David
Doctor Jen Wagner. How are you today?

Dr. Jen
I'm great. David. So good to see you.

David
It's always good to see you. Did you run this morning?

Dr. Jen
I did a hit class this morning.

David
Oh, how was that?

Dr. Jen
It was awesome, as always. 100 burpees. So it's a good way to start the day, you know. Great little body weight. Work some, playa. Work some, you know, a little bit of sprints and some weights in between.

David
Oh, after my conversation with Stacey Sims a couple of weeks ago, I started incorporating sprint training, which I just have to say is like one of the most unpleasant things you can do to yourself.

Dr. Jen
It is, but it's so, so weird. Like, yeah, I kind of love it on days where I'm like, I got 20 minutes. Boom.

David
Oh, yeah.

Dr. Jen
So peak Hill, do it four times.

David
I do it on a calibrated spin bike. Okay, so what I try and do is I keep it over 500W for 30s. That's good, I can. Well, I don't succeed. This is try. I usually make it to about second 25 and the whole unit just falls apart. But you're right. You do four rounds of that and then that's it.

David
Yeah.

Dr. Jen
Yeah. It's fantastic.

David
Thank you. Stacey.

Dr. Jen
Yeah, man. She's a she's a beast I love her.

David
She's amazing. I wrote her a note afterwards, and I said that the sort of asymmetry of her training protocols, which if you don't listen to it, she's like, yeah, you can do that zone to sort of walk in the park. It's good for your soul. But it's really all about short, either super heavy or super fast. Yeah. And how it reminds me of Nassim Taleb and his ideas of Black Swan and Antifragile while like, how come antifragile, this highly asymmetric.

David
Yeah, sort of way of living?

Dr. Jen

And I love the way she describes it as being like, polarized, which I think it helps a lot of people. Like you're either really on or you're off. You don't spend time in this middle now.

David
And she said, if you're off, like if you feel it's an off day, it's it's just an off day. That's it. Don't do anything anyway. What we're going to talk about today. You're a clinician. You're a physician. You're not an ObGyn, but you are a member of the Menopause Society. Yes. And there's a big conference in Chicago recently, which I think was of the Menopause Society and a lot of interesting thoughts there.

David
Something Stacy brought up was the idea of menopause hormone therapy for people who are symptomatic versus what is known as HRT hormone replacement therapy. And she makes a difference there. And I wanted to get your thoughts as a physician and a member of the Menopause Society, to help us sort of unpack where the thinking on this is going, because what's interesting, the stat that flew out for me from that conference was that in 2007, 4.6% of women in America were using hormone replacement therapy.

David
In 2023, 1.8% of women are using hormone replacement therapy. So the usage of this has gone down quite a bit, while at the same time, the data that I'm seeing would seem to see there's a lot of preventative upsides to doing something like HRT. But again, I'm not a physician, I'm of the wrong gender and I'm here to be educated on this.

Dr. Jen
Oh my gosh, I think this is it's exciting that we're talking about this. And, you know, I think it is something that even being a woman wasn't really on my radar until it started to affect me. And then you're like, what's going on? And then you kind of dive start to dive into this and I am grateful for Stacy and the work that she's doing for Mary Claire Haber and the work that she's doing, and Vonda Wright, and they're all of these women from, you know, some are physicians, some are clinicians in other capacities who have really taken it upon themselves to say, we need to educate the public about menopause or about hormones

Dr. Jen
and the different strategies that women can use to feel better, because I think it's been universal that as you go through perimenopause, you see most women, I think it's something like over 90% of women have some sort of symptomatology. And even just recognizing that some of that is menopause is a step forward, you know, from going from the classic like vasomotor symptoms.

Dr. Jen
So those are your hot flashes, your night sweats, which everyone kind of equates to menopause to maybe more vague symptoms like you're not sleeping as well. You're having more urinary tract infections. Maybe intercourse is painful, like some things that are changing. Mood might be changing. You know, brain fog. All of these things even are things like gallbladder disease and heart palpitations.

Dr. Jen
And tonight it's in your ears and other musculoskeletal things going on. So I think that women have suffered in silence for a really long time. And, you know, it used to be prior to 2002, which is when the Women's Health Initiative came out, our moms were pretty frequently prescribed. People felt bad. They went in, they got some hormones, they felt better.

Dr. Jen
Life went on. And I think, you know, in 2002, the Women's Health Initiative, which a lot of good things came out of, but there were some mis conclusions drawn from that data, and the media got a hold of those mis conclusions, and all of a sudden it was hormones cause breast cancer. And I think some crazy stat. And I'm probably going to get this a little bit wrong, like 80% of women who were taking hormones just through my.

