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Presentation: ***The Four Horsewomen of the Menopocalypse***

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Intended audience: CWC PCN physicians and nurse practitioners

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I'm really excited. Who's excited about menopause? I should go through. I don't have any financial disclosures that I need to make. I don't use artificial intelligence largely because I don't know how.

Um, I'm not gonna read learning objections, that's important.

Today, I call this presentation, and I'm very proud of myself, because the four horsewomen of the men apocalypse, I like my clever names. I think it's very clever. And it's because when I was working in primary care, which has been a while for me, but when I was working in primary care, I come into the office in the morning,

And I'd look at my day sheet for the day, and I'd see a handful of women between 20 and 60 with these big symptoms, or maybe they said specifically to talk about menopause. And it was my nightmare. I had no idea how to help them.

The only thing I learned about menopause when I was in medical school was that you should never treat them. That was the only thing I learned. We simply didn't have a single lecture.

So, I got out into practice with no idea how to treat menopause, and that lasted A decade until I decided to do some retraining, so...

When I looked at it, when I really thought about it, there were sort of four basic presentations of menopause patients that I saw in the family practice office. And those were my horsewomen. Each of them was a horsewoman. These were people who brought nothing but dismay to my office. And so then I pivoted and I started doing sexual medicine and suddenly I was seeing menopause for six people a day, not six people a day, and realized that actually it's really quite straightforward, only I've never been caught.

And so now I'm hoping to try to make it straightforward to other people. So we're going to talk about some basic stuff, and then we're going to do some cases. And each case is one of my four horsemen. So that's sort of the plan.

And that's why it's called the Four Words Movement. And you guys know this stuff is all over social media now. It's a huge trend. You can't get away from it if you tried. To the point that

people come in with 20 pages of stuff printed off the internet, demanding the weirdest things. Usually they you know, even like, they'll ask for stuff. I had a lady ask for things that were all British names because she found some British influencer and was like demanding this stuff. I was like, that doesn't even exist in Canada. So that's what we're going to talk about, the menopause.

And so the four horsewomen are vasomotor symptoms, genitourinary symptoms, sexual symptoms, and the catch-all health promotion wellness.

That's the worst course.

Why don't we even talk this? I mean, menopause is going to happen if 50% of our patient population, if they live long enough, and 80% of those affected will have symptoms that affect their quality of life. They can last for over a decade. And the average woman has more than five symptoms in any given the age of 6. The average duration of symptoms is 10 years. And some people, they last forever. I like to use my mom as an example. She's still hotflashing in 79. It's not a lot of fun for her.

But we never get taught this, and the reason why.

we're going to talk about. First, the symptoms. There are dozens of them. This is a short list. The full list would take pages, right? There are so many symptoms. And some of them are really easy to pay, right? The hot flashes, the night sweats, the insomnia, that one's pretty easy. But what do you do about fatigue?

Is that menopause? Is it stress? Is it just life? Like life is tiring as it turns out. So a lot of the symptoms are hard to know. Is it menopause? Is it something else? Patients want it to be menopause because they think that means they can fix it. Itchy ears. Itchy ears.

Yeah, that's right. And as it turns out, sometimes that gets better when you treat with menopause. So it sucks because then you feel stupid for not knowing when their itchy ear is worse. Not everyone gets all the symptoms and they can happen in any order. So some people will get vaginal dryness at 42 and not get hot flashes till 56.

And some people get hot flashes at 42 and never get vaginal dryness. Why? I don't know. There's no way of figuring it out. We don't have a test. It just happens in what order it happens in. Some people sleep through menopause barely noticing it happen. And other people's lives come to almost a complete stop. I mean, imagine my job standing up here giving you guys a lecture and suddenly I'm bright red dizzy and sweaty. Makes it pretty hard to function, right? It's not a lot of fun when these things are happening to you.

But most of us weren't taught, even about the major symptoms, never mind the vague ones. And we weren't taught about treatment. And the reason why we can't talk about menopause without talking about the bane of my existence, which is the Women's Health Initiative. The Women's Health Initiative was a study that came out in 2000.

It actually came out as the wrong word. It was leaked to the media prematurely. And the media hype thought the study ended before we had all the data.

It was, to be honest, a terrible study.

But we don't talk about that because it's one of the biggest, sort of most definitive studies that everybody mentions. And nobody talks about the multiple retractions that have been done since. So we see this study and we're going to talk about the details. We think don't treat menopause, you're going to give somebody cancer.

And that's where we stop. And that's what I got in medical school. Menopause treatment causes cancer full stop.

But the thing is...

