Dr. Tori Hudson Transcript
From the Blitzed by Menopause DVD

There's kind of a short list of symptoms, and a long list. And the short list, the most common thing really would be hot flashes. That's the thing that probably brings women most to the doctor's office is hot flashes. Whether they are daytime or nighttime we call them hot flashes, although some people say night sweats. If we are in the peri-menopause, of course there are changes in the menstrual cycle, but once one has stopped bleeding, then you don't have a period anymore.

-Hot flashes
-Insomnia
-Mood swings, including: weepy, irritable, anxious, very snappy sometimes, not being able to tolerate the world so well

Those are probably amongst the most common. And then we get to less common things.

Some of the less common symptoms would be in the transition time when hormones are going up and down: headaches, in particular. Other than that time, once one has kind of settled in to menopause and their hormone levels are low, other less common things might be irritable bowel; gas, bloating, changes in bowel habits, dry skin, itchy skin, the voice getting kind of deeper, dry eyes, vaginal dryness, vaginal thinning, discomfort with sexual activity (we probably should move that up to one of the more common symptoms). There are some rare and peculiar things like ringing in the ears, or shoulder, almost a frozen shoulder kind of issue, body aches are not on the super common, but frequent list.

Urinary frequency as well as involuntary loss of urine; a little dribbling, a little leakage, that is all related to changes in estrogen levels and the genital area. Once that tissue gets thin, there is not only just dryness and itching, but there is also loss of tone and changes in angles of things, changes in how the sphincters work, and so then there is that involuntary loss of urine, or frequent urination.

So the reason why hot flashes, mood swings and sleep problems are the most common is not absolutely known. But we do know that once the hormonal changes occur in the brain, then our brain chemistry is different. So estrogen, progesterone, these things in particular affect serotonin, dopamine, norepinephrine; important brain chemistry that determines our feeling about life, our reactions to the world, our irritability. So, changes in brain chemistry, how those brain chemicals work with hormones, is very well connected. That also affects the sleep cycle.

The hot flashes are a little bit more complicated even. In terms of vascular instability with hormonal changes, changes in the temperature setting point, changes in our blood flow to our skin, all these things are changing because of fluctuating hormone levels, but ultimately, low estrogen levels by and large.

Hormone replacement therapy in any form really helps to stabilize vessels, it helps to stabilize brain chemistry, it helps to re-estrogenize tissue that is being deprived of estrogen like vaginal tissue, the skin, the collagen. Estrogen determines tone, collagen strength, pH of our bladder or our vagina. It determines the stability of our brain chemistry. It is massively connected to all these things and men and their hormones have not so dramatic of connections, but also we have these hormone receptors virtually everywhere in our body.

Memory loss and confusion can be very difficult to determine what that is due to because there are normal age related changes in our memory, in our focus, and in our concentration…*stay tuned for more* There are also other health problems that affect memory and concentration other than menopause, like low thyroid function can affect memory and concentration. Depression and anxiety can affect memory and concentration. Medications, chronic pain, all those things. But as it relates to menopause, again we have changes in our hormone levels in our brain affecting how things are firing, and blood flow to our brain. So brain

chemistry, blood flow affects memory, concentration, focus. And this is an area, as time goes on, that can be more difficult to understand. Is this a more serious, progressive problem ultimately leading to dementia? or is it just a hormonal change that can be fixed with something hormonal?, or is it normal age? or as I said, one of those other problems.

In women, estrogen and testosterone in particular can often improve these hormone related memory changes. There are also some natural substances that improve blood flow, that improve some of the neurological inputs. There is a little substance called NADH that can improve memory quite a bit. Gingko maybe doesn't so much improve memory day to day but can help slow the decline of memory loss. There are actually numerous other plants that can improve memory. Gota Kola, things that people haven't necessarily heard of, although one of my favorites is Rodiola. It's sort of a more eastern European plant with a considerable amount of research. Men in particular might be interested in that Rodiola has been studied to not only improve memory and concentration, but athletic performance. Recovering much more quickly from your workout for example. So, for both men and women, that is kind of a good little tidbit to know. But, it's actually a significant plant in memory loss.