Dr. Jen
Yeah. And we haven't recovered from that. And it's 22 years later and we're just starting to see a resurgence and we're just starting to talk about it, and we're just starting to see, you know, I think the Menopause Society, which used to be the North American Menopause Society, shortened it down a little bit, has just released their position papers in the last two years.

Dr. Jen
So, you know, we're we're still playing catch up.

David
What are those position papers.

Dr. Jen
So it basically is kind of going back through and saying, this is where we as a society say hormones are definitely indicated. This is where they may be indicated. This is what the FDA saying. It's just kind of a recalibration of the data. And kind of a beginning of a framework for clinicians to put their heads around to say, how do we talk about this?

Dr. Jen
How do we risk stratify? How do we approach patients and answer questions?

David
So it it seems to me there's sort of a couple parts to this. There's symptom alleviation and then there's long term health.

Dr. Jen
Yes.

David
Which they seem to be sort of two different things. Yes. Two different reasons why one would prescribe. You mentioned some of the symptom alleviation that can happen. What are the long term health consequences of. And I'm going to use HRT hormone replacement therapy and not using it.

Dr. Jen
Yeah. So I think you know, the one that probably is most apparent to people is bone density. We lose, women lose about a fifth, can lose up to a fifth of their bone density in the first 2 to 3 years following menopause. And that's shocking and striking, especially if we're talking about women living 1600 days longer than men.

Dr. Jen
Like that's a significant increase in lifespan with possible risk of fall and fracture, which we know has a ridiculously high morbidity once that happens. So I think the ability to maintain that bone density is critical. And that is probably where we're seeing the best current evidence of continuing on menopause hormone therapy longer than just pure symptom treatment, because we know when you stop it, your bone density will drop dramatically.

Dr. Jen
What's interesting is that they don't necessarily see an increased fracture rate with that. But we know it's happening, which can obviously lead to increased fractures down the way. You don't have a lot of great data because we looked at the data for the Women's Health Initiative. That study population was much older because the design of that study was to look at cardiovascular outcomes.

Dr. Jen
And so they needed to study the women in the age ranges in which they would be more likely to have cardiovascular events, which was kind of 60 to 70. And so we don't really have a lot of great data right now. More studies are being done about what happens when we put women who are 45 to 55 on these hormones and keep them on them.

Dr. Jen
So we're just starting to learn a lot about that. But we know when we stop them, bone density goes down. So if you're a female at great risk of osteoporosis, maybe that benefit for you of staying on hormones long term outweighs some of the risks that can develop later on. It becomes a very personal and individualized scenario that women just have to be able to work with our health care providers, which is a big problem because there's not many of them that are very good at this and have a lot of knowledge in this space.

David
One of the other stats I saw out of that conference is 70% of women have musculoskeletal issues due to menopause. You mentioned skeletal but also muscular because I recall one of our previous conversations. Estrogen is an anabolic. Yes. Helps you build muscle.

Dr. Jen
Yeah, absolutely. And so obviously for bone and for muscle and for some of the other things that we'll talk about this is using menopause hormone therapy systemically. So this is giving estrogen. And if you have a uterus pedestrian in a way that enters your bloodstream versus you know, we can talk about using vaginal estrogen for a more localized thing.

Dr. Jen
And that can be used in certain populations. But using systemic menopause hormone therapy definitely can improve your lean muscle mass, because estrogen is our main anabolic steroid as a woman, as a female. And so there are other ways to facilitate getting some of that muscular stimulation. And I know you just had Stacey Samson, who's the world leading expert in that.

Dr. Jen
But for some women that may not be an option, you know? And for some women that may not be a realistic pathway and lifestyle for it. You know, Stacey works with a group of women, and a lot of her advice is designed around these very athletically conscious women. And she's the first to say that, you know, this is my population.

Dr. Jen
And so there is a larger group of women where maybe that is just not as they're not as familiar with, that they don't have access to that. That's not part of their lifestyle. And so hormones can be very helpful in preserving lean muscle mass, allowing women to continue to build lean muscle mass. Now, to build you have to do the work.

Dr. Jen
You know, you need to get in the gym, you need to lift the weights. You need to put the time in. But with that, and if women are willing to do that with some help from estrogen, so they can actually make those changes a little faster and maybe at a less intense level than what's required without the hormones.

Dr. Jen
It also helps the metabolically, you know, it improves their insulin resistance, it improves their utilization of glucose and all of those things that we lose when we lose our estrogen.

David
And from what I've read, Doctor Lisa mosconi talks a lot about brains and estrogen. Yeah. So that would seem to be another reason for long term hormone replacement therapy would be brain health. To me. My recollection is that women suffer diseases of the brain like Alzheimer's, something I know 2 to 1 of them make that up. But it's a big number.

