
"You literally saved my life with your compassion & ability to explain confusing information!" - Amazon Review
FEEL AMAZING
Your invitation to rethink perimenopause, menopause & postmenopause
by Shirley Weir
Amazon Best-Selling Author
Founder, Menopause Chicks

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Proud partner of the MENOPAUSE CHICKS community to empower all women and help them navigate peri and post menopause with confidence and ease.

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#MENOPOSITIVITY

SCAN ME FOR MORE INFORMATION

COMMITTED TO SKIN HEALTH SCIENCE.

By Shirley Weir
MOKITA: How to Navigate Perimenopause with Confidence & Ease
FEEL AMAZING: Your Invitation to Rethink Perimenopause,
Menopause & Postmenopause
[this book is an updated adaption of MOKITA]

FEEL AMAZING

Your **Invitation** to **Rethink**
Perimenopause, Menopause
& **Postmenopause**

Shirley Weir

Amazon Best-Selling Author
Founder, Menopause Chicks

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Disclaimer: The content of this book is for informational purposes only and is not intended to be a substitute for professional medical advice or treatment advice of any kind. Menopause Chicks does not provide medical advice, diagnosis or treatment. Always consult a physician or other qualified health provider before starting any new treatment or protocol, or with any questions you may have regarding perimenopause, menopause or other health-related experience.

This book is dedicated to:
Every smart, savvy woman who wants to be proactive with her own health.
You deserve to feel amazing.

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Author's Note

Before starting Menopause Chicks, the words "menopause" and "hormones" sounded like swear words to me; always spoken in a negative context.

Was it the same for you?

How often did you hear *"oh, she's so hormonal,"* or that *"menopause sucks?"*

"Symptoms-this. Suffering-that." Every time there was a mention of menopause, it conjured up thoughts of: hot, old, tired, moody, miserable and more!

My guess is that if you stepped outside right now and said the word "menopause" to the first person you meet, you would likely receive a similar response.

This negativity alone could be why millions of women are now waking up in their 40s or 50s without a full understanding of their hormone health; which hormone is responsible for what, how hormones work, and some of the common experiences associated with hormone fluctuations as we navigate perimenopause-to-menopause-to-postmenopause.

Wait a minute! We worked hard to get here. This can't be the beginning of the end, can it?

What if it was ***the beginning?***

Yes, what if conversations about perimenopause, menopause and postmenopause were reframed to mean someone who is wise, confident,

and beautiful? Who cares if she still has period anymore?! That's irrelevant. What matters is that she has her own name at the top of the priority list now—at home, at work and in the community.

Well, I'm happy to say these conversations are beginning to crack open—at least in the MenopauseChicksCommunity.com that's true.

But there's still a very large gap between old thinking and new, and it's going to take a bridge paved with curiosity and quality education in order to close the current divide.

Thank you for being curious about your health.

Thank you for picking up this book. My hope is that it creates an excellent place for you to start thinking...or *RE-thinking* how you learn about, talk about, and plan your journey from **perimenopause-to-menopause-to-postmenopause.**

Introduction: You Deserve to Feel Amazing

The following sentence is the most important part of this book: **You deserve to feel amazing.**

Fair warning: Sometimes the journey towards amazing... runs straight through a tiny little place called "not-yet-amazing." *(A quote I adapted from Seth Godin.)*

You see, (and here comes the second most important sentence in this book) women are not meant to suffer.

I know! Rather earth-shattering, isn't it? Especially when you think of the "just suck it up" messages that follow us through periods to pregnancy to post-partum to perimenopause.

But as soon as we begin to believe (really believe!) that we are not meant to suffer, we will also begin to believe that we are smart, and we are savvy, and we can learn to navigate—and course-correct—any of the parts that are "not-yet-amazing."

We can come to a collective understanding (regardless of our current age), that midlife has this ability to shine a big bright light on who and how we want to be in this world; it creates this incredible window of opportunity for us to decide what we want our health to look for the next three-to-five decades too!

After all, we are the first generation to turn 50, and have 50 more years to plan for!

Let's learn together.

Chapter one:
Changing the Conversation

In my first book, *Mokita: How to navigate perimenopause with confidence and ease*, I began with definitions. It was my attempt to get everyone on the same page right from the start.

I was inspired by the word "mokita" (borrowed from the Kavila tribe in Papua New Guinea) which means "the truth we all know and choose not to speak of" as it really paired well with the tagline for Menopause Chicks, which is "cracking open the conversation."

The Kavila tribe measures the health of its tribe based on how many mokitas they have—meaning, the more we talk about concerning and challenging topics, the healthier our community will be!

This made me assume all I had do was *talk* about menopause—simply take a previously closeted conversation and spread it widely: on social media, at cocktail parties, backyard barbecues and around boardroom tables.