Loss of libido also can be a frequently reported symptom that women talk about. A better title is, sort of for this whole category, is "changes in sexual function". Because sexual function includes desire, which we call libido, it includes arousal, the ability to kind of get "worked up", so to speak. And then it includes the orgasmic response. So, those three areas are the key areas of sexual function. The hormonal changes can affect all three of those areas. So the drop in desire; intellectually the woman might still want to have sex, and likely does, if things are going well in life and the relationship. So intellectually she does, but she just doesn't have the feeling, the juice, the joie de vie. She just doesn't think of it. That's a very much hormonally mediated symptom. She also often experiences lower ability to get aroused. It takes longer or it's less intense. The same with sensations to touch. The sensation to touch lessens. And so, less blood flow, less ability to feel and so the orgasmic responses are often slower and less intense. Now, men also have these changes with drop in testosterone, or at least, often men do. For women, our sexual function is also partly determined by testosterone, but for women it's mostly estrogen and also testosterone. And for men it's mostly testosterone.

The women who use a topical testosterone cream applied to the genital area right before sex can actually have enhanced orgasmic response. The best approach to improving libido and arousal is using estrogen and testosterone together in a prescription form. Whether that's...usually it's an oral medication, or there can be estrogen patches and testosterone pills along with the estrogen. I just prescribed yesterday a testosterone patch for a woman. Now these are not in women's doses, so we can't...they are meant for men who have testosterone deficiencies. For women, since there isn't a testosterone patch on the market yet, we can *occasionally* use this rather high dose testosterone patch. She was going on her thirty-year anniversary trip to the coast with her husband. And so I said, "okay, you can have a patch. Put it on a couple of days before you go on your trip" and her testosterone levels will rise and likely her libido will rise. But, we can't use a testosterone patch very often in women because they are at higher doses that men are supposed to take.

Vaginal dryness is also a part of a woman's sexual function, because if sex is uncomfortable, then she doesn't *feel* like having sex. So that's one of the first things I do in an interview, in a woman who says "I just don't feel like having sex", I ask her about, "well when you do have sex, is it uncomfortable? And if it is, where?" Because there is dryness in the vaginal wall, but there is also... A drop in estrogen affects the opening to the vagina. It's called the introitis, and that ring kind of contracts with loss of estrogen. So, not only is the vagina now thinner and drier and less lubricated, less circulation, the opening is narrower, and so it's painful. An entry with any kind of vaginal, sexual activity in addition probably to being dry. So, that is part of libido and arousal as well, is this local phenomenon. And really, vaginal estrogen is a miraculous treatment for vaginal dryness and discomfort with sex because it not only takes care of the dryness, it then makes the tissue more elastic so now this narrowed opening can get more elastic again. So, vaginal estrogen, awesome for that. The topical testosterone to the genital area right before sex, perhaps some systemic estrogen and testosterone when some of the herbal formulas don't work for libido.

There is a condition called irritable bowel syndrome that is really kind of a basket term for a lot of this bloating that women experience during menopause. And again, hormonal influences seem to affect irritable bowel syndrome. In fact, women who are still menstruating, irritable bowel syndrome can flair up as a premenstrual symptom. Often we think this might be a little bit more related to progesterone, because progesterone is a sedative to smooth muscles. It helps the muscles relax. So, irritable bowel is that colon is hypertonic, spasmodic, irritated, not having its normal, rhythmic motions. So, progesterone can be a very helpful hormone with this abdominal pain, irregular bowel movements, and the bloating aspect. Now that's not maybe where I would always just start, because we have to look at dietary influences. Even though it might be a hormonal, menopause symptom, we might start with digestive enzymes, some lactobacillus, supplements, those kinds of things and then if...or coated peppermint oil is an anti-spasmodic to the gut. If those don't work, and this is coming on with other menopause symptoms, we should think big picture. "Okay, maybe this is hormonal and we need to approach it in a more hormonal way." Now, women that have gas and bloating often feel like they are gaining weight there, and they are not really gaining weight, they are just bloated there. That is one category.