Dr. Jen
Whatever it is, it is. And, you know, again, I think this is where the data is really hard to tease out because when they looked at some of these measurements from the eye, they said, oh, they have an increased risk of dementia on hormones. Well, that was women starting hormones well past the age we start them. And and so it was hard to again to tease out whether it was the hormones related to this or other factors.

Dr. Jen
I think we are seeing when women are starting menopause hormone therapy in the timeframe where they are symptomatic that we are seeing benefits, beneficial protection and cognition. Again, they're not saying, you know, the FDA's not saying that that's a reason women should be put on hormone therapy or stay on them, but it could definitely be a benefit. You know, I come from watching my my mother just recently passed away from dementia.

Dr. Jen
And so it's key on my mind. And I also think because we are encouraging women to be active in this phase of life, to maintain bone density, to maintain lean muscle mass, then we have the risk of having more injuries. You know, it's like if we're biking and we crash our bike and hit our head, we also know that estrogen and progesterone are very protective, neuroprotective.

Dr. Jen
And so if we are having a TBI of some sort or a concussion event, it's important to have these hormones around. That's another kind of secondary benefit is if we're on hormones to feel better, to maintain our bone mass, we can heal better. And we probably do have some preservation of cognitive effects. There are studies showing that that evidence of brain fog is lessened because we're not losing estrogens.

Dr. Jen
Impact on our hippocampus and our ability to remember we're not losing estrogen impact on our prefrontal cortex, and our executive function stays as we perceive it, sharper than when we start to lose estrogen in those regions.

David
So let's talk about the counter invocations. Why would someone not do this?

Dr. Jen
True medical contraindications are very few. You know, if you have an estrogen receptor positive cancer, that has to be a really detailed and specific conversation with your health care team and your oncologist. Outside of that and some very unique endocrinology diseases and states, there's very few true contraindications to using this. So I think the biggest obstacle, I think for women being more proactive in this space is fear.

Dr. Jen
I think there's a lot of fear from what was put out in the media as one thing, and then never really recanted as aggressively as it was expressed, like we, you know, we love catastrophe. And so that's what headlines are. And when the catastrophe isn't really real, nobody really talks about that. They're just like, oh, it'll just go away.

Dr. Jen
It doesn't create that splash that oh, maybe this was a wrong interpretation of this risk. And we have been denying women really useful care for a long time, an intervention.

David
I had an ob gyn on a while back. So Susanna Gilbert Lens is a doctor practicing in Los Angeles, and we had a discussion about HRT and cancer, specifically breast cancer, and about how if one is diagnosed breast cancer very often, not only is HRT not indicated, but there are other drugs applied to remove all the estrogen. But this causes a whole slew of other consequences.

David
And she had been diagnosed with breast cancer maybe five years earlier. And I asked her, so what are your thoughts on this? And she cautiously said, it's being reevaluated.

Dr. Jen
Yeah, I think that's true. I think, you know, that the studies are saying that the vaginally supplied estrogen that gets very little to almost zero systemic uptake can be very helpful for some women who are having general urinary symptoms, which I think we as a culture have decided. Why would you even treat that? It's not that big of a deal.

Dr. Jen
I think if you're a woman that's getting a UTI and getting sick all the time and are getting septic from that, it's a very big deal. You know, I think we have all learned more and more about the importance of sexual health, and that is a very big deal for people. You know, there are good proven health benefits to having a enjoyable and productive sex life.

Dr. Jen
And so I think that there are preparations that they have found to be safer in women that have had breast cancer. I also think some of this selective estrogen receptor modulators, the streams are a drug class that's being more and more investigated. So though they block estrogen at certain receptors, like tamoxifen is, one of those drugs are often used in the breast cancer population, but they allow estrogen at other receptor types.

Dr. Jen
So drugs like that I think can be helpful for women. And so there's a lot we can talk about this. I think the medical education around this is 100% lacking. And I don't think anyone would argue with that. And I think that it has been siloed so much that people are say, you know, health care providers like I myself am I'm an anesthesiologist, right?

Dr. Jen
I'm not an ObGyn, I'm not an endocrinologist. And so for years I was like, this isn't my work. Like, why should I? I shouldn't be I'm not qualified to talk about this. But the problem is nobody is qualified to talk about this. And you talk to

most OB GYNs and they get maybe six hours of menopause training in a 4 to 5 year residency.

Dr. Jen
We rely on that six hours to treat a population, and most of them just can't do it. So I think that, you know, I think there are people in this field who are really trying to make a difference. I think the Menopause Society is trying to make a difference by offering education and certification, regardless of how you're classically trained, because it probably doesn't matter that there are orthopedic surgeons who are trained as menopause doctors now, it's an opportunity for family practitioners and internal medicine doctors and anyone that takes care of a woman should be able to have at least a basal level conversation about this and should be asking, because I think a lot of

Dr. Jen
things that we see a specialist for can be tied back to menopause, and we should be able to have an introductory conversation about your shoulders frozen as a physical state. You know, you go see your pet or you have a frozen shoulder. Maybe there's actually nothing really wrong with your shoulder. Maybe it's menopause. I think there are. Mary Claire Haber is she happens to be an OBE guy, and she's really taking this upon ourselves to create curriculums for other physicians and other types of care providers to say, let's educate each other about menopause.

