



977: Perimenopause Isn't a Problem—It's a Clue:
The Cyclic Approach to Hormones, Health & Vitality
With Emily Sadri

Child: Welcome to my mommy's podcast!

This episode is brought to you by NativePath and in particular, something I have been experimenting with and really, really loving lately. And here's what you need to understand. A lot of us think calcium is important for our health, especially for our bones. But is this actually true? Bad news. It turns out maybe not, or at least there's more nuance here.

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It was not a medication or even a workout. It came down to one simple thing added to their morning routine. And that's why a lot of people, especially people over 50, are making this one simple change and seeing massive results. I'm sure you're probably curious what it is, and it's a particular protein from one of my favorite brands called NativePath.

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This podcast is brought to you by LMNT, and this is a company you might've heard me talk about before, and I really love their products because proper hydration leads to better sleep. It sharpens focus, it improves energy, and so much more. But hydration is not about just drinking water because being optimally hydrated, a state called euhydration is about optimizing your body's fluid ratios. And this fluid balance depends on many factors, including the intake and excretion of electrolytes, which many people don't get the right amounts of. Electrolytes are charged minerals that conduct electricity to power your nervous system. I talk a lot about nervous system on this podcast.

They also regulate hydration status by balancing fluids inside and outside of our cells. LMNT was created with a science-backed electrolyte ratio of 100 milligrams of sodium, 200 milligrams of potassium, and 60 milligrams of magnesium with no sugar. Since electrolytes

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So replacing that lost sodium with electrolytes can help you feel good on a fast. Since LMNT is zero sugar, it also doesn't break up fast. Electrolytes are also important for maintaining blood pressure, regulating digestion and proper fluid balance. Keeping skin hydrated, which is a big one that I feel like often gets missed and so much more.

I feel like proper electrolytes is a missing piece for a lot of people and I love LMNTs new canned drinks, which are sparkling water with all the same ratios and minerals I just talked about, and they are delicious. You can check it out and learn more at drinklmnt.com/wellnessmama. And at that link you will receive a free sample pack with any order.

Katie: Hello and welcome to the Wellness Mama Podcast. I'm Katie from wellnessmama.com, and I am here today with Emily Sadri to talk about how perimenopause isn't the problem, it's a clue. And understanding the cyclic approach to hormones, health, and vitality. She has so much practical information in this episode.

Emily is a double board certified women's health nurse practitioner and certified nurse midwife. She hails from New York City and obtained her graduate education at the University of Pennsylvania. She was drawn to midwifery, which means with women or to stand in front of, because it was a practice rooted in relationships. And she believes that women need across their lifespans, someone to walk alongside them, not to tell them what to do.

She practiced in conventional medical settings for a decade before founding Aurelia Health in 2021, which I will link to in the show notes. And she gives a lot of really practical wisdom in this episode about perimenopause and why she doesn't even like that word. So let's jump in. Emily, welcome. Thank you for being here.

Emily: Thanks so much for having me, Katie. It's a real pleasure. I feel like I've known you for so long as I'm sure that many of your listeners do, and it's a real honor to be here. So thanks for having me.

Katie: Well, I'm excited to learn from you. I feel like our topics are going to be very relevant to a lot of people listening. And in the span of two episodes, we're gonna get to go deep on two particular topics. And in this first one, I would love to deep dive on the topic of perimenopause. I know I get a lot of questions about this.

This is a phase I will also eventually be moving into, so I've been researching it quite a bit. And I love what I've read from your approach and your work already on this and would love to learn more deeply from you. And in particular, you've said that perimenopause isn't a problem, it's a clue. And I would love to start there as a foundation for this conversation because I feel like often, especially in the realm of women's health, so many things are framed as a problem.

Women often feel like something's wrong with them or something's broken, and I love the way that you shine light on this topic.

Emily: Yeah, I think that even in the natural health space, we have a tendency to sort of conceptualize everything through the lens of like what a woman is doing wrong. You know, it, it's really interesting if you look back to 2002, and I'm sure that other guests of yours have talked about the WHI, the women's Health Initiative study.