But then, weight gain in and of itself is something that happens to menopausal women. There is normal, (again, kind of like memory), weight gain related to age. Our metabolism is slowing down, we are losing our muscle mass, the fact that we are sedentary is catching up with us, just because of time. We also though, with a drop in estrogen, our insulin levels essentially kind of go up, or our cells become more insulin resistant. Maybe the most important thing to say about that, because it is kind of complex is what happens then is we just don't handle starchy foods as well anymore. Or, what are called high glycemic foods like bananas. They cause our blood sugar to rise quickly, our pancreas says "oh, okay, insulin", to bring down the blood sugar a bit, but our cells out here anymore now don't see that insulin so well, and so then it becomes a fat storage hormone. So less estrogen, more insulin, more insulin resistance, more weight gain. This is why peri and post menopausal women say "my diet is the same as it's always been" and let's say it's good, and "my exercise is the same as it's always been", and let's say it's good for the purpose of this conversation. But, now it's not enough because we are insulin resistant and these same foods are becoming a fat storage hormone. So, we have to lower our starch. Even if it's whole wheat bread, we have to eat less whole wheat bread. Even if it's brown rice, we have to eat less brown rice. Let alone, if we still think bagels and pasta are a health food, we definitely have to lower those. Potatoes, terrible in terms of increasing our blood sugar and causing this fat storage dynamic. Bananas, same thing. I encourage people to check out the low-glycemic index diet and the South Beach diet is actually a very good diet for menopausal women because it's talking about insulin

resistance, lowering the starch as well. Women in menopause start getting this abdominal weight gain much like men have already experienced abdominal weight gain. And these are both hormonally influenced phenomenon related to changes in our hormonal balance, if you will. And, the acquisition of this insulin resistance phenomenon.

Fatigue is another new symptom that women often talk about in this peri-menopause/early postmenopausal transition. Sometimes that is also one that is kind of hard to nail down and it's hard for partners and family members to understand. Well, there is nothing really “wrong” with you, you don't have a “disease”, you don't have an infection, “why are you fatigued? Get with the program!” But there really are, again, changes in the sleep cycle, that's the first place I look. Maybe she's not having night sweats that are keeping her up, and she thinks, “that's not that”, and she thinks she is sleeping, but actually she doesn't get into the deep sleep anymore. Again, brain chemistry. So this lack of deep sleep affects our energy. Also, as our estrogen levels are low, our testosterone levels are also low. Our DHEA levels, another hormone we haven't talked about, mostly from our adrenal glands are also low and that combination also affects our vitality, is a good way I like to put it, our vitality. So, yes, fatigue is a fairly common menopause symptom, but we want to make sure it's not something else first. Is it hypothyroid, is it anemia, is it depression, and is it another health problem? If the doctor does their sort of “due diligence”, and we don't find a good a good explanation, we might easily come back to “oh, it's how these hormones are affecting brain chemistry and vitality”.

So the most common symptoms that women come into my office for around peri-menopause and menopause is if there is still peri-menopause then it's a lot of abnormal bleeding problems. That could be light, that could be heavy, that could be long, that could be short. Any way, shape, or form. Once the periods have stopped, then peri-menopause or menopausal we are talking about hot flashes, night sweats, irritability, depression, anxiety, overreacting, overwhelmed. You used to be able to handle twenty feet of stress before you got pissed off. Now you can only handle ten feet of stress before you're triggered. Just the reserves aren't there. Also, changes in vaginal tissue. Vaginal dryness, pain with sexual activity in the genital area. That's pretty common, as well as less libido. So, changes in sexual function from all kinds of angles. A little less common would be maybe headaches, body aches, fatigue, heart palpitations, dry skin, itchy skin, urinary leakage. These are not as common, but pretty darn common. And then there is some less common, or even rare things, like ringing in the ears, like frozen shoulder, like burning mouth syndrome, dry eyes. These are things we don't hear about as often, but clearly can be related to menopause. The gas and bloating, changes in bowel habits, that might be sort of a less common, but certainly not rare. The list goes on. There is hair thinning, hair loss, there are changes in the voice, and the voice becomes deeper. We could probably come up with something unusual that someone has experienced. Tingling is another one that might come to mind. Even coldness. We talk about hot flashes, but coldness is sort of a subset, you might say, hot flash, kind of a chilled feeling.