Dr. Jen
She had to do it herself as an ObGyn. And so I think as clinicians, clinicians and practitioners, we have to get out of this silo that we think we are in. And if we can provide some information and education to our patients and have a discussion and help them get the help they need, that's step one.

David
I'm glad you brought that up. I had Doctor Vonda Wright and this podcast if you're. Yeah. And she's an orthopedist who, as a consequence of her work, orthopedist work with bones, has educated herself on estrogen and menopause because, you know, as you point out, this is not a singular. If you break your arm, okay, that's not systemic. It's just your arm.

David

But what we're talking about here affects everything. All of your organs, systems, everything. And so really, everyone needs to understand this.

Dr. Jen
Yeah, I think it is going to take a movement of clinicians and practitioners who are interested in this to self educate, because if we wait for the medical education system to catch up, we're never going to get there. And so I think it is finding these alternative pathways to education and, and some certification and using some very vetted institutions to help clinicians get there and understand.

Dr. Jen
And then also creating and compiling lists, you know, to go back to the Menopause Society again, they they're a great resource because they have a list of clinicians that they have certified because it's really hard to find a menopause certified practitioner. And, you know, luckily, this is something that is very that telehealth can provide. You know, you don't need to be in the same town or the same city as your health practitioner to talk about a lot of these things.

Dr. Jen
This is something that can be done pretty easily over telehealth and and so hopefully more people can start to access these. And, you know, there's a few commercial health care company telehealth companies that are coming online that are actually providing really great services.

David
I'm a little bit familiar with that. There's this intersection of, as you said, very little education on this and it's huge impact. And the OB GYNs are just overwhelmed with this is going to sound bad, but making babies, I think that's their thing, right? They don't have really the brain space to take this on. So some of these telehealth companies have come in.

David
It seems like they're fulfilling a need.

Dr. Jen

Absolutely. And I also think, you know, I've had two children and you see your O.B. and you have a lot of high touch points around that time. I don't think I've gone to an ObGyn in years. My primary care is kind of taken over that that side of my health care. And, you know, you and I have talked about this before, the idea of women's health is so much broader than just reproductive health.

Dr. Jen
You know, just what you just mentioned that you have estrogen receptors on almost every cell in our bodies. And so it's not going to fit under one silo. And so thank God there are the Vonda rights who are saying, wow, you're coming into my clinic. I can see your bones have a problem. Let's talk about this. This is a systemic issue, right?

Dr. Jen
This is not your arm or your knee or your tibia. Like this is a systemic issue. You know, I even think about some of the people that I could have touched in the operating room if I would have had more education about this when I was still in that clinical practice to say, gosh, you're you're complaining of all these vague symptoms, like, have you talked to your health care provider that this might be going on, even just to teach them to ask the question?

Dr. Jen
Because I do think sometimes you don't connect the dots is the patient. And our health care system is so specialized that as a provider, sometimes you don't connect the dots, oh, you're coming in with palpitations. I it would be interesting to do a poll. How many cardiologists would equate palpitations with menopause, right. I'm guessing not very many. You know, I think that takes an awareness and being taught that or it's really low down on the list.

Dr. Jen
And of course they have to rule out serious things. I'm not saying that everybody should just equate everything to menopause. When you start to piece all of these symptoms together, there can be some uniting things, which I think then hormones can really be helpful for.

David
I know we'd say at the beginning of this podcast, but I just want to be clear here. I'm not a clinician and Jen is not giving medical advice here. We're just

having sort of a discussion of what the landscape of this is. Yeah. The other sort of interesting thing I hear about this, which you don't hear with a lot of other parts of medicine, is that this is a natural phase.

David
This is a natural thing, and this is somehow good. And I just think, well, so is entropy is. But that's not necessarily so good. Again, I don't really have a dog in this fight. But what are your thoughts on this?

Dr. Jen
This is probably gonna be an unpopular statement. But I think, you know, if if this happened to the other half of the population where their sex hormones insipidus decline to almost nothing and they're very symptomatic through it, something would probably be done. And I mean, it is I, I heard this the other day, I was listening to someone talk about this and they're like, well, men can go down the street to circle K and get testosterone.