So I'm not gonna go in depth about that study and kind of how it changed our opinion and stance on hormones as a medical community. Even the natural health community at the time, you know, began really demonizing estrogen. And we began to, at that time, more than any really talk about perimenopause in terms of how we need to sort of be better, how estrogen is this demon that we need to detoxify better.

And anything that was wrong was related to estrogen dominance. Right? And that sort of still stays with us today in the sense that on the sort of natural more integrative side, I think there's still some confusion about the role of estrogen and about declining estrogen and what that is a catalyst for in the body. And on the traditional medical side, there is still an overemphasis on this symptom management, as you said. And you know, the last most updated guidelines from the Menopause Society in the North America, the US that's our governing body, still emphasize that our approach to this phase of life, which I really think of as just part of the trajectory of aging and as so many things are, because most of the medical model is like a male lens.

If it's female, it's like it has to be kind of different, but it's not. Instead of talking about it as a physiologic change, we're pathologizing it and saying like, well just treat the symptoms. Think if you take a more longevity or even like a biohacking approach to thinking about aging for females. If you think about how we approach the rest of the body, like you talk

about this in terms of metabolic health, or you could talk about it in terms of, you know, really any aspect of the body. We are working to not, we know that aging is inevitable, but there are lots of ways that we can kind of intervene to slow, say telomere shortening right, actual physiologic changes that occur as we just get older. When it comes to the endocrine system and to hormones, the ovaries are aging and that is a systemic issue because there are receptors for estrogen on every cell in the body except for the red blood cell. So it's not so much that we need to worry about making a person comfortable.

Of course, I want people to be comfortable. But if we're just taking the approach of like, just give a little bit of hormone or maybe a little bit of ashwagandha or a little bit of black cohosh or whatever you wanna treat someone with on any side of the spectrum, we're really missing an opportunity to dial in and say, is there anything that can be done to kind of extend positive physiology and positive physiologic sort of processes in the body by assessing really well. And then intervening to first, I would say in very early perimenopause or really like any, any amount of ovarian aging. I don't even like to use the word perimenopause anymore.

Because again, it makes people feel like, are they in it or not? And it's like in reality, we're always on this trajectory of our ovaries being dynamic in aging, right? From from the beginning, right? We are in utero when we're in our mother's womb. We have a lot of follicles, right? And then we have less by the time we're born, then we have less by the time we're menstruating.

And then we have less by the time we're 30 and 35 and so on and so forth. So it's really just this, it's the lifespan, it's the female lifespan. And so if we're just taking this, again, symptom-based approach and saying, well, you're in perimenopause now. So now you get to have, say, birth control because that will suppress your symptoms or you get to have a low dose estrogen patch 'cause that will suppress your symptoms. We're really missing this broader scope of saying, let's see your health through the lens of your ovarian function and what can we do to optimize that earlier on. Much in the same way that we wanna optimize fertility, right? Menopause is really just the cessation of fertility, that's all that it is. So in the same way that we can optimize fertility, we can optimize ovarian function as we age.

Like for someone like your age or my age where we're sort of post child bearing, but we're not necessarily in the depths and the throes of like right at that end of ovarian function, right? We're somewhere in the middle. What can we do to optimize it first and then how can we augment it if our physiologic reserves are just no longer there?

Katie: I love that reframe and the idea of being aware of this earlier, not framing it as a problem. And I feel like even that lens of looking at how do we support ovarian function in

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each phase and not kind of demonizing one or making it a demarcation point of this is now perimenopause. It feels so much more empowering and I feel like it's not usually talked about in this way.

So can you explain a little bit more on like the hormone side, what's happening with our hormones in the normal physiological function of our ovaries? And then from understanding that, what are some of the ways we can begin to be aware of and start supporting our ovarian function at any age?

Emily: Yeah, no, I love that. And I know that you're a big fan of circadian rhythm, so your listeners will appreciate that we each also as females, have an additional rhythm, which is our infradian rhythm, right? So this is our rhythm of hormones that is dictated by our hypothalamic pituitary ovarian axis.