So in 2002, the authors came out with a statement after this stuff was leaked to the media. They came out with a statement stating that menopausal hormones should not be initiated for primary prevention of heart disease. They didn't say they should never be used. They said that they don't provide primary prevention. They said that there were other medications that could be used to treat osteoporosis and that there was a risk of breast cancer. They called it significant.

Fast forward 15 years and this is now the statement. Amongst, and this is the same authors from the same data. There's no new data here.

But they analyzed it better.

Amongst postmenopausal women, hormone therapy was not associated with risk of all-cause cardiovascular or cancer mortality. How did the same data get us from.1 to.2?

The reason is because the study was terrible.

The Women's Health Initiative was a cardiac study. It was originally randomized and controlled for cardiac risk. The breast cancer was a secondary endpoint. It was an afterthought that happened after they had already randomized their work.

And so when they randomized it, they randomized it for known cardiac risk, smoking, diabetes, cholesterol, right? Like you do with a randomized controlled trial. What they did not do was randomize it for risks of breast cancer.

So as it turns out, one of the placebo groups, just by chance, had a 25% lower risk of breast cancer based on their risk factors, just by chance. And yet that was turned into evidence that hormones caused cancer. Even though their own data didn't make sense amongst the different groups they had.

The risk of cancer in one placebo group, because there were two arms, there was the estrogen alone group and the estrogen plus progesterone group. The placebo groups of both sides, so people who got no hormones, had a 50% difference in their rate of cancer detection.

Just by chance, the study was randomized for me.

It also was used, they recruited people who are between the ages of 50 and 86.

Probably starts hormones on an 86 year old who's never been on hormones before. That's nuts. But then they generalize that data to apply to everyone.

The average age was almost 65. This is not what we do in clinical work. They were using oral Premarin, right? The pregnant Maryam fun stuff. They were using oral Provera. These are known slightly higher risk agents than the stuff we use now.

So that isn't necessarily applicable.

And they actually excluded people who had menopause symptoms. And they did no work to try to determine quality of life differences.

So who gives hormones to someone with 0 symptoms?

No, buddy, right? That's crazy.

On top of that, it just gets worse every time you read something about the study. They had almost 100% unblinding because patients knew they weren't on treatment. They didn't feel any different. It was quite obvious. More than 10% of the placebo group went to their family doctors and got hormones anyway.

So a good portion of our placebo group were not placebo to begin with. And 100% of the doctors involved knew who was on what, because they had to know in order to deal with postmenopausal bleeding, because they needed to know the risk of postmenopausal bleeding. So it was completely unblinded. So this study was just...

terrible in every way, but because it was large, it was given too much credibility. And so the results were leaked. One of the authors actually leaked the results to the news. That author later said, oops, my bad. So helpful. Thanks, guys. And so we never got the end results of the study. The study was ended too soon.

But there was no evidence. When you go back, when you exclude the 85 year olds, when you exclude and better control for risk.

the risks actually disappear. And in fact, may be better with hormones. Those on hormones probably have a lower risk of cancer.

But this study came out, no one read the retractions, and now we're all terrified of menopause. Now, the advice I'm going to tell you does not apply to hormone-sensitive breast cancer survivors. That is a different case. That is a very controversial case that's still undergoing studies. We're not going to talk about that today.

Today, we're going to talk about your average patient who has never themselves had cancer.

So the best evidence that we have when we reanalyze the Women's Health Initiative, when we look at the newer studies, is that there may be benefits in terms of cardiac disease and in terms of breast cancer. There does appear to be a benefit in terms of colon cancer, which no one's been able to explain. There's a benefit in terms of osteoporosis.

If you use the right things, there is no anticipated increased risk of stroke or DVT, even in people with pre-existing risks.

If you do it right. Not oral. That's why you have to do it right. There were fewer fractures. And there is no evidence that you have to discontinue hormones at a point because of years. If they have, they develop cancer, they have problems of some sort, you may discontinue.

Cancer is the biggest one, really.

But otherwise, you do not have to discontinue. That five years or 10 years was not because of proven risk. It was because doing a study longer than 10 years is really expensive, so no one did it. We don't have good 25, 30, 50 year studies because nobody can afford to do a study that long.

But it's not because we have evidence of risk. And in fact, recently they did a study. So they went the other way. They took women older than 65 who had been on hormones already for a minimum of five years, and there was no increased mortality.

So we are not harming people by giving them hormones and leaving them on them for as long as they would like to take. There is really no no harm.

So I hope that that helps you not feel afraid. So that when you see these people in your office, you're like, okay, we can do this. Which horsewoman are you? I mean, you can have a questionnaire on the door. I don't know. So let's talk about the horsewoman.

horsewoman is Janine. She's a patient who saw first at 46. Her periods are weird. I call it menstrual chaos. She's having trouble sleeping. She feels hot in the night. She's constantly kicking off her blankets, but she's mostly COVID. By two or three years later, she hasn't had a period in eight months.