Fast forward to 2022. While there are a lot more conversations about menopause—both on and off the internet—I have learned one important lesson. More conversations about perimenopause, menopause and postmenopause won't work if they continue to perpetuate myths and outdated information. For example, when an influencer goes on Instagram or a celebrity sits down on a late night tv talk show and claims "menopause is hell," it doesn't motivate anyone to want to pick up a

book like this one to learn more.

It accomplishes the exact opposite—it reinforces the negativity. It instils fear and overwhelm, causes more women to delay learning about their hormone health ("I'm not 50 yet!") or they might just shrug their shoulders or resort to "crossing their fingers and hoping for the best" (*not* a recommended health strategy, as our health is not a lottery!)

There is a quote I love by Gloria Steinam that says, "Our first challenge is not to learn, but to *UN*-learn."

This speaks to me because I've learned through both our Menopause Chicks research and thousands of conversations, that it is common for women to arrive at perimenopause (or beyond) relatively uninformed and unprepared for what it could mean. (Ah-hem, that was me!)

And for many of us, before we can learn about what hormone changes to expect, and how to build our health team and how to be our own best health advocates, we must first UN-learn all of the myths or misconceptions we picked up—consciously or unconsciously—along the way.

So, we will get to definitions in Chapter Two.

Task one is to address some of the elephants in the room; these are many of the things that get in the way of women having informed conversations with their health care provider, or things that are getting in the way of accessing the quality health care we deserve.

Words matter: Words and phrases I don't use

"Menopause Symptoms":

- I don't use symptoms in the same sentence as perimenopause or menopause or post menopause because:
    - These are life phases and not ailments or diseases *(we never say "puberty symptoms!")*
    - It is important to find and treat the root cause. For example, let's say someone told you that difficulty sleeping was a "symptom of menopause." This language

is often met with an eye roll and innuendo that insomnia is something you must endure; but not always met with action or a solution. If you are experiencing sleep disruption, I want this to be your invitation to get curious; to find and treat the root cause: Are your sleep challenges due to lifestyle? Magnesium deficiency? Fluctuating progesterone? Cortisol (stress hormone) imbalance? Or something else. And know that it is ok to ask for support!

Perimenopausal, Menopausal, Postmenopausal:

- The life phases we are discussing are nouns. I don't know when they became adjectives (again, there is no equivalent for puberty) and most of the time, these adjectives get used in places where it is completely irrelevant to know whether the person still has a period or not. Example: Someone asked me the other day about her "perimenopausal ankles." It makes no sense. Except I know media and marketers use it to help with search engine optimization. Watch for this, and don't get sucked in.

Normal:

- I do not use the word "normal" except when talking about a setting on my dryer. When we (society) tell women that their pain, discomfort or any adverse health concern is "normal," we are telling them to put up with it, suck it up and that their health is not important. I do use the word common instead of normal, followed by ideas for how she can find and treat the root cause.

"Going through" or "During":

- So many women ask me things like "how long will this last?" and "when will things get back to normal?" Phrases like "going through menopause" or "during menopause" are outdated and imply that if they just suffer "through," things will be better on the other side. This is not true. The best thing you can do is repair the roof AND then put measures in place to prevent future leaks. The same is true with our hormone health.

By not addressing our hormone health, we are missing out on opportunities to prevent things like osteoporosis, vaginal dryness/atrophy, reoccurring UTIs and incontinence.

Words matter: Words and phrases I do use (a lot!)

- You are not alone!
- You are not meant to suffer
- You deserve quality of life
- Think of any adverse experiences (such as hot flashes) as a "tap on the shoulder" from your body that it needs something? What does it need?
- Get curious
- Get informed and choose the journey that's right for you!
- Invest: What we do now will pay dividends down the road!
- There is sex after menopause (sometimes even with a partner!)

Myths, Misconceptions and Media Innuendo

"Menopause is not something I need to learn about until I am 50."

Truth: While the average age of menopause (12 consecutive period-free months) is 51.2, hormones begin to fluctuate (perimenopause) 5-15 years before that date. When we consider stress (cortisol) into the equation, hormone health education needs to begin years, if not decades, before age 50.

"Things will get better with time or "on the other side"; I just have to "get through it."

Truth: If your roof is leaking, it will not get better with time. Consider

any signs or symptoms of hormone imbalance as a "tap on the shoulder" from your body--telling you it needs something; this is an invitation to INVEST in your quality of life NOW...as well as your heart, brain, bone and vaginal health for the next 3-5 decades.

"I haven't had a hot flash yet, so I must not be there yet."

Truth: We have been led us to believe that hot flashes are the hallmark of menopause. While hot flashes are a sign of hormone imbalance, we are failing to inform women about signs of low progesterone, for example, which can cause heavy bleeding in perimenopause (over 70% of gynecological visits are due to heavy bleeding.) We are failing to inform women that estrogen and hyaluronic acid decline leads to vaginal dryness (80% of us will experience vaginal dryness, yet less than 4% are currently receiving treatment!)