So it all begins in the brain, with the hypothalamus and the pituitary, which are kind of like air traffic control. They surveil the body. They are aware of what's happening in terms of levels. But unlike the thyroid hormone, or say adrenals that have a daily rhythm, right? Our ovarian hormones have a monthly rhythm, right?

Some people, you know, kind of equate it to like the lunar cycle. Now evolutionarily speaking, I don't think that every woman needs to cycle with the moon because it wouldn't make any sense if everyone was always fertile at the very same time. In terms of like populating the earth. So, you know, I think that there are light reasons why that may happen, but I don't encourage people to like sync your cycle with the moon, that it's absolutely necessary.

But what is happening is that FSH, which it stands for follicle stimulating hormone, on day one of your cycle when you get your period right, is starting to climb. It's starting to rise. And that is responsible for releasing estradiol or estrogen from your ovaries. Estrogen is at the lowest at day one of your cycle, so when you're bleeding,

It begins to rise around day 5. And we're gonna frame everything in the context of a 28 day cycle, but for many women, that might be 27, 32. So you can extrapolate from there. So from day 5 to say day 12, estrogen is on the rise. Peaking one time in the beginning of the cycle in the follicular phase, that's the first half prior to ovulation, peaking one time about two days before ovulation. When estradiol peaks to its highest level that it has at any point in the cycle, for the most part, it will then trigger the release of luteinizing hormone from the brain. Okay? So it's this beautiful ebb and flow, and you should, we should link a picture of it in the show notes, because if you've never seen it, like I think, you know, you really kind of understand it if you see it.

LH is released, this is what you test if you're doing ovulation predictor tests, right? Because this is the hormone from the brain that triggers the release of an egg from the ovary. So LH surges, a follicle is released, and then what's left behind in the ovary is called the corpus luteum, and that is sort of a temporary endocrine gland that secretes progesterone for about 12 to 14 days. And then as no pregnancy occurs from about day 21 to 28, estrogen and progesterone start to decline. And then the whole cycle starts again. When they get to their lowest level, it triggers a release of the uterine lining and then it starts again. Now, this is important, and many of you might understand it in the context of fertility or the context of your period, right?

If you've done any fertility awareness method, if you've just tracked your cycle for your own kind of health understanding. And what I didn't understand and was not taught in my Ivy League education, which is wildly surprising, was that like this physiologic process, this rhythm is actually responsible for health in all areas of the body, in all systems of the body. It's not just, it doesn't just serve the purpose of like changing your uterine lining. And we know this because we know that we feel different, right? And we know that we've heard things like, you know, it's better to fast in certain parts of the cycle. So we understand sort of how it impacts our metabolism, our mood, maybe our sleep, maybe our energy. But beneath the surface, there are a cascade of things that are triggered by these undulating levels of hormones and rhythms.

Katie: Yeah, this is so fascinating and I've tracked my cycle now for over 20 years, and it's given me some fascinating insight. I've also used that for planning pregnancies and avoiding pregnancies. One thing that used to frustrate me was in my Oura ring data, in my luteal phase, I would always have lower readiness scores, and I used to kinda get angry and ping them and say like, of course temperature rises in the second half of the cycle.

Why am I getting dinged for this? And then I realized like, actually, if I look at the data as a whole, my readiness is somewhat lower in my luteal phase, my resting heart rate is a little bit higher, my sleep is not quite as good at certain points. And so it was actually accurately giving me insight there. And I was getting annoyed because I thought they were just honing in on temperature.

But to your point, this affects so many areas of health, which I find so fascinating. Especially if we track it we get that insight kind of on a day-to-day basis and can then like tweak based on the data and based on how we feel to make those changes.

And I know we also hear a lot about progesterone and progesterone changes kind of being the first sign of perimenopause. And you touched on it briefly, but I feel like that one gets so much attention. I would love your take on progesterone and what to know about that.

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Emily: Yeah, no, I was actually thinking while you were talking that some of the things that we don't understand about the cycle is there are things built in here that are cancer protective for women, right? This is why most incidents of breast cancer happens after the age of 50 for women, because it's when this dynamic, very protective cycle falls apart completely.