She's having significant bothersome nighttime and daytime symptoms, including insomnia and hot flashes. She's had a frozen shoulder spinning physio for six months.

And the question is, what do you do with this?

The first thing is, do not do blood work. Now, you may need to rule out other issues if they have symptoms that are atypical. You know, you might want to check their iron levels or thyroid, something like that. But you do not need to check their hormones. And if they ask for it, you should decline.

Because the hormone levels will only confuse you. They will not help you. The hormone levels vary drastically. They did a study a few years ago. They convinced some crazy person to do blood work every day for a year. I don't know who they talked into that study, but they did. The graph of her estrogen, progesterone, FSH, and LH.

All 4 look like they were drawn by a toddler on meth. It is like this. Any given day, the levels could be through the roof, way above what we consider normal for physiologic levels. Any given day, they could be nearly zero. And you never knew. Because the symptoms...

are usually a few days behind the levels. So there's no correlation between the levels and the symptoms. There's no correlation. And so if you get a level comes back, you have an FSH that's normal and estrogen that's normal, that doesn't actually rule out menopause.

Now, if your FSH and LH are through the roof, you can at least prove their perimenopause.

But the chances of catching them on the right day, pretty slim, especially when their periods are crazy. So the first thing is don't send them for blood work. Just treat them based on their symptoms. And people say to me all the time, what if they're only perimenopausal? They're still having periods. I don't care.

Actually, perimenopause or menopause, the problem is the same. The hormone levels are low. The treatment is the same. Give them hormones. The only difference is dealing with their period. And so we're going to talk about that. If their periods are weird, I mean, for the most part, give them a Mirena, right? Just put an IUD in. It's so much easier.

You can try cyclical progesterone. It's not great, mostly because who only wants to sleep half the month? You don't love it. So deal with their periods. Whatever their period is doing, fix it, right? Make them have no period. I don't care exactly how far along in menopause they were. I don't care.

If it went through menopause in 48 or 52, I mean, their symptoms, doesn't matter what the period is doing, just fix it.

If they are having night sweats, insomnia, this is a progesterone.

Estrogen does not fix this. So if you have somebody who has no other symptoms, but they just come in with terrible insomnia that's new onset at 48, give them progesterone first. Often the progesterone alone will be enough for a while.

And then they start getting the daytime symptoms, they start getting the hot flashes, their mood goes to pot, they have all these other issues, and then you add estrogen. But this is actually really straightforward. Treat their period, treat their night sweats, treat their daytime hot flashing.

Easy, peasy, straightforward. How do you do that? Estrogen. You want to use transdermal most of the time. 90 to 95% of patients you see in menopause should be on transdermal estrogen. They can have a patch, they can have a gel. Well, they can have a patch if they can find a patch.

Yeah. And if it'll stay on. Yeah, they're terrible. But, and don't use the generic patches because they're the size of your head and they don't stick. So they need the brand name patches, which are hard to find right now. But patch or gel don't care. Let them pick whatever they prefer. Why? Less DBT risk, less stroke risk.

When you take estrogen orally, you have a risk of clotting because of something called first pass metabolism, which is something I really hope to forget after medical school, but it's still in here somewhere. The liver sees a big dose of estrogen, freaks out, starts pumping out clotting. It's not helpful. So we don't want to use oral estrogen most of the time. There are rare exceptions.

The rare exceptions are people with a past history of terrible endometriosis, breast density that is extremely high, or people who just refuse to use a transdermal product. But those are going to be pretty few and far between, and those are a reasonable set to someone who does menopause regularly and is more familiar with the other.

The ones you should be prescribing for is only 95% transdermal estrogen. For high density breast, why oral estrogen is? Not oral estrogen that you want, it's that you want as a doxy, and that only comes in a product that has oral estrogen. We'll talk about that.

For progesterone, it's just oral micronized progesterone. One pill a day, unless they're on really high estrogen doses, then go to two. You can cycle it. I don't like that. I want to sleep all month long. Like I said, use a Mirena for their periods if they're crazy. You can use a Mirena

and progesterone together. They are totally compatible with each other. One is systemic, one is local. They don't even see each other. They don't even shake hands. The synthetic progested gins do not help with sleep. So this is not the patient population you want to use slind.

or norlutate or those, you know, the synthetic, the combo patches, if their sleep is a mess, those things will not work. It is only oral micronized progesterone that works for sleep.

There are common products. So the one that I mentioned for people who have endometriosis or extremely high breast density, it's called Duoviv. That's the branding, right? It's Premarin plus bazodoxyfine. Bazodoxyfine is a selective estrogen receptor blocker. It is the most effective thing that we have to block the endometrium and the breast.

