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Transcript

So I am Dr. Rebecca Dunsmoor-Su. I'm a board-certified OB-GYN and I practice in Seattle, Washington. I did all my training on the East Coast and then moved out here for – to be back on the West because I was born and raised on the West Coast.

I have several jobs as an OB-GYN. I do some in-patient hospital medicine with obstetrics and gynecology and then my other real focus is menopause medicine. So I have a private practice where I treat vaginal atrophy and sexual function and I work at the Director of Health for genneve, the website that's sponsoring this webinar and my goal in doing that part of my job is to really make sure that women have accurate, valid information as they go through this menopausal transition because I know that that has been an area of life that has been completely ignored for women for the most part, especially on the web. There's a lot of stuff focusing on fertility and some on sexuality, although most of that is written by men. But menopause tends to get left out.

So our goal at genneve was really to bring forward good, valid, accurate information for women from a variety of sources. It's not all Western medicine-based. There's some complementary therapies that – complementary providers and therapies that are mentioned as well. I'm happy to talk to those to the best of my ability. But my background is in Western medicine and so that's where I come from.

I think I will start by addressing questions that were sent in ahead. So Shannon, if you – wouldn't mind throwing into the chat some of the first questions that we had previously submitted because that helps me to make sure I'm addressing the right thing.

Premenstrual disorder, which PMDD. Some people think of it as the same as premenstrual syndrome but they're different. The difference really is in impact on life. So PMS is sort of a – premenstrual syndrome is a vague description of all the things that can happen to you surrounding your period, cramps, moodiness, things like that.

Premenstrual disorder is actually a diagnosis where you actually have genuine depression, anxiety or panic surrounding the menses. Typically we diagnose it when it happens in the luteal phase. So the luteal phase is the two weeks leading up your period, after ovulation before you bleed and it's a time when you're sort of high in progesterone.

Now if it were purely a hormone-driven thing, all women would have this and that's not what happens. In fact, most women don't have premenstrual disorder. So although the research is not perfect and there's a lot more for us to learn about it, what research seems to indicate is that PMDD or premenstrual disorder tends – is in some way an interaction between hormone levels and a woman's serotonin system in her brain. It doesn't happen in all women because every woman is different genetically and how her hormones interact with her brain.

Thank you Laura. So in terms of what do we do about premenstrual disorder, there are sort of a series of things that we can do. There are therapies that have been shown to help women and then there are therapies that may help and then there are therapies that are shown not to help. So I'm going to go over those three things.

In terms of therapies that have been shown to help women with PMDD, the biggest one is actually antidepressant medications, what we call SSRIs, so selective serotonin reuptake inhibitors. The one most people have heard of is Prozac. It has been studied and given a new name. In PMDD, they call it Sarafem and that's when it's given two weeks out of the month. So you take it in the luteal phase or from ovulation through the menses.

You can also take it fulltime and how you take that medication is dependent on your particular sentimentality and how it affects you and how regular your menses are and how predictable it is. So those are the things you do sort of individually with a physician.

That has probably got the best evidence for management of PMDD. If Prozac itself is not the right medicine, there are several medicines that can work in that sort of drug class and in the SNRIs, selective norepinephrine reuptake inhibitors, which is another type of antidepressant.

Some of that is just working with a patient one-on-one to figure out what medicine best works for her. There has been some data that shows that particular birth control pills can be helpful in managing PMDD and those are combined oral contraceptives that contain a particular progesterone which is drospirenone and so if you use those, it seems to work better than other birth control pills, although birth control pills in general can manage symptoms somewhat and people who are not as really affected.

One of the things we sometimes do in people for whom those two first-line agents don't work is actually suppress ovulation altogether. So we can actually almost put you into menopause basically with medications and for some women, that extreme of a treatment is necessary to get other things stabilized. So sometimes we use that in conjunction with antidepressants while getting women stabilized. But that's sort of a third line that we go to.

Therapies that in literature have been shown to sometimes be effective for some women are those birth control pills without the particular progesterone and also significant levels of exercise. But when you look at exercise for prevention of PMS or PMDD, we're talking about pretty significant, pretty heavy-duty exercise and daily.

The things that have not been shown to help and this is important because there are a lot of things out there in the web about – there's a lot of things in the web about vitamin supplements and vitamin B and different vitamins.

When studied, they're not shown to be any different. So when you compare vitamin supplementation to placebo, it does not show to help and there are certain vitamins you do have to be cautious of just overdosing. So certainly if you're considering doing like pretty significant dietary change in order to manage it, you definitely want to talk to your doctor about that.

Then the next question I remember seeing on the – on our pre-questions was – oh, yes. How do I know if I'm in perimenopause? So this is a great question and I was sent a whole bunch of hormone values and I personally do not check hormone values when someone asks me if they're in perimenopause. I'm going to pull up a screen that everyone can see because I want to go through why hormone testing is not helpful and why when you go to your OB-GYN and somebody told you to get all your hormones tested, they say, "No, that's not going to help us."