Dr. Jen
You know, it's like it's become this huge thing for women to get on menopause, hormone therapy. And we've played around with language a little bit. And I think that societies and the practitioners are going in and starting to use that menopause hormone therapy language, because we can't replace what's lost. It's not a replacement. It is a treatment designed to help with long term things like bone health, long term things like cardiovascular disease, long term things like cognitive health and short, shorter term symptoms like basal motor symptoms and things that sometimes get better.

Dr. Jen
We're getting better about when we start these things. We're not as good about when we end those things. And again, I think that becomes a very specific conversation that is very personal to the individual patient and their provider based on a lot of risk stratification and symptomatology about when do you stop and how do you stop? But yeah, I think the conversation would be very different if this was happening to the other half of the population.

Dr. Jen
And when our life expectancy is double what it used to be, I think we have to really think about how women are feeling in these other decades. You know, if

we want women in the workforce in their 60s and 70s, they need to feel good. They need to be healthy. Their bones need to be strong. You know, they need to be metabolically healthy and cognitively healthy and all of the things that hormones can help protect against.

Dr. Jen
And so, yes, it is a natural phase of life, but it's not one that people need to suffer through. One is like there's no badge of honor in that. And that can have really deleterious side effects that, you know, if you go through another 6 or 7 years without sleeping well because you're drenching your bed every night, that's not good for your health either.

David
Now, as you were speaking about this, I take an 81mg of aspirin every night. I take a baby aspirin every night, which is also not natural. But there's a lot of evidence that this is positive for my cardiovascular system. And it has some, you know, anti-cancer effects. And so, okay, I don't get any pushback about that in the way that this topic I know it's interesting.

Dr. Jen
It's shocking. It is you know, it's it's just yeah. And it's become I think part of that is because it was so taboo to talk about it. And I think some of that is protective. Like, you know, I was I was at a party this weekend with my husband in a retirement party for one of his colleagues, and I had a woman come up to me and she's like, I really would like to talk to you.

Dr. Jen
I'm like, absolutely. And my husband happens to be her boss. And she goes, do you know how embarrassing it is to sit there and be in a room talking to him? And I'm turning bright red and I'm sweating and I can't concentrate on what he's saying because I'm having all these symptoms and I just hoping he doesn't notice.

David
And oh my gosh.

Dr. Jen

I was like.

David
That's awful, right?

Dr. Jen
And that's a one on one conversation with what I would hope is a very understanding individual, given what I do for us. And I hope he's understanding when this is happening to other women. Can you imagine being on stage or in front of your boardroom or in the courtroom or, you know, taking care of a patient as a practitioner, and that's happening to you and you are so uncomfortable and you're so distracted.

Dr. Jen
It's horrible.

David
My good friend Tamsen Vidal, she was a newscaster, and this happened to her on camera first time. Oh my. Oh, yeah. Yeah. So so I think one of the important things here is both of us have a certain allergy to what we call prescriptive protocols, especially from people that don't have a lot of responsibility with declaring these prescriptive protocols.

David
Yeah, this all seems extremely personalized. And I've heard, you know, Doctor Peter Attia talk about certain estrogen levels in luteal phase and measuring these things. Some other people feel it's really not about that. It's just really symptom driven. At what point would you say that someone I think is talking about perimenopause or preparing like fairly early on, what are your thoughts on that?

Dr. Jen
So most of the studies that I'm reading, it is symptom treatment. Because if you're having a high, if you're symptomatic doesn't matter what your estrogen level is. Because again we're all different. And so and we all make, you know, our variations of estrogen and how sensitive our receptors are. Every human is different. And so I don't think you can say that.

Dr. Jen
Oh just because you're estrogen levels here, we're not going to treat you if you're having these symptoms. If you're having these symptoms, those estrogen levels have fallen enough in your hypothalamus that you are no longer regulating your your body temperature correctly, like that's a central nervous system response. And so most menopause practitioners that I follow and I have read don't worry about measuring hormones, which I think frustrates a lot of people because they want that data point.

Dr. Jen
And again, if you're if you're asymptomatic, maybe it's helpful, but then a lot of asymptomatic women are choosing maybe they don't need something as aggressive as menopause hormone therapy because they're not having the same symptoms. I think all women at this stage of life should have a Dexa scan, so they know their bone density starting, and that should be monitored yearly.

Dr. Jen
And so these kind of silent things that start happening, like maybe you'll never have a hot flash, maybe you'll never have a UTI or some of these other more noticeable manifestations of perimenopause. But that doesn't mean your bones aren't declining. We know it's going to happen. That doesn't mean some of these other things aren't preventing. You know, it's same thing with cholesterol, right?

Dr. Jen
We see women's cholesterol start to rise as they start to lose estrogens effects on their biliary systems, on their gut absorption on their blood vessel and the intimate of their blood vessels. And so we see changes in cholesterol profiles. And some people, that's how they monitor the effects of their menopause hormone therapies. Like are we on the right doses?