It works fantastic, but it only comes in one product, which is Duovine. That is changing. They're expecting a standalone bazodoxypine product, but it's not out yet.

The other oral combinations have a stroke risk in a DVT risk. Why would you do that?

I just don't see why that's been.

So I do occasionally use Duaviv for those specific cases, but otherwise it's transdermal estrogen and oral progesterone.

You can, by the way, use progesterone vaginally if people get a lot of GI upset. It absorbs very well in the vagina, use it the same dose, the same pills. You don't change the prescription, you just have them stick them in the other. You can't find them. The same pills. Okay. Yeah, and you just buy perometrium at the pharmacy.

Stick them in the other place. But you can do 100 or two, maybe two. Doesn't matter. It improves sleep if you do it less well. Yeah, less well. Yeah, that's what I thought. The sleep does not improve as much when you use it vaginally. But sometimes you're stuck. Patients are really bloated. It has bloaty. It's bloating. So this is your.

First horsewoman, it's easy. Here's your estrogen, here's your progesterone, here's your Maryam, here's your beer. Have a nice day.

It's super straightforward, and this has virtually 0 risk.

There are one hormone options, we have to mention them. They're not great. The old ones, Clonidine, Venlafaxine, other SNRIs and SSRIs, Gabapentin.

They only work well at super high doses that no one tolerates. The dose that works for menopause of gabapentin is 1200 TID.

Most people aren't vertical on 1200 TI. So they don't work very well just because nobody can tolerate the dose you need. And then the vaccine, sure, helps with the best invasive motor symptoms and then causes its own kind of sweats.

Super helpful, not very. The other one are the new ones. So we have two now, there's fezzalinitant.

And Elenzanotac, these things are hard to pronounce. These are neurokinin receptor antagonists. They affect the brain. They do not provide other menopause benefits. This is hot flash treatment only. They're very expensive. Fesalinitin cannot be used for your patients with fattened liver or other liver issues.

Elenzanitent has a bazillion medication interactions. So you have to be careful when you use these. They are quite expensive and they only hit the hot flashes. So I basically reserve these for my breast cancer patients, for the most part, because they're the ones where it's worth it. They can't get any other hot flash relief if these actually work.

So let's move on to the second horsewoman. So our first one's easy. Here's her estrogen, here's her progesterone. Problem solved. The second one is Beth. She's 55. She comes into your office for a pap smear, and you can't even do it because she's climbing up the table to get away from you. When you say,

Is it always like this? She admits she hasn't had sex in years because it hurts. And this is really common. You will see people who don't come in and tell you that they have pain with sex and have been suffering for a decade or more. This is really common. You also notice in her chart, she's been treated for a UTI annually for the past three years. And that's new. She'd never had UTI before.

And when you examine her, when you try to do her pap smear.

It looks like this.

So you can see that her skin is thin, it is pale, it looks dry. If you try to stretch her leaving out part, she's hair. Not a surprise that it hurts to have sex.

These are not a fun pap smear to do.

So this is genital urinary syndrome of menopause. We used to call it vulvovaginal atrophy, and that's fallen out of favor. Now it's GSM. GSM happens because of this. The picture on the left is what the skin looks like in a premenopausal woman. You have a layer of keratin,

like keratinized cells, you have multiple layers of colonar cells, and then you have this rugated basement membrane that has folds in it. Because the basement membrane is fibrous and cannot stretch. So the only reason that you can have sex, have a baby, do any of those things is because all of those folds can be pulled straight.

Like a piece of string.

Then you go through menopause. You get one scanty layer of keratinized skin cells, you get one or two layers of columnar cells, and that basement membrane is flat. It's lost all its folds. This

cannot stretch. It has no resilience. If you touch it too hard, you will tear it. The skin breaks open at the minimum provocation.

It often bleeds, but a lot for postmenopausal bleeding is actually this. It's not their uterus, it's their vagina.

This is painful, right? And you can see it. I mean, if you look at that, which of those would you want to own when you were trying to have sex? I'm going for the one on the left.

This is also quite straightforward, and you don't have to worry about cancer with this one. Breast cancer patients can have vaginal hormones. 100%, it is safe.

There is creams. There used to be two. Now there's only going to be one. The cream is estragine. The creams are a bit messy. You have to squirt them into an applicator and then squirt the applicator into the vagina. People don't love them. They're a bit annoying. There are suppositories. Vagifem and Imvexi are the two commonest. I like Imvexi better because Vagifem is a dry breast tablet.

It's powder that's all smooshed together. If their vagina's dry, the darn thing doesn't dissolve.