"My experience navigating perimenopause-to-menopause & beyond will be the same as or similar to my mother's."

Truth: This is a generational myth. It's never been studied. Our hormone health is unique from our mother's and grandmother's because our stress levels are different, our diet and lifestyle is different. Everyone's perimenopause-to-menopause-to-postmenopause journey is unique to them: unpredictable.

"My doctor will know what to do."

Your doctor *might* know what to do--if they have education, expertise and experience in women's midlife hormone health, such as getting certified by the North American Menopause Society or studying with The Confident Clinician or other continuing education program. Menopause/hormone balance is not taught in medical school (beyond a 1 hour lecture) and even if it was, we graduate doctors into a system that rewards 10 minute appointments and "one-concern-per-appointment." This makes it very challenging for doctors to direct physical, mental and emotional health, and challenging for women to access the information

and care they deserve.

"Hormone therapy causes cancer."

This one is steeped in a long history of myths, misconceptions and media innuendo. Bottom line is that hormone therapy does not cause cancer (if you already have cancer then of course, your health team is going to weigh the risks.) Hormone therapy must be customized; it is a complex protocol that needs to be guided by a hormone expert, and the first thing that expert is going to do is conduct personalized health risk assessment (as they would do when prescribing anything!) The North American Menopause Society's most recent positioning statement is that hormone therapy is deemed to be safe when prescribed on an individualized basis, including a comprehensive risk assessment, regular monitoring, and best started within 10 years of menopause and before the age of 60. I don't tell women they should take hormone therapy; I tell them their health is worth investigating to see if it will be beneficial for them.

"Everything will sag and dry up."

These are the words my sister's doctor used when she reached menopause at age 36 (she had cancer as a child; we believe radiation destroyed many of her egg follicles.) The truth is: hormone changes can bring uncomfortable experiences--from dryer skin, hair and vaginas...to sleep and mood changes and more. But we are smart and savvy...and there are easy, viable ways to prevent (or treat) any health challenge.

Chapter two:
Definitions & Hormones 101

We can't have a meaningful conversation about perimenopause and menopause unless we all begin on the same page, with a unified understanding of the terms we are talking about.

Definitions are a very important part of learning about our own health and having effective, meaningful conversations—with each other, and with our health providers. Using the correct language is so important in helping to clear the confusing and conflicting messages around menopause.

You might think that for a life phase that every woman experiences, education for perimenopause and menopause would be common, easy to access and straight-forward. This is not the case. However, I am hopeful. As more and more women discuss their midlife health openly—and as more health professionals invest in their learning, share their expertise, and integrate their practices—perimenopause and menopause are being redefined.

Perimenopause

Perimenopause is defined by age and by fluctuating hormones; not by symptoms. Perimenopause is not a synonym for suffering.

Perimenopause is different for every one and it is the term used

to describe the transition from our reproductive years to menopause. Since the average age of menopause is 51.2 and we think perimenopause can range from 5-15 years leading up to menopause (there really is very little research), that means perimenopause can begin as early as our mid-to-late 30s but is likely more commonly associated with age 45+. The prefix "peri" means "around."

In the years before you reach menopause, your body starts giving you tiny hints that changes are coming. You may notice differences in your periods, including changes to the length, frequency, duration, or flow. If you had been keeping track, you would likely see that your length of cycle has changed from your early 20s to your mid-30s. This occurs because maturing follicles produce less progesterone during each cycle, shortening the period of time when the uterine lining thickens in preparation for a fertilized egg.

As perimenopause begins, the number and quality of follicles diminishes to the point where not enough estrogen is produced to prompt ovulation, causing periods to become erratic—it's the mirror image of what happens when a girl first gets her period. The closer you get to the end of your reproductive years, the more changes you may notice to the duration and flow of your cycle.

Nobody told me about this—I grew up assuming menopause was like a light switch, and one day your period just turned off! Isn't it fascinating that there were plenty of ads on television for erectile dysfunction and urinary incontinence, yet women in perimenopause are frequently surprised (and frightened) when changes occur to their period.

Although there is tremendous variation in how women progress through perimenopause—no two women are alike—it is common, as this shift happens, for women to go six to ten months between periods toward the end. There is no way to tell in advance how this may unfold for you.

Menopause—Natural

Menopause is one day. It's the 12-month anniversary of your final period.

Why wait a year? Because no one ever knows if their last period will be their last period, so we "reach" natural menopause after 12 consecutive period-free months. It might be the day when you celebrate by inventing a cupcake or a cocktail. It could even be a day to throw yourself a party!

Why is this important? Some women are very focused on knowing the exact countdown of when they reach menopause and are ready to celebrate being period-free.

