

Dr. Tori Hudson

Transcript from Blitzed by Menopause DVD

Many of you are wondering about hormone replacement therapy and have all kinds of questions. I can really appreciate that because there really are lots of questions to ask and lots of questions to be answered. We want to try to address all of the different kinds of hormones that are available, the different dosing issues, combinations of hormones, delivery methods of hormones, and some pros and cons and benefits and risks of hormones. That is kind of the territory at which I think most all the questions lie.

So let's start first with all of the different kinds of hormones. And by the way, we are talking about hormones here, we are not talking about herbs that have constituents called phytoestrogens. We are talking about hormones, and there are hormones of all kinds. Some are made from a natural substance and some are made from a natural substance and then turned into various kinds of hormones, and some are semi-synthetic or synthetic.

Let's start with hormones that are made from a natural substance. Starting with even Premarin, the kind of hormone or estrogen that has been around for the very longest amount of time. It's called Premarin. It's actually made from a "gamoosh" you might say of hormones found in the urine of pregnant mares. And that is why they call it Premarin. Pre-Mare-In. Pregnant Mare's Urine. So, these are technically a natural substance, but they aren't identical to the human hormones, so therefore we call them semi-synthetic really.

There are also hormones that are made from a natural substance and in these cases, plants. They extract two different ingredients out of either Mexican wild yam or soybeans. And then they turn that substance in a manufacturing laboratory, into a hormone. Now, we can turn that into a hormone that is not chemically identical to the human hormones, or we can turn those constituents into a hormone that is identical to the human hormones. And those hormones are ones that often receive a lot of press and attention often, and are called bioidentical hormones. A bioidentical hormone is a hormone that is derived from a plant constituent, but turned into a hormone that is biochemically identical to the woman's hormones. Thus, bioidentical, or biochemically identical.

But you can also take these same constituents out of a plant and turn them into a hormone that is not biochemically identical. And many pharmaceutical options are these kinds of hormones. And again, I kind of call those more quasi-synthetic. So, so far we have the Premarin which is from the estrogens in pregnant mares' urine, not biochemically identical. We have bioidentical, plant derived, chemically identical to human hormones. And we have plant derived that are not chemically identical to human hormones. And then we have just bona fide synthetics that are also made by pharmaceutical companies. Those are essentially kind of the four different categories of the different kinds of hormones that are available to women. And some of those are actually available to men as well. Testosterone, for example. We have a bioidentical testosterone and we have a synthetic testosterone. And the bioidentical testosterone available to women is currently only available from a compounding pharmacy.

For example, we can prescribe testosterone to women and to men. It's just that there's not a bioidentical testosterone product available to women and there's not even a synthetic testosterone prescription available to women as a stand alone prescription. The pharmaceutical companies have not been allowed to produce a testosterone-only product for women yet. They have been allowed to produce that for men. So for women, when we want to prescribe testosterone, we have to go to a compounding pharmacy. And we can prescribe either the bioidentical testosterone or the methyltestosterone. And we prescribe those in pills or in creams. Testosterone is an important hormone when it comes to sexual function. We use a bioidentical testosterone cream from a compounding pharmacy, which is a specialty pharmacy, and we put that in a cream, according to a certain dose, and it is applied to the external genital area right before sex to enhance arousal and orgasm. We can also put this bioidentical testosterone or synthetic testosterone into a specially prepared compounded combination of hormones: estrogens, progesterone, and testosterone, for addressing sexual function as well as other menopause symptoms. When we want to prescribe testosterone to a woman, we have to currently use a compounding pharmacy with one exception: there is a synthetic estrogen with a synthetic testosterone called Estratest, made by a pharmaceutical company.