So I'm sharing my screen and hopefully you can all see that. Here we go. All right. So there's my screen and this is a lovely chart. This is from a wonderful study where actually one human volunteer agreed to have her hormone levels tested throughout the course of a year. So this one woman's hormone levels over the course of a year. I think they checked her weekly or even daily at some points in her cycle.

What's interesting about this and what I'm going to do is use my pointer, which I hope you can all see. These dotted lines that go up and down are when she had her periods. So this is a perimenopausal woman because you can see the periods are very spaced. This one took 99 days to come. Then she had a couple of approximately normal monthly menses and then two months and then monthly again and then 49 days. So that's very common in perimenopause and that's actually when I tell women when you're in perimenopause, it's when your menses become regular or more spaced.

Here are her hormone levels during that time. So the red line is FSH and FSH is follicular-stimulating hormone. It's actually a hormone that tells your ovary to make an egg and get ready to release it and you can see at this point in this cycle, it's really, really high. But this gray bar here is what's considered normal for pre-menopausal women.

At this point in the cycle, it's normal. So depending on which day she had come in and gotten a hormone test on, it could have shown that she was menopausal or normal.

LH is luteinizing hormone. That's the hormone that spikes in order to tell your ovary to release the egg and again it's following the FSH. It's all over the place but mostly within the normal range, even when this woman is very obviously perimenopausal.

Down here is estrogen and again an INH, which is another ovarian hormone. Again, all over the map during that time that they were looking at her hormones and I think the reason this is so important to see is that a one-day picture of your hormone levels doesn't tell us a whole lot.

We could get very normal hormone levels and you could be very perimenopausal at any given time. If we're getting FSHs that are higher, then most likely you're somewhere in the perimenopausal transition. But the hormones themselves on a day to day basis change and on a month to month basis change.

So they don't tell me a lot when I take a one-time snapshot. That's why I don't do that. I diagnose perimenopause by symptoms. So what we see is in the – there are sort of three stages of

a menopausal transition. There's what we call the late menstrual phase, the perimenopause and then the post-menopause.

The late menstrual stage is when you're sort of nearing the end of your fertility and the first thing that women tend to notice is their periods get slightly closer together. So if someone had always had a 30-day menses, they might go to 20 to 27 days, but still fairly regular.

Then you get into the perimenopause. That's when most women start to feel hot flashes, night sweats, the other symptoms of menopause. That's where the periods tend to get further apart. So first thing they might do is just lengthen your cycle slightly and then you might start skipping here and there. So you will have a 30-day cycle, then a 60-day cycle and then maybe a 50-day cycle. It just gets much more regular. During that time, bleeding can also get very irregular because the longer you build your lining – so if you go for 60 days, you've built twice the lining that you built in 30 days. You're going to have heavier, more cramping periods as well.

Post-menopause is when you have not had a menses for 12 months and that's purely the definition. There's nothing else I need to know. Twelve months without a menses is the menopause. It doesn't mean you will never see one again. I often see women get one at 14, 16 months and that is something you definitely want to discuss with your physician because they may want to evaluate that.

But in general, it's that 12 months. The symptoms of menopause, so the hot flashes, night sweats, vaginal dryness, tend to build during the perimenopause. So most women begin to experience hot flashes and night sweats during the perimenopause while they're still cycling and even before the perimenopause. Some get them in the late menstrual time.

Then in the full-on menopause is when people tend to start having vaginal symptoms. So the vaginal symptoms tend to be one to two years behind those hot flashes because when there's still some estrogen around, the vagina tends to keep itself pretty healthy. But once estrogen is dropped to near zero, that's when you start to get all the vaginal symptoms.

The last part of that question, "If I'm on estrogen and progesterone, will that stop my progress in menopause and prolong it?" So estrogen and progesterone will take away the symptoms that are going for menopause. Your body is still going through menopause but you will not feel it. So it can manage the symptoms of hot flashes, night sweats, the vaginal atrophy although we will talk a little bit more about vaginal symptoms later because I think they need to be treated slightly differently.

It will not prolong it. We use hormone to transition women through their menopause and we use hormone replacement therapy in menopause to manage symptoms. There are two different types of hormone that we give women. So when you're in the perimenopause, still cycling sometimes and having difficulty with that transition, then we use birth control pills. The reason being is they have a higher level of estrogen, so they will protect from unexpected pregnancy, which can, though rare, happen in the perimenopause. It's the right level to manage those ovarian hormones when the ovaries are still functioning.

Once you pass the menopause – what we often do is when women are in the perimenopausal state, we will give them birth control pills for a year or two at a time and then take them off for a few months to see where we are because that's the only way to know. There's no blood test we can do when you're on birth control pills, so tell us if you've gone through menopause.