And one of the roles of progesterone in the luteal phase is to stimulate the production of tumor suppressor gene. And one of the roles of estrogen, right, is to be a growth factor. It's how we grow and recycle the internal lining of our blood vessels, right? It's think about when you're building up a uterine lining, you're actually growing new blood vessels.

Well, that's just not happening in the uterus. It's happening everywhere, right? So we're recycling our blood vessels, we're creating growth factors, we're creating new stem cells. And then that growth needs to be balanced, right? Much very much in like a yin yang kind of way by the yin of progesterone, which says like, calm down.

Let me do some checks. Let me kind of survey the body. Let me like, you know, look at everything. And there's actually a study that shows that for women who have breast cancer, if their surgery for removal of a suspicious or malignant lump, is done right at that juncture, after ovulation, before the surge of progesterone, they actually have a lower chance of recurrence because of that protected nature of progesterone.

So progesterone is not just protective for the uterine lining, which we hear about, right? Progesterone you know, we will get robust amounts of progesterone when we have healthy, robust ovulation, right? And healthy, robust ovulation starts well before day 14, day 15 of the cycle. It starts back when we get that estradiol peak. So what many people don't understand is that as perimenopause, you know, if you wanna call it, that starts to set in, it's the whole cycle is falling apart because ovarian health is falling apart.

So just even though we kind of conceptualize it as like progesterone is decreasing, many people begin with a progesterone supplementation in perimenopause because of sort of lack of robust progesterone secretion. It's really due to that lack of peak of estradiol two days before ovulation that we're seeing these impacts. Because when estradiol is peaking between day 5 and 12, it's recruiting healthier follicles, right? And the healthier, more robust follicle you get, the better progesterone production you're gonna get.

So it's really like, I don't like to think of, like a lot of people will say perimenopause is a period where you have estrogen excess and irregularity and insufficient progesterone. I think that it's a little bit more nuanced than that. Certainly from a symptom-based

perspective some people will benefit from very, very early in perimenopause doing things that support progesterone secretion like, Vitex, vitamin C, and other antioxidants.

Obviously stress support because there's a relationship between the formation of cortisol and sort of your ability to produce progesterone. But we also want to think about at what point are we sort of missing out on the opportunity to really work with estrogen? Because estrogen from a systemic perspective and from a chronic disease risk factor like, perspective is I would say more, more important than even than progesterone.

Katie: Yeah, I love that idea that it's more nuanced than that versus a single solution, especially because it feels like often those solutions are not done cyclically, so they're not kind of lining up with what the body naturally does. So I love that you explained it like that. I also know another big topic when it comes to perimenopause and menopause is the metabolic changes, the increase in visceral fat, the metabolism shifts.

How often already about 90% of people have sub marker of metabolic dysfunction, and often for women, this number goes up in those phases of life. So can you talk about what's happening? Why do women seem to experience this sort of like metabolic coming undone often during perimenopause and menopause?

Emily: Yeah. I love that coming undone. I say fall apart or coming undone because that's what it feels like, I think to women. And we also know there's such a relationship between our stress, our sleep, how all of these other habits and we're kind of coming to a peak time by the time we're in our mid forties of like really holding it all. Right?

Like I am four, about to be 44 this year. I have aging parents. I have little kids, right? Many of the people that we work with, it's the same situation. It's like the amount that you're holding is growing as just as the capacity in the reserves seem to be decreasing. So you've got this like perfect storm. And then estrogen is subtly on subtly or not so subtly on the decline in the background, which affects metabolic health in many different ways.

On the surface level, right, I like, I think that it's practical to think about how when estrogen declines, our circadian rhythm can begin to fall apart because estrogen really governs the suprachiasmatic nucleus in the brain. And so it decreases our ability to really respond in our brains to the signals of the sun. And so that may be subtle at first, but it, it shows up as like waking up at three or four in the morning, having a cortisol spike in the morning.

