to get your daily 500mg dose of Urolithin A in their product called Mitopure. They've got a delicious vanilla protein powder that combines muscle building protein with the cellular energy of Mitopure. They have a berry powder that easily mixes into smoothies or just about any drink. And finally soft gels for travel or you can use them everyday if you prefer. Personally, I love the starter pack that lets you try all three forms and see which one you like the most. Mitopure is the first product to offer a precise dose of Urolithin A to upgrade mitochondria function, increase cellular energy and improve muscle strength and endurance.
Right now, Timeline is offering 10% off your first order of Mitopure. Go to timelinenutrition.com/WELLNESSMAMA and use code WELLNESSMAMA to get 10% off your order.

But I think you touched on what I think is another really important myth when it comes to this, which is that it's only really a resolution for symptoms. That the only reason you would want to go on hormones is to get rid of symptoms. And that for that reason, you'd want to for sure wait till after menopause to even consider doing this, which to me seems crazy to think because you wouldn't wait till you had full-blown diabetes, hopefully, to start making some interventions. You know, you would hopefully have that data and pay attention much earlier and avoid the more severe problems. It's just funny to me that that's not how the hormone conversation is going most of the time.

Dr. Michelle: Oh, you know, I mean, in conventional medicine, I don't know that with your diabetes example. A lot of times they do say, "Let's wait and see." Well, okay, it looks like you're going in the wrong direction. Let's keep an eye on it." And then, you come back and say, "Now that you're in diabetes and now you need medication. So, that is kind of like how the medical system likes to roll with things.

But most doctors, most well-trained doctors, who have integrative-type training in anti-aging and hormone replacement agree that as soon as you're noticing like you're feeling off, that's the time to start testing your hormones and start replacing. You may start with just progesterone.

So, that's usually the first hormone to fall for most women. I think usually because every woman is different. But usually progesterone starts to fall first. And you'll notice difficulty sleeping, you might notice some anxiety and depression, you might notice, your weight is kind of hard to manage, you might notice like you're starting

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to feel a little off and just kind fatigued during the day. And that's really the first sign that something's off. Of course, periods will start to get irregular, I guess that's the first sign that something's off as well. Your cycles will start either getting longer or shorter or erratic.

And so, you can start with just progesterone to keep that balance. And that really helps a lot of times. And then, you might need to add some estrogen and then you might need to add some testosterone support in. And so, it's not like you have to wait until everything like when the crap hits the fan and then you start doing it. There's a proverb that says, "The best time to plant a tree is 10 years ago. And the second-best time is right now." The same thing about hormones

I mean, a lot of women might be listening to this after they've been in menopause for a while. And so, now might be the best time to address it. But if you're younger, if you're in your 30s, and you haven't started experiencing symptoms, or if you're in your 40s, and you're starting to experience symptoms, now's the time to address it before you start getting all the other symptoms and you can start to do more damage.

Because one of the things that a lot of women come to me for is they feel like they aged just overnight, just like boom. They looked young one day, and then all of a sudden, now they have wrinkles, they've lost a lot of their collagen, and just feeling like they look super old now.

And the truth is, that first year where you lose your period, that's like after 12 months of not having your periods, that's considered like now you're in menopause. From that time until, like, two years after menopause, you lose 30% to 35% of your collagen. And that's due to the loss of estrogen.

So, we start losing it at around age 30. And it's like in fragile, but then we hit menopause and boom, we lose about 30%. So, if you can get ahead of that, that's better than any med spa treatment, "I need Botox. I need fillers," because you're gonna preserve your own collagen.

If you hit it after the fact, you can definitely rebuild collagen. There are a lot of different things you can do to do that. But it is huge. So, if you can catch it earlier, that's going to make a huge difference. And so, that's one of the things that people don't often talk about is the impact on your collagen and elastin and the way you look and feel about yourself.