Dr. Jen
Well, what's happening to your cholesterol? What's happening. Your bone density. Because checking these levels. And we also have to remember that checking hormone levels is really complicated, especially in perimenopause when your cycles are irregular, you don't know what day you're on. And those

levels are changing all the time, which is also the difference, which is why we've gone away from hormone replacement therapy.

Dr. Jen
You know, hormones are pulsatile chemical releases within our body. When we are put on menopause hormone therapy, it's not replacing that pulsatile nature of those hormones. It's not in the same phases, etc.. You know, it's not like our body pulses out the same amount all the time. It's very varied. Based on this complex signaling. And so that's why menopause hormone therapy is like, okay, we're not replacing what was there.

Dr. Jen
Naturally. We can't do that. But this is, you know, the therapy to treat these conditions.

David
I'm curious about the dosing here and how, you know, are there counter symptoms that come up if the dosing is too high? How do you know?

Dr. Jen
So I think again, it really becomes on symptom management. And most of what I've read in this is you start with kind of the lowest dose that you can. I don't think I have met a person where right off the bat, the patient and the provider got it right. It is an adjustment. Again, it's very individualized. Like do you need progesterone or do you not.

Dr. Jen
And that depends. If you have a uterus what form of estrogen do you want. Do you want a pill. Do you want a patch. Do you want a cream. Do you want a gel. So I think it's very it goes back to working with a provider to say maybe I tried oral and I had G.I side effects. And was that the dose, was that the route.

Dr. Jen
Difficult to say. So I think there's so much personal variation in this that I can't say, oh, you just start here because there are so many different formulations, there's so many different routes that it really does have to be a very personalized discussion. I think, you know, again, starting low and going up, and

then most of the side effects that I've read, you know, I've had a friend that instead of getting fewer UTIs when she was on systemic estrogen, ended up getting more.

Dr. Jen
She was like, this doesn't seem to be working. And so I had to kind of go back in and recalibrate what she was taking, how she was taking different preparations. So again, it's a super personalized thing where it's definitely not one size fits all.

David
So you mentioned two hormones, estrogen or variants thereof. And progesterone. Is testosterone part of this.

Dr. Jen
So for some people. Yeah. So you know, I think testosterone is probably the one thing that could be measured and is probably helpful to measure. So the idea is to keep testosterone own levels in what is considered physiologically normal for a woman, which the labs will say kind of under 70. Some providers will push that higher, more to like 100 hundred and 28 without getting side effects of testosterone, which can be facial hair, can be some other, even permanent side effects from having too much testosterone.

Dr. Jen
So I think, you know, testosterone can definitely help with libido, can definitely, you know, assist a little bit in the muscle mass. It's not the way that estrogen is going to in a woman, but definitely is a positive effect there. It's just not the same as it isn't in male physiology. And so I think that that is one thing that sometimes providers a level they do look at.

Dr. Jen
And if there are still some side effects or having some of these lower libido and other symptoms can added in and that can be done in a little more targeted fashion because you can actually target levels there.

David

So all of this is leading me to the question of finding the right practitioner to work with. And my wife went to see an ob gyn. And when she came back, you know, I was like, I had to go. And she told me some stuff. I was like, fire! That person. I'm not an expert in this field, but I know, I know enough that, like, this was not somebody who's going to give you good advice.

David
Yeah. Would you say going to that list in the menopause Society of Certified Practitioners? How do you find somebody who really knows how to deal with this?

Dr. Jen
Absolutely. I think that's a great place to start because those are providers, regardless of their formal training, have gone back in and have done the work to understand this. They've read what's recent because they have to pass a test. And so they they've had to really dive into what it means to go through menopause, what the risk factors are, what the therapies can be, both pharmacologically supplements, lifestyle, all of those things.

Dr. Jen
And so I think that's a great place to start. You know, we talked about some of those commercial telehealth companies. Moody's one totally blanking on the name of the other one. Right now. I think those are interesting resources to look at. I know there's one that takes insurance. One does not. So I think those are interesting places. I think if you have a good relationship with your general practitioner, that's always a great place to start to say, I'm really interested in learning more.

Dr. Jen
Is this something you can help me with? Is this a journey you want to go on with me, or can you refer me to someone you know? I know I'm in Utah. They just started a perimenopause clinic at the University of Utah. And so there are places like that popping up. Unfortunately, it still takes a lot of legwork on the patient.

Dr. Jen
And I think the hard part is if you have patients that are motivated, that's great. But when you have patients who maybe have not had a lot of access to

health care and don't even understand that perimenopause is causing the symptomatology, they don't know what questions to ask and so I think that that is where putting a little bit of pressure on clinicians to say, every clinician needs some basic education around this.