So amongst all these symptoms, the woman and the practitioner has to decide which is best for her. The way I approach this is, in taking the history and doing the physical exam, maybe there are some tests that are ordered. Basically determine what...are her symptoms mild, moderate, or severe. So, symptom category is one issue. Then are the risks for certain major diseases, mild, moderate, or severe. Risk for osteoporosis, risk for heart disease, risk for diabetes. So we have to determine these to the best of our ability, subjectively and objectively. So after I've kind of made some kind of

determination there, then I look at my whole list of "okay, what are we going to do about the symptom relief". Is there anything in diet, exercise and lifestyle category that could improve some of these symptoms? Is there anything in the nutritional supplement category that could improve some of these symptoms? Herbal medicines. And then we have all different kinds of hormones, whether we call them...there are bioidentical hormones that are derived from a natural substance and then made into a hormone that is biochemically identical to our hormones, those are bioidentical. Those can be compounded at a special pharmacy to come up with very customized formulations and combinations and dosings that pharmaceutical companies don't make. But pharmaceutical companies also have a small selection of bioidentical hormones in a patch or a pill or a vaginal device. And then there are synthetic or semi-synthetic hormones. So, we have all kinds of hormonal options to choose from. And not all practitioners know about all, or are skilled, or are educated about all those hormonal options. Your typical conventional minded practitioner is going to mostly use the hormones the pharmaceutical companies make. And it's usually the alternative minded practitioner, whether it is a naturopathic physician or a medical doctor that's going to be using the customized, compounded hormone combinations.

But the last category I want to mention is non-hormonal options. So if you have insomnia. This is why a doctor might prescribe Trazodone or Ambien, or those kinds of medications. Pharmaceuticals for depression or anxiety. There are even non-hormonal pharmaceuticals for hot flashes. Some of the blood pressure drugs are actually used for that. Some of the anti-depressants are even used for that. So we have all these categories. In the herbal category maybe Black Cohosh. Maybe a Maca Extract. Maybe a combination herbal formula that can... either one of those three choices can address kind of a nice array of menopause symptoms. But perhaps you specifically have insomnia. So we'll use Black Cohosh and Valerian for example. But there are lots of specific nutrients and specific herbs for specific menopause symptoms. And then the hormones are nice because they target a broad array of symptoms. You can have kind of almost any menopause symptoms and a good menopause practitioner can determine what's the best hormonal approach for this particular situation.

One of the things that can become disturbing for a woman or her family members is when some memory changes start to occur. And this can be not remembering what she said, this could be not remembering what someone else said, this could be going into the kitchen and "I came in here to get something and I don't remember what it is", it could be not remembering the movie or the book. And a family member can feel like "Wow, she's just not paying attention to me anymore. She's just not, she just doesn't care, she doesn't pay attention." But it's not that. It's really a change in memory, a change in the ability to recall. Word recall, name recall, trying to speak in a sentence and trying to find a certain word. Not remembering someone walking down the street and it's kind of embarrassing, "I don't remember her name". So those things can become problematic and they can become scary. Because for some women, this isn't just a hormonal change or just a normal age related change, but it's the beginning of a progressive change. And we often don't know at this point and time, especially in the forty-something, fifty-something what it really means. And there is really not great ability to discern "is this a terrible problem, is this a minor problem?". And often, the doctor needs more time to elapse to understand what is the nature of the situation here. Alzheimer's disease is far more common in women than it is in men. And that's because of this whole estrogen deal, we think, and the brain. So it's not surprising that women have more Alzheimer's than do men. And there are other things like osteoporosis, which is related to menopause, is more common in women than in men because it's more estrogen mediated than it is testosterone mediated. But, I'm getting distracted away from memory.

So one of the ways that the hormonal changes can affect our brain chemistry, it could result in anxiety,

I mentioned that briefly as part of the mood changes. But anxiety in particular might need a little bit more attention in that it can be mild, just feeling, waking up in the morning and just feeling a little “off”, a little anxious, or lying in bed at night and worrying a little bit more. Being a little bit more anxious about going to the party or going to another social event. But it can also become much more significant and even severe. There are women that never had an anxiety syndrome, never had panic attacks, and now all of a sudden are in the emergency room with chest pain, heart palpitations, shortness of breath, and there is nothing wrong with their heart. It's a bona fide panic, anxiety attack. And that is a part of this whole hormonal influence on our brain chemistry is worrying more, anticipatory anxiety, stressing about upcoming events. Any way, shape or form, just feeling more anxious. Being more sensitive too to what someone says. You know your husband says something “did he really mean this? did he mean that?” being anxious that he's... even paranoid. Maybe more jealousy coming up around this anxiety syndrome can happen all mediated by these hormonal changes.