Let's go back to delivery methods. We have these different kinds of hormones: semi-synthetic, synthetic, bioidentical, (bioidentical from a pharmaceutical company, or bioidentical from a compounding pharmacy.) That is one little clarification we should articulate again here because those are both the same and different. Pharmaceutical companies have a few select bioidentical hormones. There is Estradiol by itself, it comes either generic or Estrace in a pill, or we have the estrogen-only patches which are actually bioidentical estradiol. Vivelle and Climara and Menostar are examples of those. And then we have a bioidentical cream called Estrace cream. Those are all actually made by pharmaceutical companies. But the pharmaceutical companies only make available a small handful of doses and very select methods of delivery. Also with the pharmaceutical company comes their patented preservative, or binder, or filler or adhesive, because, you can not actually patent the bio-identical hormone itself. So you have to patent something special that you do to that hormone. We are left with the limitations of the pharmaceutical company bioidentical hormones in dosing, combinations delivery methods.

Now, at our clinic, and what most people who are really accustomed to prescribing bioidentical hormones do, is they use specialty compounding pharmacies. Because now, we can prescribe all customized and individual doses. Maybe you don't need just the .5, or the 1 or the 2 milligram that the pharmaceutical company makes. We think you would do just as well with .25 or we need to tweak it a little bit and give you .35. So, we can customize your dose and titrate the dose up or down. We can also customize a combination. No pharmaceutical company yet makes a combination of bioidentical estradiol with bioidentical progesterone. They also don't make a combination bio-identical estrogen/progesterone formula that has the testosterone in it. So we can now individually prepare a formulation that has not only the bioidentical hormones but the select interim specific doses that we want, and in specialty combinations. And we can use other hormones that we are interested in like estriol or DHEA that have their own added benefits. In addition, we can do this in pills, in capsules, in sublingual lozenges, in sublingual drops, in creams, in gels, in vaginal, in topical deliveries. We have so many more variability's and circumstances and ways that we can help women by utilizing these compounding pharmacies than by just sticking with what the pharmaceutical companies provide. But they are, in fact, the same hormones, if we are talking about bioidentical hormones, the commercial pharmaceutical products and the compounded products have the same benefits and the same risks. It's

just that we have a lot more flexibility, a lot more individualization, a lot more circumstances that we can help with these compounding of specialty formulations.

One other difference that we can talk a little bit more about, between the special compounded bioidentical hormones versus the pharmaceutical bioidentical hormones is that with the specialty pharmacy, we don't have the binder, the filler, the preservative or the adhesive. And we can also put it in a powder or an olive oil, or a peanut oil, even if we are just talking capsules. So, that's just one other added layer of a way that we can serve an individual situation. This is especially important for some people who are very sensitive to a preservative or an adhesive, or an additive. So that's another feature of utilizing the compounding pharmacies. The issue of compounded hormones has become a very hot topic because the more conservative organizations that have to do with obstetrics, gynecology and menopause are saying that these compounded hormones are not FDA approved. Therefore, you should only stick with the pharmaceutical company, either synthetics or semi-synthetics or bioidentical. My argument with that is that the estradiol at .5 milligrams from a pharmaceutical company versus the .5 milligrams from the compounding pharmacy is the same hormone, it is the same dose, they all get it from the same supply house. It is the same. So, that argument doesn't really fly with me.

What is a problem is there are some people being interviewed these days and writing popular books that say that these compounded hormones are safe and good and better, and all other hormones, especially synthetic and semi-synthetic are bad and dangerous and unsafe. And that really isn't fair actually. There are some advantages to bioidentical hormones according to the research. Whether they are pharmaceutical company or compounded, because they are all from the same source. The advantages more lie in the progesterone rather than the estrogens. Synthetic progestin has been shown to have more unfriendly affects on some cholesterol features. It's been found to maybe contract coronary arteries, and it's maybe been found to have a more adverse affect on breast tissue, when compared to the bioidentical progesterone which has a more friendly affect on cholesterol, dilates the coronary arteries, and in two French studies, was not associated with increasing the risk of breast cancer where the synthetic progestin was. So this is actually a very important difference, we think, between the bioidentical, also called natural progesterone versus the synthetic progestin. And maybe all of our questions about breast issues are not so much to do with estrogens, but perhaps more to do with the different kinds of the progestins, meaning synthetic, versus progesterone, meaning bioidentical.

