Change Of Life?  
How Napro TECHNOLOGY Can Ease The Transition To Menopause

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How did I get into this?

- CrMS and NaPro TECHNOLOGY – Restorative Reproductive Medicine
  - Evaluation and assessment of underlying physiology/pathology
  - Bioidentical hormones to restore function
  - Do not suppress or destroy normal function
  - Do no harm
  - Respect for fertility and the human person
  - Support couples and marriage
The Continuum of a Woman’s Reproductive Life
Stages of Reproductive Aging*

- **Reproductive years**: generally regular, fertile cycles from menarche to about 40

- **Menopausal Transition**:  
  - Early: Premenopause - beginning at age 40 - CrMS reproductive category corresponds well to this - variable duration  
  - Late: Perimenopause - “skipping” or interval of amenorrhea of more than 60 days begins to happen - duration 1-3 years

- **Post Menopause**:  
  - 12 months amenorrhea after the Final Menstrual Period (FMP)  
    - Early Menopause - Vasomotor symptoms most likely  
    - Late Menopause - urogenital atrophy more likely

*Harlow SD et al. Executive Summary of the Stages of Reproductive Aging Workshop +10: J Clin Endocrinol Metab 2012
### Are We There Yet?

**What happens?**

<table>
<thead>
<tr>
<th>Stages</th>
<th>-5</th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminology</td>
<td>Reproductive</td>
<td>Menopausal/Transition</td>
<td>Postmenopause</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>Peak</td>
<td>Late</td>
<td>Early</td>
<td>Late*</td>
<td>Early*</td>
<td>Late</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of stage</td>
<td>Variable</td>
<td>Variable</td>
<td>↓ 1 yr</td>
<td>4 yr</td>
<td>Until demise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual cycles</td>
<td>Variable to regular</td>
<td>Regular</td>
<td>Variable cycle length (≥7 days different from normal)</td>
<td>&gt;2 skipped cycles and an interval of amenorrhea (≥60 days)</td>
<td>Amenorrhea 12 mo</td>
<td></td>
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</tr>
<tr>
<td>Endocrine</td>
<td>Normal FSH</td>
<td>↑ FSH</td>
<td>↑ FSH</td>
<td>↑ FSH</td>
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</tbody>
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**When does it happen?**

**At what Age do Menopause symptoms first appear?**

![Graph showing the percentage of women experiencing menopause symptoms by age range](image_url)
What do women experience?

- Increasing PMS
- Irregular/abnormal bleeding
- Sleep Disturbance
- Intermittent hot flushes/night sweats
- Changes in libido
- Vaginal dryness
- Estrogen dominance symptoms
- Fatigue
- Worry about fertility
Physiology

- Decreasing sensitivity of the ovary to LH/FSH
- Increasing abnormalities of ovulation:
  - Follicular cysts
  - LUF
  - Immature follicles
- Luteal Phase Deficiencies
  - Progesterone especially
- Estrogen Dominance
  - Endometrial hyperplasia
  - Increase in SHBG
Signs on CrMS Chart

- Changes in Menstrual flow (heavier or lighter)
- TEBB or premenstrual spotting that is new
- Mid-cycle bleeding
- Reduction in Mucus Cycle Score or Dry Cycles
- Early Ovulation
- Late or delayed Ovulation
- “Skipped cycles” – very long cycle lengths with or without Peak Day
What is a woman to do?

It’s not all in your head! There is real help!
FertilityCare to the Rescue!

CrMS practitioners may hear complaints from their clients about the development of these symptoms.

Physicians may have patients present with these symptoms.

Standard medical solutions usually include:
- Oral contraceptives
- Antidepressants
- Nothing!!!!

Yikes!
We can do better than that!!!
NaPro TECHNOLOGY Evaluation

- CrMS charting- full or modified if in early premenopause. Continue if already charting.
- Targeted hormone profile
- Ultrasound
- Thyroid evaluation
- Adrenal fatigue- DHEA/Cortisol
- Check for iron deficiency in menorrhagia
General Health Evaluation

- PAP/PE – sometimes has been neglected
- Mammography
- DEXA for Bone Density
  - Low Vitamin D
  - Low DHEA/Testosterone
  - Lifestyle interventions
- Assessment of Cardiovascular Risk
  - Changes in risk- Lipids, BP, DM
Diet and Stress Management

Don’t forget the Basics!
Supplements

Basics:
- Multivitamin
- Calcium
- Vitamin D3
- Fish Oil/Omega FA
- B-complex

Next Level:
- Phytoestrogens
- DIM
- Anti Oxidants
- Melatonin
- And Many More
Menopausal Transition

- Cooperative Progesterone Support (CPS)- Backbone of treatment
  - P+3-P+12 (if peak day identifiable)

  The following would not be done in women attempting to improve fertility- usually the women using this are in their late 40’s early 50’s and the focus has shifted off fertility to conceive:

  - Cycle Day 21-30 (fallback if no peak day)
  - 10 days every 60-90 days (if not getting withdrawal bleed with more frequent challenge)
Risks and Benefits of CPS

- **Benefits:**
  - Reduce Dysfunctional Uterine Bleeding
  - Counteract Estrogen Dominance
  - Ease PMS while still cycling
  - Give early support to a pregnancy if conception occurs
  - Improve sleep with oral progesterone
  - May counteract excessive estrogen effect on breast*

- **Risks:**
  - None other than possibly obscure signs of fertility if started before ovulation.
  - Lightheadedness or fatigue if dose is excessive; give at bedtime and monitor levels if patient is symptomatic.