So we take you off and we see if you start cycling or if not. If you're fully into menopause at that time, we typically transition, if you need it, for symptoms of hot flashes and night sweats into hormone therapy levels. Those are lower levels of estrogen and progesterone. The reason we make that transition is you don't need as much estrogen to manage hot flashes as you do to manage your menses.

By going to a lower level when we eventually take you off of that, that transition to menopause is more gentle. So you will probably get some hot flashes and night sweats after a few years on hormone replacement. But it typically is not as long as it would otherwise have been. So you've helped yourself get out of a few years maybe of menopause, the menopausal transition and those symptoms.

In terms of what perimenopause and those symptoms look like for most women, there are two big studies that have looked at what do women go through. One is out of Europe. It was a huge study and one is out of University of Pennsylvania.

Both of those studies show that the average time that women go through menopausal symptoms – hot flashes, night sweats, those types of things – is about 4.9 years, although some women it's as few as one or two years and there are outliers who go through it as long as 10 or 11 years. But on average, it's about three to five years.

I see a question that popped up. What if you had an ablation? How can you tell if you aren't bleeding? That's a really good question. So if you had an ablation, you aren't bleeding and you might not actually be able to tell. Then we really treat you symptomatically and if you're having perimenopausal symptoms, then probably you're going through the perimenopause.

It may not matter as much with the ablation. When we're treating perimenopause and menopause, we're treating symptoms. So really we should be listening to you and what your body is experiencing and what do you need from us. Are night sweats the biggest issue? Are hot flashes the biggest issue? We can treat those with hormone therapy and you may only need a hormone therapy level depending on your age.

Now if you've had an ablation, hopefully you've also had some sort of sterilization procedure because pregnancy after ablation is incredibly dangerous. So then the birth control pills may not be needed because you may not need the birth control aspect of it. So as a physician, if you've had an ablation but are having symptoms, I would probably start you on hormone replacement levels and then see how you do and if we need to dial up the estrogen, we can. That may mean that you're still on the perimenopause as opposed to the menopause.

Sorry guys. That was a lot of information. I hope it was helpful information. I'm going to have Shannon shoot me the next question in the list of things.

Oh, vaginal dryness. Now this is one of my favorite topics strangely enough but it's what I do day in and day out and week to week. So vaginal dryness is very interesting. So what vaginal dryness is, it is the vagina and the vulva, which is the external portion, the part that faces the world, are very sensitive to estrogen.

So when you have estrogen around, the vagina and the vulva are thick and plump and – you know what? I'm going to pull up another thing and I'm going to make this my screen now.

I'm going to do another screen share because I want to show you a picture. This is a histologic chart and this may not mean anything to most women. But to me, it means a huge amount. So the vagina, so this one here, the one that says follow a bit – two months. This is what the vagina is supposed to look like. The light pink stuff is the basement membrane. The darker portion is the actual vaginal mucosa, the tissues. There's all these lovely healthy cells down here and sloughing of vagina. But you see how thick and healthy that is.

On this side that says before is the vagina on menopause. So this tiny thing layer up here is what's supposed to look like this. So when the estrogen goes away, this layer stops developing into this nice, thick, rugaeted, which means bumpy, tissue and just becomes very thin and easily torn and broken.

In menopause, that tissue is very thin and very fragile. So one of the day to day symptoms that people feel is that dryness and itching or burning that just seems like it's very rough or people say – then they go to wipe the tissue paper. It's like they're wiping with shards of glass.

That's because the tissues have become so thin. There are several things that we can do to fix those tissues. Basically they fall into two categories. One is hormone and the other one is non-hormone repair-based. In this category, it's very small.

So hormone. Typically, if I'm treating just the vagina, I treat locally just vaginally. There are three types of medications we can give to the vagina that contain – well, actually, I'm going to take that back. There are five kinds of ways you can treat the vagina with hormone.

The direct hormone treatments are estrogen cream, estrogen tablet and estrogen ring. The tablet and the ring are very low dose and don't need progesterone, if you still have a uterus, which is the bonus. However, I find that they tend to be less likely to work well for women.

The estrogen cream does work well if you give it at the right dose. However, when you give it at that dose, it absorbs some of that estrogen systemically and it can impact your uterus if it's there. So we have to go to progesterone to make sure you don't develop endometrial cancer within the uterus.

If you don't have a uterus, you don't need the progesterone and you should never be taking progesterone if you don't have a uterus. The progesterone is the one hormone that has been associated with breast cancer risk in all the large studies.

So we give progesterone to prevent endometrial cancer because I can guarantee I can develop endometrial cancer in you if I give you enough estrogen with no progesterone. Progesterone does not directly cause breast cancer. It slightly increases the risk of breast cancer. So it's definitely much more worth the risk if you have a risk and you're taking estrogen.

So there are two other medications on the market that are hormonally-based that treat vaginal atrophy. One is called Osphena and one is called Intrarosa.