However, the two critical things I want you to address are i) birth control and ii) making a health plan for the next 30-50 years.

The International Menopause Society recommends that if you reach menopause and you are over the age of 50, to continue using contraception for one year and if you reach menopause and you are under the age of 50, to continue using birth control for two years.

Progesterone has already been fluctuating and declining for the last few years and in postmenopause, estrogen is about to go for a steep decline. If you haven't done so already, now is the opportune time to get curious about how you will support your hormone health going forward.

Menopause—Surgical

Surgical menopause is the day your ovaries are removed surgically, also known as an oophorectomy. If you are scheduled to have your ovaries removed, I strongly recommend consulting a hormone expert before surgery so you have a hormone health plan in place for post-surgery.

A hysterectomy is the removal of the uterus only, leaving one or both ovaries—so, the woman will no longer have periods, but she will not have reached menopause yet.

Postmenopause

Postmenopause is every day after the "anniversary" party for the rest of our lives. As I write this, I am 55 and since I reached menopause at age 49, I have been in postmenopause for six years.

Generally speaking, if perimenopause is defined by fluctuating progesterone, postmenopause is defined by declining estrogen. I try

to mention this as often as I can because you might "sail through" perimenopause (20% of women do) and then be shocked, surprised or unprepared by the experience of vaginal dryness, for example, in your mid-to-late 50s, as a result of declining estrogen.

Estrogen

Estrogen refers to a family of hormones: estradiol (produced by the ovaries during reproductive years), estriol (produced by the placenta during pregnancy) & estrone (produced by fat tissue in post-menopause.) When our cycles are regular, estrogen is the hormone that is released in the first two weeks. Estrogen is strong, focused and somewhat feisty; imagine a really confident lead on the dance floor who knows the routine inside and out. Estrogen is our "juicy" hormone. It is responsible for keeping our eyes, mouth, skin and vaginas moist, and our joints **lubricated.** Estrogen plays a role in protecting our hearts, brains and bones too. During perimenopause, generally speaking, estrogen is high. Once we reach menopause, estrogen can go for a steep decline--sometimes affecting our current quality of life and potentially compromising our future health too.

Progesterone

Progesterone is the perfect dance partner to estrogen. When cycles are regular, progesterone is released by the ovaries in the second half of our cycle. **Progesterone is calming and supportive of our mood and sleep.** It helps protect the uterus and keep bleeding regular. Progesterone begins to fluctuate in perimenopause. Generally speaking, during perimenopause, estrogen is high(er) and progesterone is low(er). If uncomfortable symptoms appear, it is often not the decline of just one hormone--but the RATIO of estrogen-to-progesterone that can disrupt mood, sleep and bleeding. Imagine two ice dance partners getting further and further apart; the quality of their routine declines! Progesterone is essential for long-term health too as it protects our brain and our bones from osteoporosis.

Testosterone

Testosterone has been historically thought of as a male hormone, but it is vital for women's health too! Testosterone is the hormone responsible for vitality and self-confidence + it's responsible for our sex desire! When testosterone fluctuates or declines, women may experience lower sexual desire, a flatter mood, lower self-esteem, loss of motivation, diminished well-being or blunted emotions.

Cortisol

Conversations about perimenopause, menopause and women's health can not happen in 2022 without including cortisol! Cortisol is our stress hormone. It is produced by the adrenal glands and plays a role in our immune system, central nervous system, circulatory system, stress response, and metabolism. High cortisol causes us to **feel tired-but-wired** and prompts our body to store fuel as fat in places it can be used easily, such as our waist. Low cortisol makes us feel exhausted and drained, like a car trying to run on an empty gas tank. Cortisol imbalance wreaks havoc on all our other female sex hormones--and can significantly impact our sleep, sex life and overall well-being.

Thyroid

Thyroid is often regarded as the gland responsible for metabolism, energy, weight and mood. Thyroid also refers to the hormones produced by this gland. When it is healthy, our thyroid produces hormones (TSH, T4, T3, T2, T1 and reserve T3) in the correct amounts to make us feel energetic, think clearly and remain upbeat! Low thyroid (hypothyroid) is characterized by feelings of sluggishness and poor memory. **Too many women interpret this as signs of getting older**, but more conversations about hormone health are raising awareness of the importance of thyroid health, and helping women realize they are not meant to suffer! Please ask your health care provider for a full thyroid panel. 15-20% of women with depression are low in thyroid hormone. Hyperthyroid (too much thyroid hormone) is less common, affecting

2% of women and can show up as heart palpitations, shortness of breath and weight loss. We have a 20% chance of developing a thyroid issue (too high or too low) at some point in our life. It's too important to ignore, so please investigate.

Chapter three:
Common Experiences

When Cycles Are Regular

When our menstrual cycles are regular, estrogen is the dominant hormone for the first two weeks leading up to ovulation, and then it is balanced by progesterone during the last two weeks.