Some other questions that I know you have are the maybe day-to-day side effects. And the bioidentical progesterone does have less day to day side effects than the synthetic progestin. That's another big difference. It seems when you weigh everything, both these day to day side effects, how women tolerate the medicines, perhaps some potential long term bigger issues, there does seem to be some distinct advantage of bioidentical progesterone over the synthetic. And we have evidence and research, and proven effectiveness at doses of natural progesterone or bioidentical progesterone that can protect the uterus in the way that it is supposed to from estrogen. Same as the synthetic progestins. So in the ways that we want them to be the same, they are good, and in the ways we want them to be different, it seems as though the bioidentical progesterone is a better choice.

When it comes to the estrogens, we don't really have so much evidence that the bioidentical, whether it is from a compounding pharmacy or the pharmaceutical company, is any safer or better than Premarin or the synthetics or the semi-synthetics. So, it's not really fair for people to be saying that these are safe and those are not safe. And I think that's a disservice to women and their partners to say that these are

good and these are bad. We don't really have that information.

So, let's just look at “why are we even thinking of using these hormones”? Well, these are the medicines that have excellent ability to relieve things like hot flashes, and night sweats, and mood swings, and depression, and anxiety, and low sex drive and less sexual arousal, and vaginal dryness, and memory, and insomnia, and the list is quite long of how these estrogens and progestogens and testosterone can help women. For example, estrogen is the main hormone that helps hot flashes. Estrogen and progesterone are the main two hormones that help sleep. Estrogen with testosterone are the two main hormones that help sexual function. So, those are examples of important combinations that we need to use to address each individual symptom. But usually a woman has more than one symptom. So, this is an advantage of coming to a practitioner that is versed in all the different hormonal options, let alone all the different herbal options. A great doctor doesn't necessarily make a great menopause doctor. So you want to find, in my opinion, a really good menopause doctor, and in my opinion, someone that has the training and the experience in this whole spectrum of options because hormone replacement isn't for everybody, and not the right thing to do for everybody, and herbs and nutrition and lifestyle isn't just the right thing to do for everybody. We need to figure out what's really best for your particular situation in the case of menopausal women.

The hormones though do an excellent job, and their primary indication is relieving symptoms of menopause. They also have benefits to slowing bone loss, lowering cholesterol levels, and probably preventing heart disease if it's started early, meaning in peri-menopause or early menopause. And probably helping prevent decline of memory and possibly even preventing dementia, again, if started early. This is a controversial confusing area right now. “Do hormones increase or decrease the risk of heart disease?” And the way the research has kind of settled out right now, 2009, is that if started in peri-menopause or within the first ten years of menopause, it looks like hormone replacement therapy can actually reduce the risk of heart disease. If started later, after ten years post-menopause, it may in fact increase the risk of heart disease.

In terms of breast cancer, it doesn't seem to really matter when it's started, but more, how long it's used. So if you use for four years or more, the current research tells us that this may slightly increase the risk of breast cancer. And it's important to hear that word slight because it's really only about six to eight more women per ten thousand women who use hormones for longer than four years. Now, that's six to eight more women than we would like, of course, but it's very slight. And in fact, most women don't need hormones long term for symptom relief because the average length of time of these nuisance symptoms is four years or so. And if you are one of the 10-25% of women who has symptoms that are longer than that four years, then we use the lowest dose possible, in the safest form we think possible, and in the safest delivery method possible, and in the case in my practice, we then use other prevention strategies to reduce your risk of getting breast cancer. Like, exercising three or more hours a week, and low fat, high vegetable diets, and high fiber diets, and green tea, and fish oils, and lowering alcohol. These things can be used in combination if you are a person that is taking hormones long term to really make, in essence, a very safe approach to managing your menopause issues. And, if at worst, slightly, ever so slightly increasing your risk of getting breast cancer.