Osphena is what's called the selective estrogen receptor modulator, which means it's sort of an estrogen but not entirely. So it's some tissues that behave like an estrogen and others that don't.

So at the vagina, it behaves like an estrogen. The thought is that because it doesn't behave like an estrogen, every tissue should be safer. That being said, we don't know that for sure.

The studies are very short term. So it says in the short term, they looked there for three months. It didn't cause development of the endometrial lining. But we don't have 12, 24, 48 months results on this stuff. So I don't know for sure that it couldn't overtime develop there.

We do know that it behaved like an estrogen at the breast. So if you are at risk for breast cancer or had breast cancer, then it's not an option for you.

Intrarosa which is a suppository is DHEA, which I'm not going to go through it. It's hormone precursor, hormone – steroid precursor and basically when you put it in the vagina, it turns into estrogen and a little bit of testosterone.

So again, if you can't have estrogen, this is no safer for you. It is very expensive and you have to use it every single day. So I haven't had a whole lot of success with that one and the cost is so high, I typically don't recommend it.

So what are our non-hormone actions? Well, step one is usually to use vaginal moisturizers and lubricants. These are fine for some women. This is all some women need and I always say try it before we move on because if that's all you needed, then great. We've found a solution and it has no risk of hormone and that's great.

If that is not sufficient and for whatever reason hormone doesn't work for you or you don't want to take it or you can't take it, then the next step is some of these therapies that you've seen on the market. The one that I use is the MonaLisa Touch laser, which is fractionated carbon dioxide laser that actually treats the tissues and actually that picture I showed you earlier of the tissue before and after is before and after the MonaLisa Touch therapy. They actually did biopsies to ensure that it was changing the tissues back to where it's supposed to be.

There are other therapies on the market. There are other lasers. There's radio frequency ablation which is called ThermiVa. There are light therapies. None of these have published data that shows that they work. So they are marketed in the US by the company as vaginal rejuvenation, so making sex more pleasurable.

Some people then use them for vaginal atrophy. But there is no data that says that they work. So when I was looking into this to start doing this in my practice, I picked the one that has data. The MonaLisa Touch has what's called outcomes data where they studied many women and said they got better on these scales of vaginal symptoms. It also works really well for incontinence issues, for mild and moderate incontinence and those outcomes have been studied.

What we're waiting on is what's called comparative data, where they actually compare it to estrogen and those studies should be coming up this year. But when I talk to women about all this, I say that the reason I do this is because at least I know it works. It doesn't work for everybody, but at least I can point to studies that show me that it works. These other ones don't have any of that data and they cost just about the same amount.

None of this of course – so the laser therapy. None of these outside therapies are covered by insurance and that is key because they can be expensive, anywhere from $2000 to $3000 per year and the reason is lasers are very expensive. I wish they were covered by insurance. I think female sexual functions should be covered by insurance. Unfortunately it just isn't.

There was a question that came in while I was talking, talking about mood swings, not being able to sleep and sex being painful. Is that part of perimenopause? Absolutely. Yes, and that's all this estrogen. The estrogen swings but also the estrogen – the loss of estrogen. So sex being painful, is that – vaginal impacts of losing estrogen. When that tissue gets very thin, it makes sex very uncomfortable. So treating that at the source, so treating that at the vagina is very important.

Mood swings. Very much like PMDD, which we talked about earlier. Estrogen interacts with the hormones in the brain. So as estrogen goes down or gets very fluctuant, the hormones in the brain also impact that. So there are two types of depression we see in the perimenopause and menopause. One is unmasking of previous depression or worsening of previous depression and anxiety and other – we also see de novo or new depression and anxiety. These are absolutely very effectively treated with antidepressant medications and you should see a physician about it. It's not something you're going to power through. Treating it is very important because it can get just as severe as depression outside of menopause and it can even lead to suicidal thoughts and actions.

So I always tell women, "If you are feeling depressed, please come talk to us. These medications can be used." Even for a transitional time or a short time, sometimes when we come back off of them. But take it seriously. It is genuinely happening to you and it's – the chemicals in your brain are changing as – because your hormones are fluctuating.

So there's a question that just popped in on adrenal glands. So I'm going to be as gentle as I can with this. Adrenal fatigue is a catchphrase. It's promoted by people outside of medicine. Your adrenal glands work every single day. They product cortisol every single day. I think we probably overproduce cortisol in our society because of sort of constant engagement. Cortisol is the fight or flight hormone. However, our adrenal glands continue to produce it. They don't get fatigued. Do they get overloaded? Sure. But treating the adrenal gland is not what we need to do, we need to look at our lifestyle and meditation and calming ourselves. Treating the adrenals is

not what we need to do. If you are alive, your adrenal gland is working because you don't live without cortisol.