Dr. Jen
And, you know, it's interesting, like every clinician got some basic education around Covid like that. I mean, that's like a perfect example, right. And menopause is something that is going to have if you have female physiology you will go through menopause. Like you said, it is a natural stage of life. That doesn't mean it has to be an uncomfortable and detrimental stage of life by any means, but it's natural.

Dr. Jen
And so like every clinician, I would even say physical therapists, chiropractors, like everyone, should get some really good vetted training and education on this because we all interact with women who have different access to health care, and those are the populations I worry about the most who really do have poor access to health care. And maybe they are seeing other types of providers.

Dr. Jen
And so just making sure that there is good vetted information out there so people can educate themselves.

David
I also want to bring up something that you mentioned about. We all just yearn for the blue pill that's going to solve everything. It's just a natural human state. But there's other sort of complicating other adjunct things that are going on here. So your diet, your weight, your activity level, all of these things, you're human with systems and these all have inputs in the system.

David
I mean, it's like some people, some men think, oh, if they do try testosterone replacement therapy and they don't do anything else, everything's going to be hunky dory. Now, you have to take a lot of other actions to actually make use of that hormone. It's the same here. So obesity would not be a I'm not gonna say it's a comorbidity, but it's a Co factor here.

Dr. Jen
100%. And we know that women who are obese have more symptoms going through menopause. They have a tougher time. Absolutely. Again, going back to the work that Stacey is doing that Doctor Stacey Sims is doing, which is amazing work to say that, you know, I have this really active population and we have found in this population that has the mindset and the ability and the want to push themselves physically.

Dr. Jen
We can overcome some of this lack of estrogen like we can. There are other pathways. And so for some people that's the right place to go. You know, there are adaptogens that can help, which are plant based. So supplements that for some women, especially women who are having really mild symptoms, some of those have enough estrogenic effects that they're seeing decreases in their symptomatology.

Dr. Jen
And that's a comfortable route for them. For other women, menopause hormone therapy has been a very advantageous route to go with all of the benefits that we've talked about with very little risk in the overall population, you know, and I think so, there are definitely ways. But absolutely, if you can optimize your lifestyle factors, you know, if you are sleeping well, which sometimes you need these things to sleep well through perimenopause and, and after menopause, you know, if you are eating well and eating like we've talked about so many times, you know, whole foods, nutritious foods, not use not eating processed foods, all of those things help.

Dr. Jen
And then I think as we come back to almost every time, movement is probably the best thing, like we were talking about right before we started adding in this, what is becoming more apparent and more well-studied, especially for women in this, in this stage of life is this idea. And again, Stacy's done all the pioneering work here with this idea of polarized training, of being really intense or recovering and not spending time in that gray area, because that's really what changes the neural signals that are coming out of the brain to tell the bones, to tell them muscles to build.

Dr. Jen

And then you have to couple that with nutrition. They found that that if you create those neuro signals by working really intensely physically, but you don't have the nutrition on board, you're still not going to get the benefit. So you're exactly right. They're all interconnected. And the more we optimize those lifestyle levers, the less symptomatic we are finding women going through menopause, and the probably more impactful the hormone therapy will be.

David
It brings to mind we have a mutual friend, Alyssa, who I remember she's been on this podcast a couple of times. She said, well, menopause didn't really happen to me, but she is like a super. I mean, her idea of a good time is like, let's go climb K2. That sounds like a lot of fun, right? Okay. Super fit and highly attuned to nutrition.

David
That's kind of one. I'm not saying that like everyone, you should not climb K2. Just don't do that. That's like this. Take that off the menu.

Dr. Jen
That's not on my to do list.

David
That's not like if you have menopause system and climb K2. No, don't don't do that. There does seem to be some sort of overlap there. It's interesting that again, I'm not a clinician, not a researcher, but like sort of what I see is this stuff that sort of like Malcolm Gladwell talks about with the tipping point that you just sort of keep putting these stresses on your biology and you get like one too many and things just sort of slip into, we're no longer at homeostasis.

David
Bad stuff's happening. So it's a combination of things. And my most recent sort of obsession is microplastics. Their accumulation, the organ system, especially brains. And I'm sorry, women, they accumulate more in your brains than male brains. All this stuff is. It's just worse to be a woman. Could I say? Yeah, you guys live longer, but there's. You got issues.

David

So you know that stuff messing with the endocrine system, which I have got to believe is going to impact everything that we talked about today. That's going to be one of the things any other sort of toxins in your life, your lifestyle in. And as we talked about, you know, activity in these things, it's really a universal package to look at.

David
And I think that's one of the things that becomes confusing and contradictory as you said, a lot of people don't spend their days reading this sort of stuff. And what I've learned is that you just sort of nibble at the edges of all this stuff and it'll be like, oh, this only makes like, you know, a 1% difference or 0.5%, but if you have like 20 of them, all of a sudden it becomes impactful.