So I pull undissolved vagifem out of people's vaginas nearly every time I do pelvic exams on postmenopausal therapy.

So I like Invexy because it melts with heat. It doesn't require moisture to work.

And that is two or three times a week. Do not hesitate to go to three if they're still a little dry on two. They were tested for safety in people using double the dose daily. And they are safe. So this is not a risky proposition to use three times a week instead of two. The other option is DHEA. There's a relatively new product called the Intra Rosa.

This probably works a little bit better than estrogen, but it's not very popular. Two reasons. One, it's a daily product, it's a suppository you put in the vagina daily, and it is messy as heck.

So they like, they need to wear a liner or some clothes they don't care about to throw down a towel when they go to sleep because it ends up all over the sheets and it's oily, so it leaves a stain. There used to be the ring. Good luck finding that. I love the ring, but it's just not available. So these are our vaginal products. And you just ask the patient, do you want to cream?

A thing you put in twice a week, everything that works better when it's daily and messy. Take your pick, right? Most people pick the twice a week suppository.

There is also Ospina. I don't expect you to know a lot about this. It's an oral product. It is a SERM, selective estrogen receptor modulator. It specifically focuses on the vaginal estrogen receptors. So for people who cannot use a vaginal product for some reason, you're not going to see a lot of those. I do. I see the ones who've had most of their vagina removed through for cancer treatment.

or they've had severe trauma and they just cannot tolerate the thought of putting something in their vagina. I see a lot of those folks. You're not going to see a lot of them. So Askin isn't a thing

you're going to use a lot, but I put it in here just because you'll hear about it and now you know what it is.

There are non-hormonal options again. So there are moisturizers. Hyaluronic acid is 1. There are lubricants. If you're going to give them a lube, get them to use silicone because the others just dry up after a while. With silicone, you literally have to wash off to get rid of. So it works better. There are studies on laser and PRP. The studies are not out yet. We don't have all the data.

They don't look all that great. So probably this is not going to work well, but we don't have all the data yet. Now, if people want to do it, I'm like, go for it. It's thousands of dollars. Have fun.

But we don't have the data. Really, it's hormones. Put hormones in the vagina, save them from urinary infections, save them from pain with sex, save them from pain with their pap smears. Just put them on vaginal estrator. We should be offering this to everybody. They come through the door, you should just slap it on their forehead.

So, that's our second horsewoman, and again, fairly straightforward. Sure, is therapy applied or is it injected?

Yeah, it doesn't hurt as much as you think. The vagina isn't very sensitive to sharp touch. Like if you ever do deliveries, we can do repairs in the vagina without freezing. It's the perineum that hurts, right? Inside the vagina doesn't really feel very much. So you can actually do it pretty well without too much pain. Yeah.

Is your package insert saying that it shouldn't be unclosed? I don't know why. Honestly, the black box warnings on estrogen were designed by crazy people. And a lot of them have come off. I'm not sure if that one's going to disappear, but a lot of the black box warnings on estrogen have recently been removed.

They basically put the same warning on every estrogen product ever made. Birth control, menopause hormones, like vaginal hormones, everything all has the same black box. It's not a resource. Safe in breast cancer patients, safe in intact uterus on a post. Yeah, because it's local only. We're using.

Such small quantities of estrogen, like it, it couldn't affect the whole body if they try. It's just not any chance we'll see if I'm coming back or is it gone? It's gone, they're taking it off the market completely. There's a lot of environmental lashback because it is making them right and merrier. So there are these vast ranches of horses that walk around hobbled with...

diverse to collect. They're actually the happiest horses out there, really. But there's a public perception that it's bad. And so they've been losing market share for ages. On top of that, for some reason I'll never understand, they decided it should smell like lilacs.

Everyone smells like lilacs. It's disgusting.

So, I'm not a fan of Permacream anyway, just 'cause, so estragine is my go-to.

Now your third case, this is sexual symptoms. So this is my bread and butter. This is what I do all day long. But you're going to see some of it too. That's how I get my referrals. Darlene is age 60. She's been on vaginal estrogen since she went through menopause a year ago. Everything was fine as far as you knew. She comes in to get all her other meds refilled.

And she declines to have her vaginal estrogen refilled. She doesn't need it. She says, no, I got lots of that. I'm not using it. You say, why aren't you using it? Like you're still in menopause. Surely you need that. And she says, I can't be bothered to have sex. And if I'm not having sex, why do I need vaginal estrogen? She just

Can't get interested.

And when you ask, she says, no to my relationships. It's...

So the first key to this is fine is not a relationship status. And you need to inquire a little further, because it turns out being married for decades comes with its complications, and you are not going to want to have sex with someone you don't like very much. So checking on whether fine is really fine is a really important thing.