So, quite simply – it's much more complex than that and I will – not going to go fully into the whole hormone pack like because it's far too complex to explain in a webinar. However, I do not believe in treating the adrenal glands instead of treating the hormones. The hormones are the issue and we can manage the symptoms based on hormones. I do not think that adrenal fatigue is a real thing that needs to be treated. And I think a lot of the medications given for that are uncontrolled and not necessarily safe in the long term to take.

Are there people who need to have adrenal support and who actually have like a loss of adrenal function? Yes, but they get very, very sick. They get hospitalized sick and then ICU sick and those are people who need to take cortisol or true adrenal support. That's different from what's being diagnosed day to day out there.

Oh yes, someone hand sent in a question about stem cell therapy with plasma-rich – platelet-rich plasma injection into the vagina. Plasma – platelet-rich plasma is – so basically, what they do is they withdraw blood from your body, spin it down to the plasma, which is one subset of the blood product and then inject it into your tissues. This was developed as a way to treat sports injuries. So, a lot of big sports people get this done in their muscles when they're having sprains or strains, or tendonitis.

In that setting, it has been studied multiple times and shown to be totally ineffective, just so you know. Like they've studied the athletes, they studied all sorts of people every single study that has looked at platelet –rich plasma has shown that it is totally ineffective healing injury. They do it anyway because they think it might help in their things like that.

It has never ever, ever been studied in vaginal injection. And so, this is totally on – it's a marketing thing. It is very expensive because even a little tube that they have to put your blood in to centrifuge it down cost $800. So, when you're starting with the equipment being at least $800 you can imagine what the whole therapy is going to cost.

Basically, it's like giving a collagen injection for the vagina. Basically, the reason people may feel better immediately afterwards is you're getting stuff injected under the vaginal tissues to pump them up. So, it will fee thicker. I think this is mostly marketed not for vaginal atrophy but for sexual pleasure, so for rejuvenation of the vagina after childbirth, something that does not need to be done by the way. But that's mostly where it's being marketed and it will feel nice or feel thicker and fuller for a few weeks until your body eats up that stuff that was injected and then you'll feel the same as you did before.

Are there risks? There's a risk with everything. The platelet-rich plasma should be coming from your own body so there's not really a transfusion risk. However, you're getting an injection to the vaginal area which can lead to infection if not done sterilely. And it can lead to infection if the sites of the injection get infected. You're adding foreign tissue in under your mucosa which can be uneven and can also get infected so I think that would be the biggest risk that I would think.

So, post-op total hysterectomy and bilateral oophorectomy for 10 months for PMDD, which is a pretty significant treatment for PMDD, and still cycling monthly. I'm guessing that you're saying cycling monthly in terms of mood and depression because obviously, without a uterus you're not having a menses and without ovaries you're not releasing eggs. No one seems to know why. You're right. No one seems to know why.

We do notice that people do tend to still cycle their depression and mood disorder even though we've taken away the hormone and that's why sometimes as we're stabilizing people on these SSRIs, we also suppress the menses to see if that will help. So typically, if I got someone who's badly affected that we're talking about surgery then I would give them a menses suppressant medication for three to six months to see if actually completely turning off their ovaries is even going to help before I go on and take their ovaries out.

The night sweats are from having no ovaries. [Laughter] Because once you take your ovaries out you're going to have those night sweats and hot flashes, you basically put yourself into menopause. And the mental symptoms are most likely at this point, menopause, I mean they're menopause related. Your estrogen HRT should help with that, if it's not sufficient you may need it turned up. You might need a higher dose of estrogen HRT.

The only thing to keep in mind is that PMDD is not just an estrogen effect. It is also a serotonin reuptake inhibitor effect. So, just estrogen is not enough then you need to be speaking to someone about treating the problem at the level of the brain, treating with either an SSRI or SNRI.

And I don't know entirely what you've gone through before but – definitely, it sounds like your case is much more over here in the complex region and you need sort of someone who can pull it all together and see what tweaks can be made both in the hormones and in the depression medications to see where we can maybe make it work better for you. The other thing to keep in mind is the SSRIs when you've been on them for many years you can sort of – they can lose their effectiveness for people over time and it might be that you need to experiment with SNRIs at this point.

So when people talk about alternative therapies I think they're generally talking about herbal remedies. So, soy, black cohosh, evening primrose oil, raspberry leaf for some of the big ones, flaxseed, and another big one. You can take that. [Laughter] The only one that has ever had any published data that shows that it might help is black cohosh. In terms of published data, small studies show that someone may get better, large studies against placebo show that about the same number of women get better black cohosh's do with placebo. Does it help? Overall, no, is the answer. But if it helps you, there's no harm in taking it.

So, with things like black cohosh or evening primrose oil and things like that, I tell people, "You might as well try it. It's not going to hurt you." Black cohosh had some concern about liver issues, but over large studies, it hasn't shown to pan out. I think it's, overall safe to use. I just don't know if it'll help and certainly not going to hurt to try.