We should probably also talk about vaginal dryness because this is an area where we use local estrogen, vaginal estrogen that comes in a tablet or a cream or a ring, from conventional pharmaceuticals. With the compounding pharmacies we can do the tablets, or the creams or suppository. Internally or externally in the case of a cream with external tissue that is dry or burning or

itching. And these are, I tell women, are like miracle medicines. Vaginal estrogen, whether bioidentical or synthetic, frankly is really a miracle medicine. And it's curative. It's not just like a lubricant, it actually restores the health of that tissue: the tone, the elasticity, the lubrication, and the pH balance. It's really an important medicine for most women, and we end up doing a maintenance dose, a low dose of vaginal estrogen twice a week. In my case, I mostly prescribe the low dose bioidentical estriol. No pharmaceutical companies make that and we have to get that from a compounding pharmacy. But that has a very nice affinity for that tissue because there are so many estriol receptors there. Very safe. There is really nothing dangerous about using vaginal estrogen in these low doses and fairly infrequent doses as I said, about twice a week.

I know that some of you again, might be interested in the sexual function and topical testosterone creams right before sexual activity enhances the sensation to touch. When it comes to libido, we might need to use estrogen with testosterone, and then if you have a uterus, we always have to add a certain amount of progesterone. But this combination of estrogen and testosterone is the most important combination for enhancing the desire, the drive, as well as the arousal.

There is also sometimes a time and a place for just progesterone by itself. And what I am talking about here is the bioidentical progesterone. Bioidentical progesterone is most famous for its sedating effect. It binds to the receptors in the brain, and it has a calming effect and a sedating effect. So sometimes I use it for insomnia, sometimes I use it for anxiety. And, it's best used under that circumstance in a capsule or a sublingual lozenge. It also comes over the counter. This is the one hormone, of the hormones that we are talking about today, that does come over the counter in a cream. And it can be applied to the palms, or the inner upper arms, or the inner thighs. It can be used quite nicely early in peri-menopause for hot flashes, some anxiety and mood situations. Because it also an anti-spasmodic, it can be applied to relieve some of that sort of belly cramping, whether it's a uterine cramping, or whether it's your intestines kind of cramping a little irritable bowel kind of thing. So it's a good option for an initial onset of symptoms, especially. And even in time as menopause goes on you might find that even that cream over the counter can help with some self selected symptoms whether it's, like I said, belly, crampy, bloaty stuff, or anxiousness, hot flashes, those kinds of things. We also use this bioidentical progesterone like in a pill, in our combination formulations, and compound it in creams, and in gels and sublingual lozenges. And when a woman has a uterus it's very important that we actually add progesterone to the estrogen because we have to have a certain balance of the two to keep the uterus happy, you might say, so it doesn't bleed or cause abnormal cell growth. This whole issue of balance between estrogen and progesterone is rather complex and certainly very individual when it comes to other issues in terms of mood, hot flashes, that kind of thing. They each have their own particular benefit. Estrogen probably being more diverse than progesterone, but they are both important, they both have a role and they each come with a little bit different benefit whether you are in peri-menopause, and maybe a little different benefit the longer you are post-menopausal.

One other long-term consequence of aging you might say, and low estrogen levels is bone loss. There is a normal amount of bone loss that occurs. About two percent per year for the first four to five years. So it's normal to lose bone in these first few years of menopause when the estrogen levels drop. Then it kind of plateaus for a couple of decades really, then it starts to go low again. While the primary indication of taking hormones is for symptom relief, some women will need or choose to take hormones for bone loss and to slow bone loss and to reduce their risk of fracture. If you have a combination of symptoms for which you need hormones and excessive bone loss, taking hormone replacement therapy is going to be a really great option. If you have just bone loss issues and your

symptoms are minor or not a problem, then, if you have significant bone loss and you meet the criteria for treatment, treatment is probably going to be better for you to take just an osteoporosis specific medication that is not estrogen. And that again has to do more with long term benefits and risks. But estrogen is an important player in the bone loss issue and it does slow bone loss and it does reduce fractures by about fifty percent, so it's part of the conversation for hormones.

The three areas of potential use of hormone therapy are:

#1 Symptom relief

#2 Disease prevention

#3 Disease treatment

And the big diseases we are thinking about related to hormones are heart disease, osteoporosis, Alzheimer's, and of course, we want to prevent and or treat those things without increasing our risk or only minimally increasing our risk of other problems, like breast cancer.