Libido is always multifactorial. Yes, menopause plays a role. So does 30 years of marriage. So does partners be annoying. So does work. So do kids. Everything has sexual side effects. So do all your SSRIs, all of your anticonvulsants, all your migraine preventatives, most of your blood pressure pills, all of your antihistamines and anti-inflammatory laboratories, they all come with low libido as a side effect.

So we really want to check. The other thing is, if you've got diabetes or thyroid disease and it's not well controlled and you are fatigued, sex is going to be the last thing on your mind, right? So we need to go looking for the other stuff, because if we just assume this is all menopause, we're going to miss a lot of important things.

But menopause does play a role. So if all else seems normal, you really inquire about the relationship and it doesn't seem like that's the problem, don't have any other medical problems or medications that you think could be playing a role, then you want to think about

options. There are, yeah, there were two options. One of them's off the market again. So Adigun or Flibanserin was a medication that was on the market. It was super expensive, which is pretty much why it's been taken off the market. They didn't have a lot of sales because it was too expensive. So it's not really available. I'm not going to talk about it much.

The other option is testosterone. This is off label. Obviously, this has never been approved. But it has actually very good evidence for safety and for efficacy in the peri or postmenopausal woman. Do not use testosterone in a healthy 25 year old. It won't work. and it has risks. But in a 40, 45, 50, 60, 80 year old, it has virtually 0 scary risks. I mean, think about it, those of us who do gender affirming care use 20 times the dose in trans men. They don't have heart attacks, they don't get liver problems.

They're fine. Hormones are very safe, even in high doses. They do have potential side effects. The side effect with testosterone is hirsutism. People get a little acne and they start growing a

little more enthusiastic of a beard. But if you follow them carefully, this will very likely not happen. I have not seen it. I've been doing testosterone in women for 10 years and I've never seen someone grow again.

because I follow them closely. The ones who come in with a beard are the ones that went to the US and got pellets implanted. All the bald, hairy women are very *****. Not what I'm looking for. But the side effects are cosmetic. It's true.

The side effects are cosmetic, right? This is not a health risk. It's a need laser hair removal risk.

I don't want to have to have laser hair removal. It's not exactly the scariest thing we do on a regular day. How many people in this room have given out prednisone this week?

100 times more risk than testosterone, but we do it regularly in family medicine. So this is no scarier than any of the other hormones you do. The biggest issue with it is that there's no convenient product available in Canada. We don't make a product for women. So you have to use products for men and make it work, which is really annoying. You have three options. You have Testim gel, you have Andro gel, or you can compound this stuff at a compounding pharmacy. I tend to use Testim because compounding is often expensive, and Andro gel comes with a pump that's really annoying or packets that are even more annoying.

Testing comes in recapable tubes.

So the tube lasts for 10 days. And I literally just, so you squeeze out like 3 little drips out of the tube because it's a runny gel. So you squeeze the thing slowly, 3 little drips. You put it on, I usually tell people inner thigh, and we'll talk about why that is. And then I get them to monitor how long it took them to go through a tube.

If they open a tube on the 1st of the month, they should finish the tube on the 10th. If they haven't finished and it's the 12th, their drips aren't big enough. If they finish and it's the 7th, their drips were too big. One or two tubes, they adjust, they know how much to use, problem solve. You can squeeze it into a syringe and dose it more directly as 0.5 grams.

But honestly, that's too much work. Just squeeze a little bit out of the thing and make it like figure out how big the drip is.

We put in certain concentration. It's all the same. 1%. We only have 1% testosterone in Canada. In the US, they have a 1.62. We don't have it.

Um...

You put it on the inner thigh. The reason is 2 things. The first is you often get a furry patch at the site of application. So if they put it on their arm or their stomach, they're going to end up with a little furry patch. Nobody wants that on their arm or their stomach. The inner thigh, you can just shave it off while you're there anyway. And we have fewer hair follicles on the inner thigh.

So we don't get as much of A furry patch if you put it there.

The other thing is testosterone can transfer through skin into the person. It can transfer through skin out of the person and to someone else or to pets. So you don't want to put it anywhere that

other people or pets come into contact with naked. So a lot of people talk about putting it on the back of your knee or the back of your calf.

But if you wear shorts, you're going to have a very angry dog. Or an inappropriately testosteronized toddler, which is bad. So we don't want to put it somewhere. Most of us don't carry our grandkids or our pets on our naked inner thighs.

Most. No, the guideline says you have to check the testosterone level first. I have asked at least 30 different experts and no one's been able to explain to me why. Because if you're in perimenopause or menopause or testosterone, it's nearly zero.