The other complementary therapy that some women find helpful is acupuncture. Again, large scale studies don't show a huge benefit over placebo, that being said again, not harmful. If it worked for you then great then you don't need estrogen therapy. There's certainly no risk in trying these things or trying them along with estrogen therapy if they help. In my experience, they're not particularly helpful. If you have very mild symptoms and just doing these things seem to help, then great. But people with significant symptoms typically end up coming back after they tried these things and going for hormone therapy.

The other question, it comes up a ton in these webinars and I think it's really important to address is the different types of hormones specifically pharmaceutical hormones versus what a lot people call bioidentical hormones. Bioidentical just means that the same that your body would make. So, for estrogen, that's estradiol and then progesterone instead of a progestin. Pharmaceutical companies make bioidentical hormones and in fact, many of the preparations we give are what we would consider bioidentical. Those are fine and safe to take.

When people are referring to bioidenticals, I know what they're talking about are hormones that are compounded outside of pharmaceutical companies in a compounding pharmacy, they're made into creams or suppositories or different pills. They're supposed to fluctuate over the course of the month. They may come with different levels. These, I do not consider safe and there are a couple of reasons why.

Although they're compounding from the same base hormones because they're getting those hormones from pharmaceutical company. When they start compounding them into creams and stuff, you get very uneven absorption. And you get very uneven distribution throughout the product that you're given. So when they've actually taken those things compounded by reliable pharmacist and tested them, they see anywhere from 10% to 425% of the amount of hormone that says it contains in any given dose. So, you never really what you're getting moment to moment and day to day.

Additionally, if you start trying to fluctuate your hormones over the month, you're trying to recreate a menstrual cycle and that's not – I mean I don't know about you ladies, but I don't think the end of bleeding is going to be a bad thing. The hormone changes that come with it is good, but I don't know many women who want to go back menses every month. Nor do you need to take the risk of progesterone if you don't have a uterus because I've just recently in the last six to eight months had women come in to my clinic being told that they're estrogen dominant and they need progesterone in menopause even they don't have uterus.

And I'm going to tell you out ladies, we're women, we're estrogen dominant. It's our – that's who we are. It's who we were at least before menopause. So, progesterone is to protect the uterus from cancer. It has no other benefit in the menopause. So, if you do not have a uterus, you should not be taking progesterone. That increases your risk of breast cancer and doesn't do you any good. In fact, progesterone has much more closer link with depression symptoms, anxiety symptoms, weight gain, acne. So, if you don't need it, don't take it. That was a lot of information at once.

Shannon, do we have another pre-question? Oh, pelvic floor physical therapy. Yay! I love pelvic floor physical therapy and I love to talk about it. So, I'm going to sort of back up a little bit before we get to the actual physical therapy. When I'm treating women for vaginal issues, I typically am treating them for painful intercourse or general day to day vaginal symptoms. The one thing I always address with them is that if you've been trying to have intercourse and it has been painful then your body's response to that is to take your pelvic floor and squeeze it tight and close it so nothing can get in there.

And it's a very – oh, bye Laura, thank you for being here. It's a very natural response to pain. You close the thing that is causing you pain and you don't want anything to penetrate it. Well, once we fix those tissues, either with estrogen or with a laser or with lubricants and moisturizers that pelvic floor still has the same response. So, oftentimes, it's very hard to unlearn that response especially if it has been a couple of years you've been fighting with this and trying to get it to get better.

So, usually when I'm seeing my patients with their laser or estrogen treatment. We start with treating the tissues. We either start with the laser or the estrogen. And then we get to the end of that therapy if they're still, I can feel the pelvic tightness on the exam, I can feel it while doing laser therapy, if I'm still seeing that tightening then I always recommend starting with working on those pelvic floor muscles. For some women, I have them do it themselves and for some women I have them go straight to physical therapy. And sometimes I have them start trying to work on it themselves and then move to physical therapy if that's not enough.

So, in terms of what you can do to your self, what I actually recommend to my patients is that they get a series of vaginal dilators. I don't give them the medical great ones because they're hard and fairly unpleasant. I actually have them go on a website and we'll put the link up after all these, to Babeland Toys, which I think is a wonderful women-run sex toy website. And they have series of vaginal dilators that are soft silicone and they come with a vibrating one. It's not so vibrating that it's a dildo per se. But what it does is when you're inserting that dilator into the vagina it just vibrates very gently so it relaxes that pelvic floor as you're using it. And then you can dial up the size over time.

For some women, they can do themselves then that's great. For some women who have had long-term issues, long-term pain with intercourse or just can't seem to move things forward on their own, I highly recommend pelvic physical therapy. The physical therapists who do this work are all women and they do it using combination of fingers and sometimes biofeedback and they teach you to manually relax the pelvic floor. The tensing and squeezing of the pelvic floor is an entirely not conscious phenomenon, you're not doing it on purpose but you can take control of it and learn to relax it yourself. And I think you know that is a key portion of chronic pelvic pain, pain with intercourse, all those things. I use pelvic physical therapy all the time I think they are phenomenal practitioners and they do phenomenal work.

