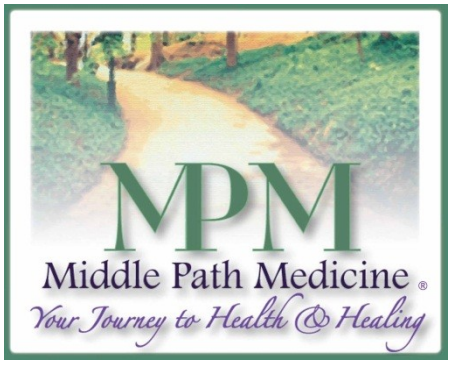

Menopause: Symptoms & Solutions

By: Gary E. Foresman, MD

THE GOLDEN YEARS

Since the beginning of time, when a woman reached that stage in life where she was lucky enough to have irregular periods, which eventually went away, associated with night sweats, hot flashes, and a myriad of mood fluctuations, she knew she was entering into menopause. She didn't need a hormonal test, whether it came from her saliva, blood, urine or eye-socket. Typical for our modern era, we have created a normal transition into a well-marketable disease which can then be treated by expensive pharmaceuticals, guided by so-called authorities who are more than willing to support the disease model.

Just like PMS, menopause is a hormonally-related condition by which no absolute hormone level can be definitively associated with any one symptom. Our entire culture of women have been misled by the idea that menopause is scientific. That is "If I only had a certain level of estrogen, testosterone or other hormone, then I would feel a certain way." When in truth, every scientific study has shown this to be untrue, and that at best we can make broad generalizations about hormone levels and symptoms.

So what is a woman to do? Just like with any symptom, listen to it. Is my transition difficult due to stress, or lack of exercise, or a diet high in processed carbohydrates with too few good fats? Do I need to slow down, listen more carefully, spend more time in nature, "be" more and not "do" more? Maybe these are the answers that you and your body are looking for, not necessarily a drug or an herb. You see, as we head into the "Wise Woman" phase of our life, our body might just be asking us to become a "Wise Woman." Honor your symptoms, enter them, face them, but don't run from them. Our society teaches us to run from discomfort. I am asking you to listen to it. Journal, spend time in nature, vacation, and listen.

If you are having a troublesome menopause, and while you are looking for the answers as to why it is troublesome, for heaven's sake, treat the symptoms. A simple natural remedy known as "Hot Flash" by Source Naturals at 2 tabs, 2-3 times per day is an excellent natural phytoestrogen blend that can work wonders. Evening Primrose Oil 1350mg, 1-2 caps once or twice per day added on to Hot Flash, I have found beneficial many times when the Hot Flash was not enough. If the natural approaches aren't enough to treat your symptoms, and especially if you have a low bone density, strongly consider natural hormonal therapy (a discussion with your natural Doctor). Finally, if you have still not responded to these approaches, it is time to consider hormonal evaluation to help guide you and your physician further.

I tremendously respect the discomfort that some women experience during menopause. But just like with any other health condition, the key comes in actually listening to the symptoms, and listening for the answers that are always there.

THE HORMONE FACTOR

The above section is a general overview of my approach to perimenopause/menopause. If a woman continues to have menopausal symptoms despite her continued efforts at good nutrition, stress reduction, exercise, and appropriate detoxification then she should treat herself. Starting with natural approaches whether with herbs, supplements or essential oils each woman should experientially evaluate each remedy for herself as there is little science to guide your practitioner/healer. What your healer does have is experience, which hopefully you find valuable in helping guide you to what your best and safest options may be. The following are natural remedies I have found helpful:

Hot Flash (Source Naturals) Dosage: 2-6 tabs daily, taken day or night based on symptoms. Effects can be seen immediately, but full effect can take up to 3 months. It is a combination of soy isoflavones, black cohosh, dong quai, licorice and Chaste Tree Berry.

Women's Phase II (Vitanica) Dosage: 2-6 capsules per day, is a different herbal combination that I find highly effective for treating the symptoms of menopause.

Menopause Multiple (Source Naturals) Dosage: 2-3 tabs twice daily with food. Think of this as a good multivitamin with Hot Flash added. This is not quite as potent as adding Hot Flash to your multi-vitamin but more convenient.