I've never had to come back at anything other than nearly zero. I've stopped to check.

If it's not nearly zero, I would just put supplements there on. So that was my next point. The only time it's not nearly zero is the people who are on ashwagandho, ***** goat weed, maca, and all of the other stuff. The reason those supplements work is because they are often contaminated with testosterone.

It's not the maca that's helping their sex life, it's the contaminating testosterone. So if they tell me they're on a bunch of supplements, I'll check them first. But otherwise, there really is no point. You do want to check them after you start them. So if you give someone a prescription for testosterone, you need to get a trough level

Six to 8 weeks later.

And it's a trough level, so you want them to go right before their next dose. If they go in the four to six hours after a dose, their level will come back through the roof and we will all have a heart attack. And you'll call me and call me dirty names. You have to get a trough. So if they usually use it in the morning, have them delay their dose that day and go to the lab first thing in the morning.

If they usually use it in the evening, have them go at the very end of the day before their next dose. Your aim is for their total testosterone to stay less than 30. We can tolerate two to three, which is technically higher than the cis female range, but it's not really because our cis female range is dreadful, very poorly figured out, but nonetheless. So you can tolerate up to three. Above 3, it's again, not dangerous, but their chances of growing a few beard hairs start to rise. So you want to keep it less than three to avoid their beard hair. Now, it doesn't always work. You give people tests on them, they don't always get better. It does take 6 to 12 months to work.

So this isn't a thing you give them for a week and then you quit when it doesn't give you the effects. You give it to them for a year and at the end of the year, if they don't think it helped, you stop.

And that's the thing with hormones. It's the same with perimenopause for estrogen. Someone comes in and says, I think my itchy ears are menopaused. Give them hormones and find out. Because the risk is minimal. And you can solve that question in no time. Just give them the hormones, try it, see what happens. The same is true for the libido. Give them testosterone

one time, give it six months to a year, and if it doesn't work, quit. It's very easy to do, no long-term issues.

So this is our third horse.

The 4th is the one we all drink. This is the woman. She's been seen at one of those predatory private hormone clinics. She's taking random compounded weird, who even knows, and she wants you to refill it because it costs her $300 every time she goes back to get a refill.

She's never had vasomotor symptoms. She's cycling irregularly. She wants the hormones for health benefits, TM.

Or anti-aging is the other one. Of course, this is all over social media, right? If you go on social media, you will find 100 influencers telling you that everyone should start hormones in their late 30s because everybody has all these long-term problems from not having enough hormones. And they don't know any better and they believe it. And we're partially responsible for that because for the last 20 years, we've been gaslighting women about their menopause.

And so they were driven to go to other places to learn about menopause because doctors weren't helping them. So part of this is our fault. But they start going to these other crazy places and doing these crazy regimens. And they're really quite unsafe. The compounded atypical products.

often have different types of estrogen. They don't just have estradiol. Some of them have estriol, some of them have estrone. We have never studied those other hormones to find out what dose of progesterone we need to use to protect their uterus. When they are on these compounded products, they may be at very high risk of endometrial cancer. And we don't know because those tests have never been done.

Bioidentical is not a thing. People walk in and ask me for that. It's a marketing term. It's not a medical term.

Although, by the marketing definition, transdermal estradiol, oral micronized progesterone, testosterone, and vaginal estrogen are all bioidentical. So if they say, I want bioidentical, I don't care what you say about marketing terms, I want bioidentical, I give them exactly the same thing I was going to do anyway.

Doesn't change a thing for me.

Progesterone, micronized progesterone, cannot be absorbed through the skin. The molecule is enormous and it does not absorb. It must be taken orally or vaginally, or actually rectally.

It can't be absorbed through the skin. So when people come on and they say, no, no, I'm on a progesterone cream, they are not protected. These people are watching cancer risk. Do not do this. Right?

The other thing you're going to see is people who are taking DHEA orally, pregnanine alone, oral estrone, topical trias, topical bias. We have no outcome data. We have no safety data. Don't do that. If they want it,

They can go pay the $300.

Right? The other thing they're going to ask you for lately, the big trend is put estrogen on your face. And the estrogen that they're using with that is estrone, which it turns out is the same estrogen that's found in the estrogen crepe. So I have a whole bunch of women who are coming covered in acne because they're using their vaginal estrogen on their face. That stuff is so thick and gloopy, they might as well be putting glue in their pores. It's a terrible idea to not use vaginal estrogen on someone's face. There is studies coming on how to do this safely, on what protection they made. It's not available yet.

So when people ask you now for estrogen on their face, say no, but tell them to ask you again in two years. Because we're going to have something by then, we just don't have it yet.

So, no estrit on the face.