It shows up as having less resilience to things that also disrupt cortisol, like alcohol. So women will drink an alcoholic beverage and then they find that they're waking up at three o'clock in the morning. And that's because alcohol initially will tank cortisol. And then because that also works by a feedback loop, we'll get a spike around three or four in the

morning. And that can happen without alcohol too. And people will say, I think it's just because of all this stress and I'm ruminating about the stress, but there's again, a physiologic component to your ability to manage the stress, right? They work hand in hand. And I don't wanna overemphasize that, you know stress management of course is important. And you talk so much about this on this podcast and I think anyone in the wellness space hears about that so much.

And it's important. But we also don't want to oversimplify and also get into a tendency of kind of blaming people. Because I meet so many women who are just like, feel so bereft because they feel like, I'm doing everything for my sleep and I'm doing everything for my stress and I just like can't nail it.

And that may be because of the loss of resilience just inherent in losing estrogen. We also lose the ability to, regulate the vagus nerve. So we lose parasympathetic tone. So that means that if you have a stressful event, like I always say, maybe your kid walked in and like knocked your favorite glass on the floor and it shattered and like, it's a small thing. It may cause a brief sympathetic uptick, but we should realistically be able to recover from that. But if you're feeling like that, just like you can't shake that physically, that's lack of dynamic parasympathetic tone, right? And estrogen also impacts that ability. So you have all these factors that dysregulate stress, and I think that that absolutely plays a role in the way that our metabolism is regulated.

Particularly we know that gluconeogenesis, which is the process by which our liver sort of keeps glucose levels high. And this is something that's very much regulated by stress and some people are genetically a little bit more prone to doing this. I'm someone that's very prone to kind of keeping glucose levels higher than I actually need them. Like before, you know, I really could have understood this work I just sort of lived in like a high nineties, low, one hundreds place, despite lots of dietary changes. And it was a very physiologic response to stress. So that will often worsen for women in perimenopause, meaning that their increased cortisol is creating, is making their liver kind of unload stored glucose and keeping their glucose levels higher as if they would be kind of ready to run or exert heavily physically.

But it's, we, you know, we're obviously mostly not doing that. We're sitting at our computers. Additionally, estrogen, just at the cellular level, helps improve insulin sensitivity, meaning that it changes cellular signaling. So when insulin comes to the cell, the cell is more receptive to insulin moving glucose into the cell.

We want glucose in the cell, not outside of the cells, because when it's in the extracellular space, right? Glucose can do all kinds of damage to the body. We want it in the cell where it

can be used up and converted into ATP, which is our, like energy form, our cellular energy. So the other thing that it does is it just seems to deposit more abdominal fat. And we see that with cortisol patterning too. So I think that we haven't fully elucidated, like how much of that is driven by estrogen's unraveling of cortisol balance and how much is directly related to just the loss of estrogen in itself? I think it's probably a combination of the two.

But if you are like, am I sort of moving toward that place where I should be thinking about what can I be doing to either optimize my endogenous production of hormones or potentially supplement? The initial symptoms that people are gonna experience often are like, I haven't changed anything in my diet or exercise routine, but I just notice that like around my waist I have more belly fat.

And that obviously feels really demoralizing and frustrating to women. And number two, I would say it's the psychological shifts, the feeling like I just have more baseline anxiety. I feel like I can't multitask or tolerate things the way that I used to. And little glimmers of brain fog. Right. Brain fog is a really important symptom to pay attention to.

Like if you've ever been driving a route that you drive all the time and you just miss your turn. Right. Or you're like, mid-sentence like on this podcast and you're like, I can't remember the word that I was gonna say. Like something that you say all the time. Those little things that, you know, I think we have a cultural tendency to just sort of like shrug off.

And I think if many of us who are sort of millennials or young Gen Xers, when we think back to our childhoods, it was just very socially and culturally normal for women in their forties to just take on a different appearance. They were more fluffy. Right. They were kind of more cranky and this was like an archetype that was very generally accepted.

And I actually thought, I remember having thoughts as a, as a small child at like 13, 14, that like once you have kids and you get to be 40, you just end up kind of being fatter and crankier. Like that's just a natural physiologic progression. And that's like wildly amazing to me that as a small child, I had that impression. And thank goodness that I live in the age that we live in now, where I think age is so much more.