These two hormones are like perfect dance partners. Estrogen is strong and somewhat feisty, and then along comes progesterone to provide calmness and support sleep. Women feel emotionally grounded, their metabolism is forgiving, their skin feels hydrated and clear and their bones and cardiovascular system are strong.

Along Comes Perimenopause

Generally speaking, as we enter perimenopause and begin anovulatory cycles (no egg released), progesterone production goes down, and this can lead to some of the experiences outlined below. This can be quite a confusing time for women if we still have a period (even if it's lighter, heavier or irregular) and especially if we are unaware of the important role progesterone plays in hormone health.

During this time, estrogen is also fluctuating, and again, generally speaking, can be high or higher than previous years—until postmenopause, and that is when estrogen goes for a steep decline.

Common Experiences

Progesterone

Fluctuations or decline in PROGESTERONE may contribute to:

- difficulty concentrating
- mood swings
- depressed feelings
- anxiousness
- headaches
- difficulty sleeping
- painful or swollen breasts
- hot flashes
- bloating
- PMS
- hot flashes/night sweats
- heavy bleeding and/or irregular bleeding

Estrogen

Fluctuations or decline in ESTROGEN may contribute to:

- hot flashes/night sweats
- difficulty remembering things
- vulva/vaginal dryness
- pain with penetrative sex

- UTIs
- incontinence
- pelvic organ prolapse
- lower sexual desire
- joint pain
- dryer eyes, mouth, hair and skin

Testosterone

Fluctuations or decline in TESTOSTERONE may contribute to:

- lower sexual desire
- loss of motivation
- flat mood
- diminished well-being
- blunted emotions
- lower confidence

Cortisol

Fluctuations in CORTISOL may contribute to:

- feeling stressed
- "tired-yet-wired"
- insomnia
- irritability
- lightheaded

- anxious
- depressed
- weight gain (waist)
- fatigue/exhaustion
- food cravings
- aches & pains
- frequent colds/flu
- chronic conditions like diabetes

Thyroid

Fluctuations in THYROID may contribute to:

- fatigue/exhaustion
- cold hands & feet
- low body temperature
- inability to lose weight
- constipation
- depressed feelings
- dry skin
- nails & hair or hair loss
- poor concentration
- muscle aches
- puffy eyes/face
- lower sexual desire

Chapter four:
My Story

My story actually begins with my older sister, Brenda, who modelled what it means to be your own best health advocate; she demonstrated what it looked like to "get informed and then choose the journey that is right for you!"

Brenda is 10 years older than me. She is my best friend, and I have looked up to her all my life.

I turned 12 in 1979, and that summer—a few months before my sister's wedding—I got my first period. I didn't tell anyone, but of course, Mom knew. She sent my sister to talk to me, and I remember the two of us counting days off on the calendar to determine if I would have my period at her wedding.

That was the day I learned that Brenda didn't get her period until she was 17 years old—and the average age is 12.

Brenda, is a survivor of childhood cancer, and the radiation treatments she received as a child destroyed some (but fortunately not all) of her eggs. She spent most of her teenage years either pretending she had her period, hoping her friends assumed she did, or avoiding any conversation about it.

Brenda reached menopause at age thirty-six. The average age of menopause for North American women is 51.2 years of age; 36 is

regarded as early or premature menopause.

It was 1992 when Brenda's periods stopped for a year, and researching health questions on the internet was not yet a thing. Her family doctor's recommendation was the birth control pill. The pill brought Brenda's periods back, except instead of the two-to-three day periods she had been used to, they were now a week long with severe PMS, which she had never experienced before.

After a year on the pill, Brenda found herself discussing hormone therapy options with a gynaecologist. Perhaps the word "options" is not accurate.

He said, "Your ovaries have shut down. You need to go on hormone therapy."

She remembers asking why, to which he replied, "If you don't take hormone therapy, you will be putting yourself at increased risk of heart attack, stroke, osteoporosis, and everything will sag and dry up!" He also told Brenda she could take hormone therapy for the next twenty years and then decide how she wanted to age from there.

I was only 26 at the time, so learning about menopause was not yet a personal priority, but my sister's good health certainly was. I distinctly recall needing clarification on what her gynaecologist meant by "everything will sag and dry up."

He meant that without hormone therapy, her skin and breasts would sag, and she would most likely experience vaginal dryness. As this was the first time I had even heard about this, I wasn't sure if he meant this to be less frightening or more frightening than the potential risk of a heart attack!

Brenda was her own best health advocate (although that's not the exact phrase I would have used back then); she did her research, got informed, and when she started hormone therapy, I knew it was the right choice for her. I also remember learning that our mother reached menopause at 49 and thinking that I had plenty of time to get informed and prepared for my own journey to menopause, and I had every intention at the time to do both.