Late Perimenopause through Menopause
“No Man’s Land” - the unpredictable part
Not Cooperative, but Reasonable

- Intermittent Progesterone Challenge
  - 200mg or 100mg oral or vaginal micronized progesterone
    - Prometrium (brand or generic)
    - Compounded preparations
  - Avoid Dysfunctional Uterine Bleeding
  - Not uncommon to not get a withdrawal bleed - OK

- Low dose Progesterone transdermal crème
  - 20-100mg daily
    - OTC (20mg) or RX compounded
  - Stop if you get a menses and restart in 2 weeks
  - Often helps moderate hot flashes when estrogens are still sufficient
Common Concerns in this Phase

Need for Support

Marital Tension
12 months! Whahoo! Menopause!!!
An Ancient Blessing

May you see your children’s children, peace be upon Israel!
Psalms 128:6
What about BHRT - Bioidentical Hormone Replacement Therapy?
Not everyone needs hormone replacement—Who Might?

- **Severe Vasomotor symptoms**
  - Goal to slowly wean off in 3-5 years
- **Osteoporosis or moderate to severe osteopenia**
  - May need low dose long term treatment
- **Atrophic Vaginitis/recurrent UTI**
  - May need low dose long term treatment
Risks and Benefits of BHRT*

- **Benefits:**
  - Reduction in disruptive hot flashes
  - Improve sleep quality
  - Improve or stabilize bone density
  - Restore vaginal mucosa
  - Reduce recurrent UTI

• **Risks:**
  - Hx of Fibroids: may feed growth
  - Hx of Endometriosis: may reactive lesions
  - Hx of Fibrocystic Breasts: may continue this condition
  - Breast Cancer risk: not clear*
  - Hx of DVT: reduced with transdermal and lower dose, but not eliminated, discontinue before and after surgery until ambulatory.
  - May be contraindicated in acute liver disease, CAD, estrogen sensitive cancers.

Treatment Strategies:

* Vasomotor Symptoms
* Bone Density Loss
* Atrophic Vaginitis
Vasomotor Symptoms

- Low dose transdermal estradiol and low dose transdermal (or oral) progesterone.
  - For severe symptoms- start with standard dose- 0.05mg/day estradiol balanced with 100mg progesterone.
  - Takes 4-6 weeks to get full effect
  - When symptoms under control, check labs about 3-6 months later after good control to make sure levels are not too high
    - Estradiol serum levels over 50 likely to cause bleeding eventually in woman with uterus
    - Progesterone serum levels over 3.0 more likely to cause fatigue, may be from retention from slower metabolism and clearance. Take a 3-5 day break each month.
Bone Density Loss

- Might consider low dose estradiol/progesterone support long term
  - Serum estradiol keep under 20
  - Serum progesterone keep under 2.0
- Check DHEA/Testosterone- esp. with oophorectomy or adrenal fatigue
  - DHEA 5mg to 10mg orally may bring up both DHEA and Testosterone
  - Rarely have to use RX low dose testosterone directly
- Check Vitamin D
- Resistance and weight bearing exercise
- Moderate Calcium/Mg
- Avoid smoking
Atrophic Vaginitis

- Will be addressed with doses sufficient for Vasomotor symptoms
- Low dose topical estradiol with or without progesterone
  - Vagifem 10mcgm tablets twice weekly
  - Estradiol Rings- -.5, 1mg, 2mg every 3 months
  - Estradiol crème- 2-3 x week
  - Estriol vaginal crème for those at high risk with estradiol (less strong than estradiol)
  - Personally, I always use some progesterone with any estrogen product.
Progesterone vs. Progestin
Go for the Real Deal!

The difference in chemical structure is obvious...

Progesterone
(Natural, human)

Medroxyprogesterone acetate
(Synthetic)
Why not Premarin or Prempro?

• Why use an artimone when a bioidentical hormone is available?
  o Basic tenet of NaPro TECHNOLOGY*

• WHI Study only looked at Premarin and and Prempro- All findings not applicable to BHRT, but more study is needed**

*Hilgers TW- The Medical and Surgical Practice of NaPro TECHNOLOGY. Ch 26
BHRT not “FDA Approved”

- Media attention- driven by ???
- Not True- estradiol, progesterone and testosterone have a number of pharmaceutically manufactured forms. Compounding pharmacies can make preparations using these compounds
- Estriol and Estrone – not FDA approved products, however they have been used extensively in Europe. Estriol is not as strong an estrogen. Estrone does not seem to have a place in BHRT at this time.
Questions?