All right. In terms of timing because there was a question about timing of PT, I mean it really depends on the patient. It really depends on where they are on that tension cycle, how long-term their pain is. If I see someone and I can't even get the vaginal probe in for the laser therapy, they we go pelvic PT upfront. If I think it maybe something that they can solve on their own, we

might try the dilators first. And you know it just really depends patient to patient when I time that.

Oh, sleep. Yes. Well, menopause is like sleep for two reasons. One is the hot flushes that happen at night, the night sweats are very disruptive to sleep. Because the huge sweat you go from extremely hot and sweating to extremely cold and shivering and that takes an hour out of your night. So, that alone has a huge impact on sleep. The second is, again, it's brain chemistry. So, as your hormones are changing, the chemicals in your brain are also changing. And sleep patterns change. Using estrogen can help with that sometimes but the other thing I tell women is that I think as we age and as we head into menopause, we just need to be much more hyperconscious of sleep hygiene and how we put ourselves to sleep and how we create a sleep environment.

And what I mean by sleep hygiene is some people find melatonin very helpful in the evening, avoiding caffeine after noon, avoiding things that will make you get up and pee in the middle of the night like water after 5:00PM, no screens in the evening because screens wake you up, that light into your eyes wakes you up. So, the best you can do and you know, having like a meditation or mindfulness routine that helps you get to sleep, music, scents can be very helpful for some people. It's really about treating sleep as something really important and making sure that we used the best hygiene that we can. And if that alone is not enough then maybe talking about hormone therapy to help with it.

Basically, when you look at vitamin supplements and I'm not your best resource for all the vitamins because I'm not a nutritionist but the ones I typically worry about are the B vitamins. You don't want to go too overboard with them. They can cause neurologic damage when taken in too high of dosage. And they're often touted as the thing people need for sleep or for different symptomatology.

Vitamin D, it's very hard to overdose on because it's well-distributed in your fat and you know, it's – you'd have to take an awful lot to get too high. Many vitamins are water-soluble so you're going to be fine with them. Vitamin C and things like that are all water soluble so whatever you take over the recommended dosage you're just going to pee out.

But for me, when I'm talking to patients, it's really the B vitamins that I say you need to – yes, you need them in your diet and you need to have adequate levels but you should not be overdosing on them on high doses, those can be dangerous.

In terms of supplements, I'll give you my general warning because I can't go through every supplement there is out there in the market. Just because something is natural or an herb does not mean it's necessarily safe. As I like to say, cyanide is natural and organic so is arsenic. They exist in nature. They're not safe. So, if someone tells you because it's natural it's safe then you need to question them because they should know their herbs and supplements well enough to know what are the risk from anything. All the medications we use, at least most of the medications we use, have their root in herbal medications. So, if medications have risks so do herbs. It just depends on who's preparing them and who's telling you how to use them. And so, you know, if you're being given something and told it's safe because it's natural then someone doesn't fully understand what they're giving you.

Oh, magnesium and sleep. Yeah. Some people do find that magnesium is very helpful. I find magnesium most helpful in people who tend to have sort of a restless leg type of awakening from sleep, so it tends to be a muscle relaxant.

Which is best? I don't think we know that because most supplements are really unstudied and untested. The only thing I'll say is you can be careful because one of magnesium preparations mag citrate is not for getting magnesium it's for actually cleaning out your bowels prior to colonoscopy so just don't use that one because you'll have unpleasant side effects so to speak.

But I think – I usually tell my patients if they're going to use magnesium supplement, they might as well use a calcium magnesium supplement because then you're doing your best possible thing for your muscles in muscle relaxation but also helping your bones. And I also tell my patients – magnesium glycinate is fine too. I don't think we know which is better. We just – we've never tested it.

OK. MonaLisa Touch. So this is something I know a lot about. The treatment – so, MonaLisa Touch treatment is done in three sessions at six week intervals for the first year. So you do three sessions upfront and that takes by several – of course 12 weeks total and then that last a year, I need to do a yearly touch up.

In my practice, what I'm finding is women with just vaginal atrophy generally the three sessions are sufficient, sometimes they need a fourth on that first year. But when they pay me for MonaLisa Touch, they pay me for the first full year so we can do as many treatments as their necessary. And then yearly touch-ups is pretty much on seeing a need for. So it's once a year, not three times again. And that's much – you generally much less expensive than that first year.

The one caveat I'll give you is that when it's like in sclerosis which is very specific autoimmune disorder of the vulva need much more frequent MonaLisa Touch therapy and that's a totally different protocol. So, I treat them very differently than I do people who are doing it for vaginal atrophy or for incontinence.