And that's your confidence. That's a lot that really matters. And our hair also, when our estrogen and progesterone are super low, we lose something in our body called sex hormone binding globulin. So, it's kind of like the brakes on our hormones. Our body has a lot of checks and balances to make sure things stay balanced. And one of the things it does is it has sex hormone binding globulin to bind up hormones that it doesn't want to use right now.

And because we don't really have storage for hormones, like you think your gallbladder stores bile, we don't really have a storage bank for our hormones. So we have this sex hormone binding globulin to kind of find out what we don't want to use. When estrogen and progesterone drop, so does the sex hormone binding globulin, and that can release up a lot of testosterone that's still there.

Not that women have increased testosterone, their testosterone will stay the same that it's been it doesn't usually drop right away. And that can cause androgen dominance. And then women notice they start to get like dark hairs on their chin, they start to get those whiskers, they might start to lose hair on their head, they might start to get a little irritable, maybe start gaining weight around their belly instead of women generally gain weight around like their hips and their thighs. Men usually gain weight around their belly, but that belly

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fat is usually due to that androgen dominance and that drop in the sex hormone binding globulin. So, you can get ahead of that, too, the earlier you replace your hormones.

And then testosterone will eventually drop as well. And then some women need to support it. I have women in their 70s who their testosterone is still pretty strong because that primarily is going to be coming from your adrenal glands. Our adrenals make DHEA, and that converts over to testosterone first before it converts over to estrogen. And if it's going to do that at all. So you can still have pretty strong testosterone, although some women will notice even earliest, their early 30s, they have a drop on testosterone. So it's really individual there.

That's why I always recommend testing hormones and not just replacing hormones. It's not standard of care in the United States to test hormones for women at all. It's thought that it's a waste of time. If they're in menopause, hormones are low, and not in menopause yet, hormones are fluctuating, so why should we test them?

But it's really not fair because if a man goes into a doctor's office and starts complaining about symptoms of low testosterone, it is standard of care to immediately test his testosterone, prescribe him testosterone, and then retest his testosterone in a few weeks to make sure his testosterone is at a good level.

A woman goes into the doctor's office, explains all the symptoms of low estrogen and progesterone, she is not offered hormones at all. She's not offered testing. A lot of times she's offered, like I said, antidepressants or gabapentin, which is a really potent pain medication with lots of horrible side effects. But it's one of the go-tos for menopause treatment, unfortunately.

And so it's really not fair. It's really a double standard there. But like you said, men are often awkward pain medication before women are. Men are often guarding for heart disease before women are. And so, it's really something that we're trying to change in our practice. And we're trying to really get the word out so women can really demand these things.

And unfortunately, insurance may not pay for your hormone test. But there's a lot of affordable, direct-to-consumer tests. In our practice, you can just order tests, you don't have to be a patient or anything. We think that knowledge is power. And the more you know about your body, the more you can direct your medical team to help you.

I always feel like doctors are the facilitators. We have access to the testing. We have access to the prescriptions, that like you said earlier, you are really the one has to be in charge of your health. And you can't expect the insurance industry to take care of you. Like when you think about like your insurance for your house, like we all have home insurance. But it doesn't pay for like cleaning your house. It doesn't pay for things like day-to-day maintenance. It's there if your house burns down.

And our health insurance is really the same way. It's not really to keep you healthy and to optimize your health. It's there if you, like, get hit by a car and you need to go into surgery right away. But it's not really there to keep your hormones balanced. And that's not really what it's for.

Katie: Yeah, and you touched on something so important. And I'll make sure I link in the show notes to your website because you have so much educational content around this. I feel like you yourself are a walking, breathing encyclopedia of hormone knowledge. And I know you have resources where women can directly get in touch with you and order these tests.

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But I think this touches on another big issue in this, which is like for a long time, testing wasn't available, it was hard to figure out. Even now, I feel like it's overwhelming to try to figure out what exactly should women be testing? What levels are they looking at? When is it a good time to get a baseline for that so that you know? Like what are some general guidelines you give women of an optimal case scenario with like if you want to navigate hormones throughout perimenopause and menopause without hitting these more negative side effects. When do you start? And what do you look at?