David
And I think that with all of our health, I, as I say, women's health. But but like everyone, it's really important to keep that in mind. And the other point I really want to stress here is this idea of we are individuals prescriptive protocol. If you look at the way any sort of science is done, there will be a distribution of data from which a curve is drawn.

David
And I can absolutely guarantee you, everyone who's listening to this, there will be one of these curves where you're way out on the left or on the right, and all of the suggestions are based on the center, but you really need to speak to someone who's a responsible clinician who can understand all of these bits and how it goes together to deal with whatever symptoms or non symptoms or whatever your goals are.

Dr. Jen
Yeah, I can't agree more. And I think that as we develop more and more understanding of the human body and systems and how they interact when they map the human genome, you know, there was all this excitement that we were going to have, you know, our each own very prescriptive plan based on our genes. And that just hasn't happened.

Dr. Jen
But I think what has happened is really the need for more personalized approaches to how we treat patients. And it's hard because that takes time and

that takes resources that are just usually not available to most practitioners. And, you know, those that have the ability to do that usually, unfortunately, can only reach a socioeconomic class that can afford to pay for those services at that level of personalization.

Dr. Jen
So it is really hard. And so I think, you know, again, I want to applaud the efforts that are being made to provide really high quality education materials to clinicians, to consumers. And I think it's hard to weed that out through the noise. And menopause is a buzzword right now. And you have everyone jumping on this bandwagon, which is great for raising attention to it, but then challenging as a consumer, where do you go to get good advice?

Dr. Jen
These are really personalized decisions and just kind of dabbling in things on your own can be dangerous. And so it is a challenge to find the right person. But even just establishing and you and I have talked a lot about this, like I'm very fortunate in my primary care doctor has taking an interest in menopause and she does a lot.

Dr. Jen
She gets a lot of education in menopause and I feel very comfortable having these conversations with her. But I've also brought things to her attention from my unique physiology that she does. And she's very willing to say, well, I don't understand this. Let's get you here. Let's get you there. And, you know, I am fortunate that she is an insurance taking kind of pretty normal general practitioner.

Dr. Jen
And so I think it is just, again, learning to advocate for yourself and learning what questions to ask. We all have to be our own advocates, and it's just going to take a while for the health care system to catch up if it ever does. In our current system, it's a super big challenge.

David
Jen, we're going to give you a plug for prosper.

Dr. Jen
Thank you.

David
Tell us about prospers. What are you doing.

Dr. Jen
So prosper is a company I started about a year ago that is designed as holistic women's performance and really it is our goal. You know, we talked a lot about the clinician space. It is our goal to bring a lot of this into the business space and into the leadership space where we're on a mission to kind of redesign what professional development programing looks like.

Dr. Jen
And this is kind of our B2B offering, where we work with organizations and kind of their female leadership in their mid career to late career female talent and when I started it, I wasn't expecting to become a menopause expert. That wasn't on my radar. And the need of women in these situations to have this education and the opportunity to explore these areas brought to them has been overwhelming, I would say.

Dr. Jen
And we get in these rooms and it's all they want to talk about. And so we have really dedicated ourselves to go back and educate. One of my partners is deep in the strength and conditioning world, and another partner who, you know well, Leslie's deep in the mindset world. And so we have really gone back in to say we need to make sure that we are giving proper lifestyle advice.

Dr. Jen
You know, we don't give a lot of medical advice, but we do try to educate on how do you find a provider that can help you do this. So we spend a lot of time doing that in more in the business space. And the business world, whether it's with sports, whether it's with health care providers, whether it's with corporate executives, and then to try to get to try to reach more people.

Dr. Jen

We're launching a podcast tomorrow called It's Time, where Lindsay Donnelly and I really just explore all of these issues that are affecting midlife women. We share a lot of our stories. We're bringing on a lot of great expert, including yourself, to just talk about this stuff and really help midlife women. What to look forward to, what's in front of them, instead of always just feeling depressed that things are changing and etc. which is, I think, kind of the cultural ideas around menopause is like, you're not a useful female anymore.

Dr. Jen
You're going into this like later stage of life where you're not supposed to enjoy things and really trying to reframe that and in the meantime, giving a lot of strategies to feel as great as we can through those phases.

David
I look forward to it. Thank you guys doing great work. It's always a pleasure to have you on. This is a very complicated topic, and you're able to just simplify it and make it easy to understand. And we we appreciate you.

Dr. Jen
Well, thank you. It's always a pleasure to chat with you. I can't wait till you're back in town and we can hang out soon.

David
Yeah. Snow is coming I know.

Dr. Jen
Well, I is 80 this week, so.

David
Oh, I'll take all right.

Dr. Jen
It's always good to see you.

David

Thank you again. Yeah.