Fast forward to 2002.

The Women's Health Initiative (WHI) study on hormone therapy (which ironically was initiated in 1991, around the time my sister and I first heard of hormone therapy) came to an abrupt halt three years early. Researchers studying the non-bioidentical hormones *Premarin* and *Provera* determined that they were more dangerous than a placebo when given to women age 60 and over to prevent heart disease. The average age of the women in the study was 63. Therefore, the study's results—propensity for blood clots, heart disease, stroke and breast cancer—could have been expected, as women of this age are naturally more susceptible to heart disease and breast cancer to begin with.

However, the flaws in the study, and the public relations debacle that ensued, meant that the findings rocked the gynaecological world and made many physicians question any (and sometimes all) hormone therapy protocols they had been routinely prescribing to women for decades.

Without the context of the age of the participants, the study's findings made headline news. Women abruptly stopped taking their hormone therapy, and doctors and patients were left looking for new solutions.

For my sister, the WHI headline news meant she needed to question her own hormone therapy protocol.

"I didn't want to jeopardize my longevity," Brenda recalls. "And when I heard all the alarm bells on the news, I remember thinking—oh my goodness, they are talking about me!"

Now 46, Brenda was motivated by a conversation with her chiropractor to research all other possible options, attend workshops, and teach herself what she needed to know to make the best health decisions for her. Quitting hormone therapy cold-turkey did not seem like a good plan. After doing her research and advocating with her own family doctor, she decided to quit taking the non-bioidentical hormones and transition to a bioidentical estrogen and progesterone compounded by a local pharmacy. In order to have this treatment covered by her extended medical insurance, Brenda convinced her family doctor to write the prescription. Brenda did this for years without fully understanding that

she had more education in hormone therapy than her own physician.

"I felt so alone making all these decisions about my health," she says. "The information from doctors was conflicting, and I had no one to talk to about menopause or hormone therapy as none of my friends were there yet. I finally decided to trust my gut and to do what felt right, and logically made sense."

In 2017, the North American Menopause Society released the most updated position statement declaring that hormone therapy remained to be the most effective treatment for vasomotor symptoms (hot flashes) and vaginal dryness, but also that hormone therapy is shown to prevent bone loss and fracture.

To reduce any potential health risks, the North American Menopause Society recommends that hormone therapy treatment decisions and protocols should be individualized for each person to identify the most appropriate type, dose, formulation, and route of administration. And the recommended guideline to begin hormone therapy is within 10 years of menopause and under the age of 60 and do not have any current or high-potential risk for breast cancer, heart disease, or stroke. Hormone therapy treatment has the most favourable benefit-to-risk ratio for addressing symptoms associated with hormone imbalance.

My sister's journey, while atypical, introduced me to these two concepts: our experiences are all unique, and the key to navigating any health question or challenge lies in learning how to be your own best health advocate.

I invite you to take Brenda's story and turn it into an invitation to navigate your own perimenopause-to-menopause-and-beyond journey with more curiosity, confidence and ultimately, ease.

Read. Talk. Listen. Ask questions. Look in more than one place for answers. Review and revise your health plan regularly. And always, trust your instincts in order to do what is best for you and your health.

My journey

On December 31, 2015, I laid in my bathtub, looked down at my body,

and did something I had never done before: I thanked it.

I thanked it for allowing me to have two amazing children. I thanked it for carrying me this far on my journey. And, fairly certain that I would reach menopause in 2016, I also promised it a party.

Ten years prior, that bathtub scene had looked very different. Things were starting to change for me and I did not know what was going on in my mind or in my body, so I would retreat to the tub to try to figure out how I was going to make it through the day. Sometimes I would go to the tub to curl up in the fetal position and rock back and forth as a way to deal with the overwhelm—especially if I had just lost my cool with one of my kids for no explainable reason.

As I sat in the tub, I told myself I was a bad mother. I told myself I had to be the martyr; to take care of everyone and everything. It wasn't that I forgot to put my own name at the top of the to-do list—my own name wasn't even on the list at all! I beat myself up as I glanced at all the magazine headlines around me, most of them promising me I could lose my belly fat in just ten days. Thoughts about the potential of Alzheimer's disease danced in and out of my head. Amidst all of this turmoil, I told myself to suck it up and plunge forward. I told myself every night that tomorrow would be better, and every morning I would try to get up an hour earlier than the day before in an effort to "get it all done."

The result? I hit a wall. I suffered chronic sleep deprivation and debilitating brain fog that was affecting my ability to run my business, raise my family, and be authentically me.