Black Cohosh Dosage: is standardized to triterpine glycosides. Range is from 1-8 mg per day. Some woman prefer single dose herbs if they are on the sensitive side. Cimi-Fem (Source Naturals) is a sublingual form that has drawn good reviews.

Genistein (Source Naturals) Dosage: 2 tabs (62 mg isoflavones) twice daily. This is a brand of soy isoflavone, and in my experience is worth a try, although studies are very mixed.

Progesterone Cream (Pro-Gest or Source Naturals): Most contain 500mg progesterone per ounce equivalent to 22 mg per 1/4 tsp. Dosages vary considerably but 1/4 to 1/2 tsp twice daily is a good place to start. Consider cycling 3 weeks on and 1 week off. This can be used alone, or with other phytoestrogens.

Evening Primrose Oil Dosage: 1350 mg caps, 1-2 caps twice daily. Not really supported by scientific studies as a stand-alone product, but I have found it to be a great adjunct to other natural remedies.

I can answer questions about any other products but I have found that if none of the above work, it's time to start talking hormones. The range of and the duration of menopausal symptoms are so variable that giving estimates to any one woman on "how

long am I going to have to take this" is impossible. Some women's experience of menopause is "I just stopped having my periods", others describe decades of disabling hot flashes. My experience of the "average" perimenopause/menopause is that most women have 1-2 years of symptoms easily treated naturally, followed by 2-3 years of symptoms where hormones should be considered, followed by 1-2 years where natural approaches are best and then simple lifestyle changes suffice. The key factors are symptoms and bone density.

In regard to bone density, I believe every woman should get a bone density test, whether QCT or DEXA of spine and hip at age 50. Not from a gynecologist who is not trained in how to really approach low bone density, as this would get most of you placed on drugs. The idea is to find out where you are in the spectrum of bone density and give you and your doctor an idea on your lifelong estrogenization. This will provide you reasonable help in determining whether you need a multimineral or not and some idea about your personal risk/benefits regarding hormone replacement therapy (HRT). If you have average or below average bone density strongly consider a multimineral, and if you have persisting menopausal symptoms strongly consider HRT.

The pharmaceutical industry sold the American woman, her doctor, and anyone who would listen, the calcium carbonate myth. The politics are lengthy but despite overwhelming evidence that calcium on its own does nothing for you, it is still being sold (which is the operative word). If you have low bone density take a good multimineral and high doses of vitamin D. Monitor your bone breakdown with the urinary N-telopeptide test. Do this test while taking only calcium, do it again after starting a good multimineral. Also make sure you get a blood test for vitamin D (25-OH D), not only is it important for bones but recent trials showed that women with a level less than 50 have six times the risk of developing breast cancer compared to a woman with levels greater than 50!!! In our climate it takes supplements to get to this level.

Multimineral Ultra Bone Balance (Source Naturals) 2 tabs twice daily with food or Rebuild (Metabolic Maintenance) 3 caps twice daily are two good options. UBB is more comprehensive and includes 600 mg of Ostivone (ipriflavone), whereas Rebuild is in a capsule which many women prefer.

Vitamin D (Carlson's 2000 IU soft gel) Dosage 1-2 caps per day with food. Most nutritional authorities are moving to this dosage, but you don't have to listen to us - get a blood level to help you determine the right dosage for you. Recent trials indicate that Vitamin D is the ONLY vitamin proven to prolong life! Vitamin D truly has an anti-aging effective far more proven than any hormonal manipulation.

If a women has osteoporosis, and despite lifestyle changes and a good multimineral she continues to have excess bone loss it is time to consider medicines.
Now we get to the slippery slope of HRT; should I or shouldn't I, cycled or non-cycled, transdermal or oral, synthetic or "bio identical", with or without progesterone, with or without testosterone? The questions are endless. Let's review the data from the Women's Health Initiative (WHI) a prospective trial on Premarin and Provera in 16,608 women and in Premarin alone (post hysterectomy) in 10,739 women over approximately 7 years. These findings can only be applied to Pregnant Mares uRine (Premarin-

conjugated equine estrogens-CEE) and the synthetic progesterone - like drug (progestin) known as Provera (medroxyprogesterone acetate-MPA).