In terms of the treatment itself, the biggest key in finding a MonaLisa Touch practitioner is that they have extensive experience so we've been doing it for free years because you'll learn a lot in the first couple of years that you're doing it. And that they treat the external vulva because that's where the bulk of your nerve endings are and where the bulk of the pain with intercourse is in fact, the biggest symptom.

And so, I know there are a lot of urologists out in the world doing MonaLisa Touch and that's great because it does work really well for mild incontinence but I think they're not the best practitioner to be treating you for vaginal atrophy or sex with intercourse, err pain with intercourse, because that's not what they focus on. So, I would definitely see a gynecologist and someone who has more extensive experience. And – but as I said, generally, you just need to be seen yearly for your touch-up treatments and it tends to be much less expensive at the yearly.

When I'm counseling patients, so, in my practice, I charge $2,000 for the first year and then I charge $300 per touch-up in the first two years after we've done it and $500 per touch-up after that. And what I tell people is that if you really think about how much you'd be spending on hormone over that time, it ends up being lash even though it's not covered by insurance.

And where is my practice? It's in Seattle. [Laughter] So, you can certainly look me up, it's called RENUvaGYN. But you know, I – people travel around the Pacific Northwest to get to me. But in general, MonaLisa Touch is being done all over the country so you can – if you're not in the Seattle area, you can find someone who's near you who will be good at it.

How long can you stay in hormone replacement? That's a good question. It's not entirely clear. We typically leave women on hormone replacement therapy for five – for five years or so, sometimes as long as 10. Oh, thanks, Shannon. But it really depends on symptomatology and what we're treating. So, when I'm treating women with hormone replacement, it's generally for the hot flushes, night sweats type symptoms.

And then I tend to used it for about five years and then have them go off of it and see where they are. You can also go off every two or three years if that makes more sense. We typically are trying to give as little hormone replacement as necessary. But generally, women transitioning from menopause need about five years of HRT.

Shannon just put up my website so if anyone wants to look, even though you're not in the Seattle area, you're more than welcome to use my website. It's got a ton of practitioner information and patient information so you can look at sort of some of the information I have given you about MonaLisa Touch and just learning about it if nothing else.

All right. Finding a good gynecologist. Yeah, you know it can be a struggle. And it's a frustration for us as well. We want to all be good gynecologist and treat menopause but menopause therapy is not what you spend the most time learning in residency. You spend the most time on obstetrics and gynecology surgery. And the reason being that's going to be the bulk of your practice during the early part of your practice. Most of us learn a lot about menopause as we age because we age with our patients. And so, we start running into it more and more and learn more and more.

The best way to find someone who is very menopause focused is to go to the North American Menopause Society website. They have a list of practitioners who are NAMS certified that means they have taken a test and shown that they have – oops, there you go. Menopause.org – they have a special interest in menopause. There are many gynecologist who are fabulous with menopause who aren't on that website, just be aware, I'm not on that website because I haven't paid them $200 to take their test. But it is a start point.

In terms of gynecology, when you're looking for someone, sometimes it's just a matter of getting to know – finding the person who jives with your style. Every gynecologist is different just like every woman is different and you need to find someone who is either as blunt as you are or as touchy feely as you are. The one thing we struggle with is time and office visits and the reason being is that women's health is paid exceedingly poor. And all aspects of women's health are

paid badly. And so, as practitioners, in order to run an office and be able to pay the staff they need to run the office, and you see a lot of the patients over the course of the day.

And so, if your gynecologist seems like they're rushing, they are. They're definitely rushing and it's – have sympathy for them, they don't want to be rushing anymore than you do. We have a ton of charting to do, we have a ton of call backs to do, and we have to see 30 or 40 patients in a day. And that's all to keep offices up and running. And that's miserable and it's wrong but it is what it is just because of the payment struggle and the struggle to pay our staff.

But like I said, for menopause, start with the NAMS website, the Menopause.org. Find a menopause practitioner. If you're in a larger practice and the person you're seeing is not perfect for you, see the other people. You're not going to insult people. We don't typically get insulted if people don't jive with us. I understand what my strength and weaknesses are and sometimes I'm the right provider for a patient and sometimes I'm just not. You know, I tend to be pretty straightforward and pretty blunt. And I'm not going to beat around the bush and for some women that's not the right style and they don't see me again. And that's fine. It doesn't hurt my feelings.

All right. Thrilled to spend time with you all today. I hope I have answered some questions. You know, finding the right provider is always a challenge, I wish you all the best. And we'll have – I think we have a lot of good information on the genneve website, there's a lot of good information in the RENUvaGYN website. And just bring – the best piece of advice I can give you is bring up issues with sex and menopause and all these things. And if your provider is not comfortable with it, find a different provider. You're not going to hurt their feelings. But these are important things that are life altering, things that are important in your life and you deserve to talk about them with your provider and have them addressed.