Algorithm for Women

Menopausal

- Low Everything
- Low Something

Supplement to top 1/3 of luteal recommendations Middle of the road for menopausal is:

- Except for estrone, we want that as low as possible
- Progesterone 100 mg-200 mg
- Blest 2.5 mg or Estriol 5 mg-10 mg if patient has a history or family history of cancer
- Testosterone 2.5 mg
- DHEA 5 mg

These are "middle of the road", therefore, start here and adjust as needed*

Non-Menopausal or Perimenopausal

- Estriol 5 mg-10 mg on days 5-28 of menstrual cycle ***AND***
- Progesterone 100 mg-200 mg days 5-28 of menstrual cycle ***OR***
- Progesterone 50 mg days 5-13 of menstrual cycle and 100 mg days 14-28 of menstrual cycle

Symptoms that should correlate with test results:

- Irritability—low progesterone usually a week to 10 days prior to the start of the period, they will say,"I don't feel like myself."
- Fatigue—low testosterone, also check thyroid levels, i.e., TSH, T3 and T4.

REMEMBER--thyroid levels may be deceiving; they were originated by taking a sample of people that had thyroid problems, therefore, inherently; lab results will be scheduled to the lower range.

**Ask patient to take basal metabolic temperature every morning for ten (10) days. Normal axillary and oral temperatures are 97.6 and 98.6 degrees Fahrenheit, respectively.

****Regulate*** by using **Nature Thyroid** 16.25 mg daily and increase by 16.25 mg every 11 days until basal morning temperature is between 98 and 98.6 degrees Fahrenheit, accordingly, i.e., axillary and oral, respectively or the TSH is between 1.0 and 1.5.

**Fatigue can also be adrenals, therefore, check cortisol and DHEA *levels—Regulate* by targeting the top 1/3 of the normal range (laboratory dependent).

- Depression—most often due to low progesterone, also consider low thyroid levels. **REMEMBER**: Progesterone binds to the GABA receptors of the brain, exactly like Diazepam (Valium). Must have vitamin D above 50 for this to happen.
- Headaches—most often due to anabolic dominance. If the headache is behind the right eye, this indicates left brain testosterone dominance—check for acne and/or anger. If the headache is behind the left eye, this indicates right brain estrogen dominance—check for irrational and/or irritability.

NOTE: It is important to note that dominance can happen even with low levels, in other words, even if a patient has low estrogen, but progesterone is even lower, there can be estrogen dominance, therefore, check estrogen:progesterone ratio.

- Night sweats, hot flashes are surges of FSH and LH—happen for three reasons:
    - Not enough estrogen
    - Too much progesterone
    - Change of estrogen either up or down too quickly
- Forgetfulness—low progesterone. When the body has maintained a low level of progesterone for a long period of time, it compensates by converting pregnenolone to progesterone; when this happens short term memory suffers many patients can replace pregnenolone, however, it is better to replace progesterone and pregnenolone together.

****NOTE:** By replacing progesterone alone you will know you are at the correct dose when the short term memory comes back due to NO conversion of pregnenolone.**

- Weight gain—estrogen dominance causes sugar cravings; responsible for 5-12 pounds of excess water. Check thyroid for hypothyroidism and adrenals!!!
- Insomnia—low progesterone use half hour before bed time (HS) to give calming effect. The target should be 7-8 hours of sleep with NO residual sleepiness (drowsiness). **REMEMBER:** As one increases the progesterone, increase the Blest, somewhat, but NOT at 1:1 ratio, because of the ratio staying the same.
- Joint pain—look for DHEA deficiency, i.e., SLE (Lupus), fibromyalgia, MS, and other connective tissue problems.
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****NOTE**: 80% of the patients with these disease states have low DHEA, therefore, when the DHEA is replaced, the symptoms tend to disappear. **

- Palpitations—caused by elevated thyroid activity (hyperthyroidism), increasing thyroid hormone too quickly, estrogen dominance or low progesterone.
- Crying spells—low progesterone. **REMEMBER**: As a woman a goes further into perimenopause and/or menopause, the fat cells will compensate by making estrogen, however, there's no compensatory system for progesterone, hence the patient ends up with low estrogen as well as estrogen dominance.

**NOTE: Fat cells do not make estrogen from "thin air" they convert testosterone to estrogen. *

- Loss of bladder control—loss of testosterone over time leads to lose of sphincter and muscle integrity.
- Vaginal dryness—low estrogen and low testosterone.
- Low sexual desire—low testosterone.
- Testosterone 2% cream: place rice size amount applied to clitoris and nipples one hour prior to coitus.
- L-Arginine 1,000 mg-1,500 mg orally: one hour prior to coitus to increase chance of orgasm.
- Decreased sexual activity—low testosterone and low estrogen leads to increased vaginal atrophy causing painful intercourse.
- Estriol 1 mg via vagina: at hour of sleep for 14 days then 2-3 times per week. This will rectify the problem until the topical hormone levels are normalized.
- Loss and/or thinning of hair—elevated DHT compensated by elevated estrogen.

**NOTE: In Perimenopausal women, we must first align the thyroid and adrenals. When the thyroid is not up to par, the body will believe it is starving so that hormone binding globulin will increase in the blood and attach to steroid hormone keeping them from binding to the receptor. The blood test may show normal hormones are there; however, they may be bound and inactive.

TROUBLE SHOOTING

While a patient is on hormone treatment, as a rule of thumb, if the hormone isn't achieving the needed result, double the initial dose; if this "new" dose is too much, split the difference of the increase, eg., initial progesterone dose is 100 mg and we've established it's too low, increase the dose to 200 mg (double), if we then determine it is too high a dose, then split the difference (100/2 = 50) and the new dose is 150 mg. If this new dose is not enough, split the difference again (50/2 = 25) and the newer dose would be 175 mg.

**NOTE: This is done ONLY if the patient considers the problem a "10' on a scale of 0-10, otherwise, leave the patient on the same dose for 60-90 days; this is so because it takes that long for the receptor sites and new hormonal signature to develop.

- We must listen to the patients, therefore, increasing and decreasing dosages accordingly. Most patients will have overly excitable receptor sites and over time will calm down, needing lower dosages initially and more over time.
- Thyroid function devastates hormone balance.
- In the event of high stress, i.e., death in the family, it may be necessary to double the dose for 1-2 months.
- 11% of thyroid patients have iodine deficiency and not "thyroid problems".
- If a patient has normal T4 and low T3, think of adding Bromine supplements to the regimen.

- BE ALERT: When treating a couple and the male is on testosterone supplementation and the female partner has elevated testosterone levels, think cross contamination.
- Change one hormone at a time to remove "10's" from the symptom chart (0-10 rating).

Saw Palmetto--stops testosterone from becoming DHT
Chrysin—helps test from becoming DHT
Progesterone—helps test from becoming DHT
Zn—prevents test from becoming estrogen
DIM—allows estrogen to go down "safe" pathway, i.e., estradiol to Estriol

Generalities

Body Type	Male	Body Type	Female
Ectomorph	Norm	Ectomorph	Low Estrogen, Progesterone and Testosterone
Mesomorph	Norm to Low Testosterone	Mesomorph/"Hour Glass" Shaped	Normal Pattern
Endomorph	Low Testosterone/High Cortisol	Endomorph	High Cortisol
		"Pear" Shaped	High Estrone and Low Progesterone
		"Large Breasted" w/ Small Hips	High Estradiol and Low Progesterone