Dr. Michelle: Yeah, in an ideal world, when a woman is like 28 years old, she would get hormones tested to see like what her baseline, like when she feels her best. It may be 28 because maybe you didn't feel your best at 28. But whenever you felt your best in life, test your hormones then.

And generally, for a woman who's cycling, we like to test between days 19 and 21 of a 28-day cycle. So, about five to seven days after ovulation that's when progesterone is gonna have its peak. And then estrogen is going to have its second spike. And that gives us a good ratio.

So, when we're looking at testing, we have reference ranges based on the day that you took your test. So, if you took your test, like on day three of your cycle, we look at a reference range that correlates to where those levels should be. But if you took your test on days 19 to 21, we have reference ranges that tell us, "Okay, this is optimal for that time in a month."

And also, if you're on hormone replacement therapy, we have reference ranges for physiological dose of hormone replacement therapy. When I say physiological dose, I mean, a dose that is similar to what a woman would've made at her peak of reproductive health.

There's superphysiological doses, which some doctors will prescribe, which are 10 to 100 times what a woman would have made at the peak of a reproductive health. And I do not recommend those. We don't work with superphysiological doses in our practice. But I think that's what gets hormones a bad name. That's where women have side effects. That's where things go wrong.

And that's why I'm not a fan of pellets. They're not really regulated at all and may sometimes have a lot more hormones in them than what's stated on the package. And unfortunately, the doctors that most of the time will be inserting pellets have done like a three-hour training just to learn the procedure of putting the pellet in. A pellet is a small little, compressed...it's like a little compressed little it looks like the grain of rice that has the hormones in it that's supposed to release over time. And it's a little surgical procedure just to insert it under the skin, usually around your buttocks area. And so, there's this chance of infection, of course, it's an office visit.

But the big problem with the pellets is once they're inserted, they don't come out. And so you're stuck with that dose that's in the pellet, whether you react to it or not. And a lot of times, it's a massive dose of testosterone. It can be a massive dose of estrogen. And it can cause a lot of side effects.

And so, you have to wait for it to kind of wear off. And unfortunately, in the beginning, you get a big rush of hormones, and towards the end, at times, tends to dwindle off. And so I'm not a huge fan of pellet therapy. There are some women that love it. Generally, it tends to be younger women who do the testosterone-only pellet who are in their 30s. They tend to like it better than the women who are postmenopausal and have kind of bad side effects from it.

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So, I'm not a big fan of superphysiological doses. I'm a fan of doses that are physiological doses. So, we can look at test ratios in the reference ranges. There's a standard range and optimal range, just like every test that you can think of when you get a blood test, or the standard range and optimal range that we look at.

And so, for each woman, optimal might be different. Some women might do well towards the higher ends of the range. And some women might feel better on the lower end of the range. So, we do look at symptoms in addition to testing. And we retest our patients every four months. And we look at their symptoms now and where their levels are. And then we can tweak things because we use hormones that we can tweak very easily.

I'm a big fan of topical hormones because they're so easy to tweak. And women can do it. I can like basically tell them, "Oh, okay, why don't you use a little bit less today for these three days. And then, at the end of your cycle, we'll bump it up a little bit." It's so easy to modulate based on how the women are feeling if there's any illness or if there's a trauma in their life, they might need some more hormones or less hormones. And so it's really easy for them to regulate.

And then there's a range for menopause if you're not on any hormones. And so, there's different ranges that we can look at. So, I would definitely recommend testing as soon as you start to feel some symptoms, If you haven't tested at your peak. Start testing as soon as you start to feel some symptoms.

Now in perimenopause, the test can sometimes don't tell the full story because when month might have higher estrogen levels, and the next month you might have lower. But based on your symptoms and your testing, we'll be able to correlate and give you a good idea of where you should be.

And then, what else? Let's see. I also like to test thyroid too. When we do symptoms, we look at symptoms of high and low estrogen, high and low progesterone, high and low testosterone. We also look at symptoms and high and low cortisol, we look at symptoms of high and low thyroid, and then we look at symptoms of inflammation and metabolic syndrome.