Helping people switch from crazy compounded weirdness to established normal menopause regimens is harm reduction.

This is methadone for the opioid epidemic, right? You are saving lives from endometrial cancer. Just switch them onto something safe. The thing not to do is dismiss them. They want all these benefits, and some of them are real, right? We know estrogen improves bone density. We know it decreases colon cancer risk. We know what makes it big difference in quality of life. It may help with cancer risk, it may help with dementia, it may help with heart disease. It definitely helps with vaginal issues, right? Pelvic floor problems, UTIs, dyspareunia. What we don't know is does it do anything to the brain for brain fog?

Yeah, some people say yes, some people say no. It's never been study. Does it help with fatigue? Some people say yes, some people say yes. Skin health, probably it will help, but we don't have safety data yet. Hair health, no. Muscle and joint pain, sometimes. The problem is menopause happens to coexist with arthritis and fibromyalgia, right? Big, big spikes of both those things in the 50s. So is there joint pain, menopause or osteoarthritis? Is there muscle pain, fibromyalgia or menopause? Don't know. So sometimes it helps, sometimes it doesn't. Weight is a craps you. They might gain, they might lose, they might do both. Who the heck?

So, you can't predict what will happen.

But anti-aging isn't a thing. I don't care how much estrogen and testosterone you give somebody, they're not getting any younger.

So anti-aging shouldn't be what we consider. But switching them from their crazy anti-aging formulas onto regular menopause treatment is a good idea regardless.

So what do you do? You reduce harm, switch them when you can. Don't dismiss them. You might think their itching ears are insanity to assume they're part of menopause, but they're convinced and if you dismiss them, they never trust you again.

Treat their menopause and see if their itchy ears get better. If they don't, now you've got the evidence you need to say, hey, that wasn't it. Right? The risk is minimal and the benefit might be there. Some people's itchy ears do get better. We do lots of off-label medicine, right?

We use all sorts of things off-label. We use steroids, we use anti-inflammatories, we use birth control for various crazy things. We do all sorts of off-label medicine. This is no different. So yeah, it's off-label for itchy ears, but if it works, whatever, right? It's fine.

Just standardize it and get the patient to give you informed consent. So you need to tell them that they need to talk to you if they've had breast cancer. You need to make sure they're using things that aren't going to give them a stroke or a DVT. Just standardize it.

Still, the take away message, hormone replacement therapy is really very safe.

Don't be afraid to just prescribe it. If it turns out they don't like it, they can stop.

If they get cancer, they can stop.

And if they do like it and they don't have cancer, they can stay on it forever. This is one of those things I do not de-prescribe in my elderly book, because their quality of life is so much better on it.

Use standard regimens, transdermal estradiol, oral provenitrium, vaginal if you have to, vaginal or vaginal DHEA. Consider testosterone for libido problems. Now people will also come and ask you about testosterone for brain fog or for energy or for muscle building. You want to go work out and build some muscle.

We have no studies on that because how the heck do you study brain fog? Like, really having a definition for brain fog, so it's pretty hard to study. But anecdotally, it helps. So I'm not going up to people who complain of brain fog and saying you should really try testosterone. But if they come in and say, I saw

Marie Claire Haver on Instagram and she said testosterone solves brain fog and I want to try it.

What's the harm? Tried for six months, doesn't work? Stop.

Right.

The one thing I'll mention, and again, this isn't something I expect most of you guys will be doing regularly, but sometimes all the horsewomen coexist in one person. They've got the hot flashes, they've got the dry vagina, they've got the low libido, they've got all the anti-aging wishes that they want solved, and they don't want to take four or five different.

There is 1 standalone product you can use that is called Tibola.

It is a synthetic progestogen that mimics estrogen, testosterone, vaginal estrogen, and progesterone. It is a foreign one. There is likely a very small increase in DBT.

Probably. So this isn't the person I'd use and somebody who's had a past TBT or has a known clotting disorder. But otherwise it's quite, it works very well for some people. It hits all four things with one easy pellet name.

So it's something to think about if you ever have questions people pain post breast cancer? We don't know.

So, I don't.

These are resources if you're looking for further information. There are clinical practice guidelines. There's a pocket guide, right? And you guys will get all of these.

So there's lots of resources if you're looking for more.

I also have some resources for your patients. So if they're looking for actual science-y information, the Menopause Manifesto is a great book. There's A guidebook for patients on menopause.org. If they have sexual dysfunction, Come As You Are by Emilie Novais is the best book out there.

There are a couple of good podcasts. Hello, Menopause is 1. You Are Not Broken is the other one. I have to say that I've been interviewed on You Are Not Broken a few times. But they have lots of information about menopause for your patients.

That's the end of my presentation.