We know, we know that age is actually like a chemical, biologic thing, not so much a chronologic thing, right? You have your chronologic age, but there's so much that you can do to impact your physiologic age. And that's really what we're talking about. It's like how can you support your body to stay within this rhythm for as long as possible, producing hormones in the best way possible, at the best levels and the best rhythm, or when that is no longer available, how can we then augment to reproduce that rhythm? If you're a candidate for that and you're interested in kind of being all in on this hormone journey,

that's an option too. Either way, it's a much more, we have so much more ability to modify our outcomes. Does that make sense?

Katie: It does, and I like that you talked about at the beginning of that kind of losing our sensitivity to light, which to me indicates that this becomes a very important factor to be intentional about as we get older. I think it's wildly important at any phase of life, actually. And even in my kids, I see massive circadian changes when we get the light exposure piece right. But at the end of the day, I feel like humans are solar powered. And so perhaps for women in this phase of life, it's a little bit more intentionality about our light patterns and our exposure to natural light and getting enough of it and how we know that increases our nutrient absorption, it affects our circadian rhythm.

There's so many benefits there, and I know it also gets tougher when we have teenage kids and aging parents and all the demands on our time. And I love the way you kind of explain the first principles of this idea and really take like that 10,000 foot view and then dial into the specifics that we could do.

I'm curious for women who are tracking their cycle and as I have for so long, how can we tell when these things are starting to shift? When supporting ovulation isn't enough anymore or when we, like, what signs should we watch out for and what do we do when we start noticing changes?

Emily: Yeah, it's such a good question. And for any of you out there, I know there's lots of you who are cycle temp tracking, so maybe doing it with an Oura or a thermometer and using an app like Natural Cycles or all the other ones that are out there. Which I've also been doing forever and love it and love having 20 years of historical data on myself. Another tool that's really cool, and I don't know if you've done this at all yourself, Katie, is there's a lot, there's a couple of urinary hormone trackers now out there.

The Mira monitor, the Inito monitor that you can really kind of combine your self knowledge and monitoring with these tools where you would just actually pee on a stick, kind of like a pregnancy test or an ovulation test. And then you stick it into this little device that syncs with your phone. And you can get your estrogen, LH, and progesterone levels every day, which is super cool because sometimes temperature, which is the core measure in traditional fertility awareness in addition to cervical mucus, cervical position, et cetera, those are other fertility markers that you can be aware of.

It's really cool to be able to dial in to the hormones. It's kind of like having your own Dutch test at home. So, and those are really affordable, especially the Inito. So I definitely recommend checking those out. But the things that you may begin to see, number one, if

you're only temp tracking, it's very possible that you'll see a shorter amount of time that your temp remains elevated. You may also see that the temp elevation is not as significant. So if it used to be a degree to a, you know, 1.2 degrees, it may be like 0.6 or 0.8 or 0.4, right? And of course there are other things that impact this: thyroid health and thyroid sufficiency, which is something that I really encourage everyone to have an in-depth thyroid assessment annually. Especially as we're moving through ovarian aging. So really starting at 30, 35, an annual complete thyroid evaluation is super important because a lot of the symptoms and people think like, oh, it's gotta be my hormones, because that's become so buzzy.

And they're convinced that it's that. It's like, we actually correct the thyroid and then all of a sudden progesterone production becomes robust again, and temperature stays elevated in a beautiful way. If you're monitoring with an Inito or a Mira, what you might see is that there's a little bit more of like a chitty chitty bang bang quality. Like a kind of clunking happening in that follicular phase when estrogen should be on a consistent rise to like, you know, that the rollercoaster, how there's like the one really steep hill at the very beginning that like clink, clink, clicks up all the way that how our cycle should be in the follicular phase.

It should be one big hill at the beginning. And in perimenopause you might start to see there's like kind of a chunkiness. Like you go up and there's down and up and down and you don't really get that sufficient peak in the pre ovulatory phase. And that's really interesting to watch because what sort of happens is that if you're tracking your actual hormone levels, what you will find is that instead of having a high peak on day 12 and a moderate peak on day 21, you'll see a really big peak in the second half of the cycle in the luteal phase instead.