Often women ask me the question is “how long is this going to last, Dr. Hudson?” and “when is this going to end Dr. Hudson?” and I wish I could answer that question “it's only going to last this time”, but the truth is it's...I can not. It's unpredictable. It's different for all of us. The severity is different for each of us, the duration is different for each of us, which symptoms we have on this long list of potential symptoms is different for each of us. But, on an average, according to the research, menopause symptoms for seventy five to ninety percent of women last four to seven years. Now, there's the ten to twenty five percent of women for whom that's different. And we don't know if at year three, at year four or at year seven if you are going to be on your way out of these symptoms or are you going to be one of these ten to twenty five percent that is going to last longer. There is no way to really know that. We are trying to get some understanding. If you've had severe PMS, it seems to have some prediction on menopause being more severe. That's one thing we seem to see a correlation with now. But unfortunately, we can't really predict what your menopause is going to be like, let alone, can we predict how long it's going to last. But we can work with the law of averages and try to give some reassurance. And most symptoms are temporary in most women. The problem is there's the women that are not “most women” and the problem is that there are a few symptoms that tend to be progressive, like vaginal dryness, vaginal thinning, urinary incontinence, that set of symptoms tends to get worse with time because that tissue gets more consequences as it is deprived of estrogen for a longer period of time. But most other things, symptoms, not bone loss, not some of those things, but symptoms. Most of those are temporary in most women.

So far we don't have any strong connections as to what your mother's menopause was like in telling us what our menopause is going to be like. And also, a lot of forty, fifty something year old women now who are just going through this key menopause time have mothers that in their generation, many health problems were solved by removing the uterus and the ovaries. We have more progressive surgeries now, many more medical options, so the doctors and patients don't have to choose that as often. But, for some of us, we don't know what our mother's menopause would have been like anyway because she went through it in a rather unnatural fashion by having suddenly her ovaries removed. And of course hormones were prescribed more easily, less judiciously, you might say, back in those days as well. It's more selective now, more weighing the benefits and the risk and more desire on the part of the practitioner to use hormones for the shorter amount of time mostly in this sort of temporary window of symptoms.

If you are watching this video and your partner is going through menopause, you might wonder what

you can do to be helpful. And the first thing I think to maybe look at in terms of your previous experience with your partner is, have you already been through years or months or decades of PMS? And how that has been going and what that has asked of you. It's similar. You know I think many men can find it very difficult and challenging to have empathy and really understand what is going on with their partner during this time of menopause changes. And I empathize with that. It's a challenge, because often you don't know what to expect, and you don't know if it's you or if it's them. If it's them is it some character defect or is it a health problem. And I would just really encourage men to try to learn as much as they can about menopause and I would encourage men to ask their wives and partners questions and really kind of try to bring forth your best inquisitive self. You're curious. You are asking questions, you are wanting to understand. I think that's a useful approach because chances are, she's not faking it. Chances are, she's not lying to you about what's going on with her. Chances are she's really needing some help. And if she's had a difficult time with PMS, and that's already been challenging for the family, it's very similar here. The mood swings. If it's been difficult to deal with a teenager and their hormonal changes, it's very similar. It requires us being more patient, it requires us being more caring, maybe even anticipating, much like you would if someone you knew didn't feel well. You just try to do a little TLC. You try to do a little bit to help out here and there and even just the littlest things can make a really huge difference. A little piece of dark chocolate under the pillow, or “can I help you with the dishes tonight”. “It looks like you've had a really hard day”. Just a little extra and I would gather that would come back in a favorable way to you. And I know that we want things to be balanced in relationships and you don't want to feel like you are always trying to compensate for what seems to be not going well with your partner but men have hormonal changes too and generally that comes a little bit later and looks a bit different. But I think just this inquisitiveness, trying to learn yourself, bring forth your best questions and empathy, I think that's what my advice would be.