Coronary Artery Disease: In CEE/MPA an overall 24% increase in myocardial infarction (MI) and coronary death. In CEE alone, women age 50-59 experienced a 37% decrease in MI and coronary death, age 60-69 no overall effect, and age 70-79 an 11% increase in events.

Stroke: In both groups a 31% - 39% increase risk.

Venous Thrombosis In CEE/MPA: > 100% increase in DVT, in CEE alone a 47% rise.

Urinary Incontinence: Both groups experienced a near doubling in the rate of stress urinary incontinence.

Cancer: In the CEE/MPA group a 24% increased risk with much more aggressive tumors. In the CEE alone group a 23% decrease in tumors but an increase in benign abnormal mammograms. The CEE/MPA group had a 44% reduction in colon cancer not found in the CEE only group.

Dementia: In the CEE/MPA group a doubling of the risk of dementia, in the CEE alone group a 49% rise. These results apply to those over age 65.

Osteoporosis: Both groups had a 33-35% reduction in hip and vertebral fractures.

Diabetes: In the CEE/MPA group a 21% reduction in insulin and glucose, in the CEE only group a 12% reduction in insulin and glucose.

Gallbladder Disease: Both groups had a 60% rise in the rate of surgery.

Well, what a mixed bag of results. But surprisingly when you factor out the poison known as Provera, and apply the results of this trial to women most likely to benefit from estrogen (those ages 50-59) even the worst of the estrogens (Premarin) dramatically reduced the risk of heart disease and breast cancer, the two most common reasons women give to me for not taking HRT!!! Mull on that one for a while and notice it also dramatically reduces fracture risk. I can't recommend Premarin to anyone but the idea that it is bad for everyone is simply not true and I have 2 or 3 patients where Premarin is all they can tolerate.

The choice of HRT is a very personal one to be made between you and a health care professional knowledgeable in all the options. There is no one right answer and once you see a book proclaiming to have the one right protocol you should know you haven't found the truth (but something to perhaps consider trying when other options fail). A very simple protocol I have found to be very effective for women with refractory symptoms and/or low bone density is naturally synthetic "bioidentical" Bi-Est (80%Estriol-E3/20%Estradiol) 2.5 mg 1-3 caps per day based on symptoms combined with micronized progesterone 50 mg per capsule if the woman still has a uterus or

clinical benefit seems to be derived. Although controversial, the mildly potent E3 really has some theoretical advantages and seems to "even out" the more practically effective E2. No, I don't always add progesterone as I have found it to have vastly more adverse effects than estrogen and only rarely adds to the efficacy of HRT (except in reducing the risk of uterine cancer.)

I prefer oral to transdermal as it is usually better accepted, and the first pass metabolism through the liver that so many claim is a negative is actually the primary basis for most of the metabolic benefits. However if the woman prefers transdermal, that's fine.

In women early in perimenopause cycling estrogens and progesterone can provide a regular period. Most of my patients with or without intact uteri prefer to do regular non-cycled HRT due to convenience and not wanting to have a period.

If a woman has persisting or unclear symptoms, I find blood, or rarely, saliva tests to be useful adjuncts when empiric therapy doesn't seem to be working. Especially useful when the issues of sexual arousal or desire are present, serum specimens for pregnenolone, DHEA-S, estradiol, progesterone, testosterone and FSH may be useful in terms of what adjunctive hormones to consider and approximate if we are approaching the "right" dose. This is especially true if we are concerned that we are taking too much of any of our hormones, as we don't have to worry, we can just measure the levels.

Experimenting with androgens such as DHEA is best guided by a professional, but the combination of 25 mg of pregnenolone with 10 mg of DHEA first thing in the AM and sometimes repeated mid-morning I have found especially useful when the question of adrenal exhaustion is being raised, or when sexual desire is an issue. If a women wishes to experiment with testosterone, this is one hormone I would only prescribe transdermally under the guidance of an experienced physician.

In conclusion, every woman is an individual, and the age of cookie-cutter HRT is finally being put to a slow death. Inordinately false claims about the presumed risks of HRT are now taking place of the overly dramatic once-claimed benefits. Empower yourself with the knowledge to allow your body to decide what is the right path to take on your path of menopause.

Your Journey to Health & Healing,
Gary E. Foresman, MD

References:

Upon Request

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