And I think the reason is because FSH is always aware of what's going on and kind of knows, your brain knows intuitively that you never hit that peak that you were trying to hit pre ovulation. And then it kind of hits it in the second half of the cycle, which is why some people may describe things like what we would maybe classify as estrogen dominant symptoms in the second half of the cycle.

So like increased breast tenderness, increased PMS. And theoretically that's related to an imbalance in the amount of progesterone, relative to progesterone in the second half of the cycle. So if you're having, I would say symptoms, like you're feeling a lot of mood and brain and cognitive changes, you're seeing sleep changes, you're seeing, like temperature regulation changes. So not quite night sweats or hot flashes, but you feel even more cold, kind of like a thyroid symptom.

Like these can all be signs that this system is falling apart. I would say if you're like up for the challenge and you're the girl who's got the CGM and you're doing the temp monitoring and all that stuff, go get yourself an Inito or a Mira because it just kind of elevates your awareness of what's really going on.

Katie: I love the availability of all these kinds of tools now and that we can get this data at home. I feel like we're living in such a amazing era for that. And sometimes it's helpful, really helpful to have people like you kind of explain how to use these things. Because often we can get data overwhelm as well, like with lab data and genetic data and all this testing we can do. And knowing how to actually use that to our advantage kind of becomes a really big factor.

And we've touched on hormones. I'd love to, before we end this episode, talk a little bit about hormone replacement therapy. I know that's a big topic in these phases of life, and based on everything that you've said, I'm wondering, is there kind of a rhythmic approach to this as well that more closely mimics the body's natural rhythms and that is more supportive of ovarian function and health as long as possible.

Emily: Yeah, so I like to think of hormone replacement therapy. And I very intentionally use the term hormone replacement therapy versus menopausal hormone therapy because in my opinion, we do not need to be, you know, a year without a period before we think about using hormones. And there are lots of indications for hormone replacement therapy, including conditions like PCOS or primary ovarian insufficiency. Things where there's dramatic hormone insufficiency well before the time that we would think of it as like traditional ovarian decline. So the way that I categorize hormone replacement therapy is we've got basic static, okay? That's one type. That means that we're giving like a low dose, continuous estrogen every day, and we're giving a low dose, continuous progesterone.

The reason that we need to give progesterone in addition to estrogen, from a very traditional medical standpoint, is to protect the uterine lining from getting that growth that I talked about: happens between day 5 and 12 of the cycle leading up to ovulation, which would be theoretically preparing the uterus for a pregnancy. In a traditional approach, we never want the uterine lining to grow.

Once someone is, you know, relatively menopausal because if that goes unchecked and it's not shed with a sufficient period, it's a risk factor for endometrial cancer. So, most HRT when you're hearing about people talk about it in kind of the menopause, all the menopause glory that's happening on socials right now is that methodology.

It's using some type of transdermal or oral estradiol, and some type of continuous progesterone with the same dose every single day.

Then I have the second category, which is cyclic, which means also a low dose static estrogen, usually transdermal, sometimes oral. And using progesterone for only 12 or 14 days a month. Sometimes this can be effective in perimenopause as just sort of like a top off, a little bit of estrogen, kind of helps your natural rhythm maintain and stay in place. But it's a little bit of a double edged sword because with any type of HRT that you use, especially if you're initiating it in perimenopause, there's always the risk that the exogenous hormone supersedes your and your endogenous, so internal hormone regulation.

So it, gives so much feedback to the brain that your own brain stops stimulating your production of hormones. And you can end up with lower levels than you even started out with to begin with. The third category would be called physiologic or rhythmic. So I like to call it physiologic, HRT. And it's a methodology that we've been doing for several years in our practice that really happened by accident.

I didn't even start my practice to be a hormone care provider. I started doing functional medicine and obviously I had a background in women's health because I'm a midwife and a women's health NP. And I just had all these women come into my office who were 45, 49, and I did all of the things that functional medicine taught me to do with them, and they would get a little better, but like ultimately they wouldn't get fully better no matter how many elimination diets I did with them.