Even though for women who are working with us for hormone replacement, we might only initially test their estrogen, progesterone, testosterone, and DHEA. But if they score high on, when we do their symptom questionnaire for thyroid symptoms, for instance, like let's say, they're knowing they're feeling cold, and they're having constipation, and their hair's falling out, and they're fatigued, then we might say, "Hey, you know what, let's also test your thyroid if you haven't had thyroid health lately because your symptoms kind of points to the fact that you might also have a thyroid issue, which can be helped by estrogen and progesterone."

So, estrogen and progesterone, when they're at healthy levels, can support optimal thyroid function. A lot of times, women will have hypothyroid symptoms, and they start hormone replacement. And they actually start to feel better. So, it's not always a need for thyroid medication. It could be a need for some nutrients, like some selenium and iodine, that might be missing from the diet. That can be something that can be supported. But we like to look at the whole picture of the whole endocrine system because it's really, everything supports each other.

Katie: That makes sense. And it seems like with anything in health, the more I learned, the more I realize it's all about personalization and individualization and moving away from a one-size-fits-all approach, and putting people in the seat of power of figuring out what's going to work best for them and actually listening to them and responding to their specific use case, which seems like exactly what you do in your practice.

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And I can't believe our time has already passed so quickly. I hope we can do many episodes together because you are such a wealth of knowledge. I will, of course, link to your website in case people want to work directly with you. Do you do virtual work with people?

Dr. Michelle: We do. We're 100% virtual. We have a whole team of hormone specialists around the country. So, we're here to help. Even if you just have a question, I do a lot of free Q&A. I have a YouTube channel where it's free information. So, I'm all about empowering women, one way or another.

Katie: I love that. And then a couple last quick wrap-up questions until we can do more rounds in the future. The first being if there's a book or number of books that have really profoundly impacted your life and, if so, what they are and why

Dr. Michelle: Probably the book that was the biggest impact on my life is called "The Power of Now" by Eckhart Tolle. And that just helped me to really focus on what's important and what's going on right now in my family life. So, if I have a lot going on at work, and I'm gonna go in and see my son, I don't pull with it the whole day. I actually am present with him and enjoying the moment and just being able to interact with people and keep my emotions in check.

The book really taught you to kind of be an observer and be able to look outside yourself. So, if you're being reactionary, you're able to actually, after reading that book, able to actually like kind of step outside and actually see myself overreacting and think about what's really happening. And it's really helped me to center myself really to get more out of my meditation, and I just kind of that book with being able to really focus and achieve all the things I've achieved in my life. So, I'm really thankful for having that book in my life.

Katie: I love that. I'll put a link to that in the show notes as well for everybody listening, all of that, as long as all the notes I've been taking during this episode are all at wellnessmama.fm. And lastly, any parting advice for the women listening today could be related to everything we've talked about or entirely unrelated.

Dr. Michelle: I think just knowing that the body is incredibly intelligent. And our bodies are really designed to have a state of health, a state of wellness. And your body will continue to do everything it can to help you get there. And the only problem is, sometimes there's so many unnatural things that we're exposed to that inhibit it. And so, just working with your body and not against it and really focusing on helping your body to protect you and to heal for you. And knowing that we really have limitless ability to heal as long as we just facilitate and really support our body in doing so through diet, through exercise, through mindset. And just keep learning and keep really just doing the things that you know in your heart are going to bring you to where you need to be.

Katie: I think that's a perfect place to put a pin in it for today. And like I said, I hope we get to do many more episodes together. But for today, I'm deeply grateful to you for all the work that you do and for being here and for sharing today. Thank you so much for your time.

Dr. Michelle: Thank you so much for having me.

Katie: And thanks, as always, to all of you for listening and sharing your most valuable resources: your time, your energy, and your attention with us today. We're both so grateful that you did. Please check out all the resources in the show notes and reach out to Dr. Sands if you have questions. And until next time, thanks for listening.

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