Sometimes people will ask me what my first signs of perimenopause were. Looking back, I want to say it was that rogue chin hair I discovered the day of my wedding. But it is likely more accurate to say that it was sore breasts around age thirty-nine—which, in hindsight, was not that big of a deal. Of course, I didn't know at the time that fluctuating hormones were the cause, because when it comes to menopause conversations, media, marketers and the medical community have convinced us hot flashes are the first sign. This information is inaccurate and misleading and I work hard every day to debunk this misinformation.

I had two healthy children, my husband had had a vasectomy, and

all was good in our world. Except...my boobs hurt. Could I be pregnant? Not possible. But, I checked anyway, and the answer was no.

Over the next two to three years, other changes started happening. I experienced pronounced PMS for what seemed like the first time in my life. My periods were heavier than before I had children. I started experiencing bouts of rage, something I had never heard of at the time. I would be fine one moment, and then without warning I would come unglued and snap at the people I love the most. This was very upsetting. Then came the brain fog, which was frustrating. I could make a list, but all I could do was stare at it; I couldn't seem to accomplish what I used to in a day. I was having trouble remembering things—simple things like people's names, cupcake day at the kids' school, and my suitcase at the airport. I lacked focus, which was really scary as a self-employed entrepreneur. I also had low sexual desire, but we are a busy family so it felt legitimate and understandable that I didn't seem to have the time or energy I once had. Besides, I was waking up every morning at 3:00 a.m.!

Now, I'm not the kind of person who goes to the doctor for every little thing; in fact, I don't really go to the doctor much at all. But after noticing these changes for a couple of years, I decided to mention that I was possibly experiencing the first signs of menopause (I wasn't aware of the term perimenopause yet) to my doctor...at the end of my Pap smear appointment.

My doctor was lovely, and her entire practice focused on pregnancy and babies. It didn't even occur to me that I should ask her about her education, expertise or experience with menopause. I just had this preconceived idea that if there ever was something concerning to me that I wanted to discuss, the conversation would be directional, informative, validating, and above all, supportive.

So, there I was, lying on her examining table post-Pap, donning a paper-thin gown the size of a Post-it note. My doctor says, "Go ahead and sit up. Is there anything else?"

I was crunched forward, trying to strategically position the Post- it.

I can't remember if or how I described my sleep deprivation, brain fog or mood swings.

I felt vulnerable and unprepared—and a little bit like a teenage girl—as I conjured up the courage to say the word "menopause" for the first time. I stammered out, "Well, actually I wanted to ask you...errr... well, I'm just wondering...you see, I think I might be experiencing the first signs of menopause."

It felt strange to say the word. I was embarrassed at how little I knew. I was in denial that I might be "that old." I was sad to think my reproductive years were coming to an end.

And I was scared. I really, *really* wanted to rule out the idea that I might be experiencing early-onset dementia.

She looked at me, and then looked at the birthdate on my chart.

"Oh, you're 41," she quipped. "You're too young for menopause." *(I know now that is actually true; I was too young for menopause--but I wasn't too young for perimenopause...or burnout!)*

You might think her quick reply would have made me feel better. It did not.

I thought, *Wait a second—if it's not that, what is it?*

I know my doctor went on to say something about birth control pills, sleeping pills, and anti-depressants, but I couldn't hear her because my internal voice was screaming: "*SHIRLEY, SUCK IT UP! THIS IS ALL IN YOUR HEAD!"*

If you are reading this and thinking "damn doctor" or anything of that nature, I beg you to stop.

Yes, I was disappointed at how that particular conversation left me with more questions than answers, but it is not my doctor's fault.

Do not fire your doctor simply because your initial conversation about perimenopause or menopause doesn't meet your expectations!

Also, do not assume that a female doctor will meet your needs better than a male one—this is a common misconception, and you must remember that both were educated beside each other in medical school.

You need your family physician. However, you may need to change how you form your expectations and approach your conversations about your midlife or hormonal health. Knowing what education and options your doctor (or other midlife health professional) has in his or

her toolkit is an important first step!

I made a decision that day: my midlife journey was my responsibility. Yes, I did feel confused, and even embarrassed, after that particular conversation. But the more I thought about it, the more I convinced myself I could not possibly be the only woman in the world living these experiences.

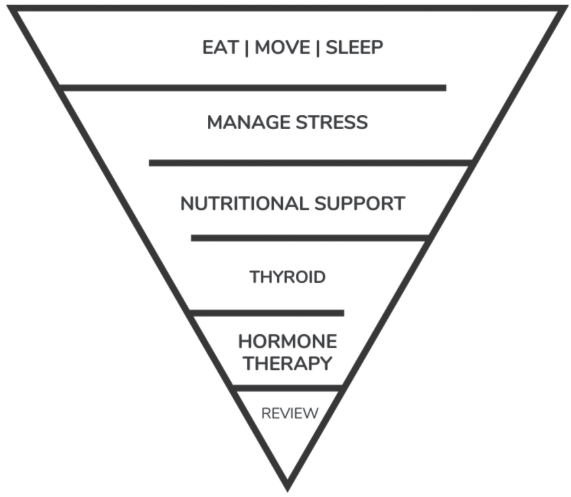
Life remained busy, and my experiences of perimenopause ebbed and flowed throughout my early forties. By the age 46, I embarked on some research. I became obsessed with the lack of quality information and online conversations for women to prepare themselves for perimenopause and menopause—at least in the same way we all prepare our children for puberty! And I was driven to fill the gap for women trying to navigate this journey as I was. I wanted to crack open the conversation so women would feel more informed and less alone.