And I mean, that's a whole other topic for another time. But what I discovered was that women on traditional HRT regimens would often get initial relief, and that we certainly know that it's effective for management of hot flashes, right? Which is sort of the characteristic thing that we think about when we think menopause.

But we know that perimenopause and menopause in this trajectory of ovarian decline is affecting the cardiovascular system. It's affecting the bones, it's affecting our immune system and our ability to sort of monitor and control for uncontrolled cellular growth, right? In gene expression, which is the case in cancer. It's affecting our neurotransmitters and our mood and all of these things. And when you take the approach of, let me give the dose that was appropriate for shutting down hot flashes, that's really all you're doing. You're not conferring all of the possibility of physiologic benefits. And so I actually had a patient who was like, I wanna try this methodology.

And I was like, okay, let's do it. And in physiologic HRT you're using a transdermal estrogen, it generally has to be compounded. And you're using a delivery method that allows you to

give very precise amounts of cream so that you can give a different milligram amount every day in the follicular phase of the cycle.

So day one to five is one dose, day five and six are a different, six and seven, day seven, eight, et cetera, up until you do a singular peak on day 12 with your dose. And then it drops down just like it would, in a normal physiologic cycle of a cycling woman. And then it surges again for the luteal phase.

And then progesterone is done in a very similar way. So a smaller amount beginning on day 14, larger, larger, larger, up to day 21, and then down, down, down. And I find that this is really nice done in a sort of at the very, at a very sort of beginning beginner dose with women who are in perimenopause, because their bodies are already used to cycling.

So they, well you know, people who are cycle centric, who are aware of their cycle, understand how it affects their mood and their behavior and just sort of their energy, right? Many women sort of organize their work life and their productivity and their creative time versus their kind of bookkeeping time based on where they are in their cycle, because it makes our brain feel different, right? And so this is possible to sustain. Now, there's no clinical research on this methodology, right? There's not hard evidence, randomized controlled trials or big systematic reviews of any sort on this type of approach. However, we do have a lot of research that really elucidates what happens when women don't ovulate, right?

We know that women on birth control, women who have PCOS, women who have primary ovarian insufficiency, women who have cycle fall apart earlier than typical, have a much higher risk of chronic diseases like osteoporosis, cardiovascular disease, diabetes, and depression. And so essentially menopause is the breakdown and fall apart of this very essential internal rhythm. And along with it comes risk factors and side effects. And a low dose static approach has some ability to stave off some of these things.

We know that the estrogen can reduce the risk of cardiovascular disease, can reduce the risk of diabetes, that it's effective for improving insulin resistance. But I guess the question is like, how good can it get if managed really individually? Right? This is like a very individualized, tailored approach, really dosed per the person, and it's for the woman who's okay with the monitoring. Okay with the frequent testing. Okay with a maybe occasional ultrasound to make sure that your body is getting a period appropriately and shedding a really you know, complete uterine lining.

So, it's not for everybody, but it is certainly something to look more into. And if you're interested in it you can go to the womenshormonenetwork.org, which we can put in the

show notes as well, which is sort of the consortium of providers across the country who are practicing in this way. And you can learn more about it.

Katie: Amazing. I will make sure those are linked in the show notes, and I know you have specific resources for anybody listening who wants to continue to follow up. I will make sure those are linked as well. But where can people find you and learn more and dive deep on their own health?

Emily: Yeah, I'd love for you to follow me on Instagram at EmilySadri_NP and also you can visit my clinical practice. We're currently licensed in 11 states in the US. That's aureliahealth.com, or my website emilysadri.com. And if you go to emilysadri.com/wellnessmama, we have some resources for you and some information about our programs.

Katie: Amazing. Well, those will all be linked and I feel like this was such a comprehensive and helpful episode. We got through so much in a short amount of time, and I will make sure there are relevant links for all of you listening on the go. Those are all at wellnessmama.com. Emily, for this episode, thank you so much for your time and for all that you've shared.

And you guys stay tuned for another round. That we'll go deep on mental health and GLP-1s, but Emily, thank you so much for the time today.

Emily: Thank you, Katie. It's been a pleasure.

Katie: And thank you for listening, and I hope you will join me again on the next episode of the Wellness Mama Podcast.