And that was the beginning of Menopause Chicks.

I'm now 55 and every day I learn something new about how to invest in my current and future health.

Your story will be different from mine. Being your own health advocate means being curious and willing to talk about any questions you may have. The MenopauseChicksCommunity.com has become a go-to place for members to do just that.

Chapter five:
The Hormone Health Pyramid



Why an inverted Pyramid?

When thinking about your hormone health, I invite you to use the visual of an inverted pyramid. The pyramid visual is useful for investigating our health for three main reasons:

1) It helps provide an order for where to begin, and how we can get curious about any new change or health concern.

2) The inverted pyramid shape reminds us that we can't "jump" to a "magic wand solution" (i.e. hormone therapy) because if we do, we could skip over another root cause.

3) The pyramid helps to illustrate there could be more than one health area that requires investigation and attention for one particular concern. A common example is hair loss: is it due to iron deficiency, thyroid imbalance or other hormone imbalance?

Eat | Move | Sleep

How we eat, move and sleep are extra-large topics on their own. What I hope you take away from this section—besides 1) Eat well 2) Move often (including strength-building exercise) and 3) Prioritize your sleep—is that our body's hormone production is supported first and foremost by these lifestyle factors...at every age...and especially as we transition from perimenopause to menopause to postmenopause.

And when it comes to sleep, I want you to know this: ask for support when you need it. Sleep is so foundational to our hormone health and our health overall, and it touches all levels of this pyramid.

I have been learning a lot about sleep and insomnia recently, and unfortunately, women have a tendency to either wear sleep deprivation like a badge of honour. Or, we are quick to dismiss any sleep challenge as something we must either deal with on our own, or we self-medicate with things like alcohol or over-the-counter remedies.

Insomnia is defined as any difficulty falling asleep, difficulty staying asleep, waking too early or challenges functioning the next day due to sleep disruption.

If these definitions sound like you, I want this to be your invitation to prioritize sleep, and to prioritize making an appointment to talk with your health team about your sleep health. Explore all possible root causes of your insomnia—lifestyle, stress management, hormone fluctuations, magnesium deficiency or possibly something else. And if you do nothing else after reading this book, ask for support for your sleep!

Stress

The short answer, when it comes to stress (cortisol management) is: trust your intuition. If you think stress is maybe playing a role in how you feel, there is a high probability you are right!

In my early-to-mid 40's, I was burning the candle at both ends with a business, two young kids and my aging mother was living with us at the time. Not feeling my best, I really wanted to point a finger at perimenopause, and blame something besides myself for how I was feeling.

What I learned when I started researching this important health topic was this: stress, if left unmanaged, can really disrupt every system in our body—from hormones to sleep and more.

One of the very first women's health experts I met was Dr. Bal Pawa, a physician, pharmacist, co-founder of the West Coast Women's Clinic in Vancouver, and most recently, the author of *The Mind-Body Cure: Heal Your Pain, Anxiety and Fatigue by Controlling Chronic Stress.*

Dr. Pawa taught me how everything is connected. If I am sleep deprived, it is going to affect my mood, my ability to exercise and it will most likely impact brain fog and sexual desire too. If I am feeling anxious, it could be because I am not getting enough sleep, or exercise or both. It's such a vicious circle!

She also shared how many of her patients (like me) want to quickly blame estrogen and progesterone for their experiences—but what we fail to tell women is that if we can't manage our stress (our cortisol hormone), we are going to have a harder time with our female hormones!

That's the big connection!

Dr. Pawa likes the analogy of the gas pedal and brake pedal in a car. Having our foot on the gas pedal all the time will cause our body to be in a constant state of "fight-or-flight" which can lead to disease. 75% of disease is caused by continuous and excessive stress. Dr. Pawa helps women connect the dots between their physical experiences—everything from heartburn and insomnia, to anxiety and low libido—back to stress.

She then teaches women to use the brake pedal because that allows

rest and repair to occur!

It's better than "throwing a pill at every ill," she says, and she wants women to learn how to turn on their own "internal pharmacy," which includes a prescription of meditation, paying attention to how we eat, exercise, rest... and recover...meditate and practice mindfulness (go for a walk in nature every day!)...and to really practice prevention, so there is less need for medical intervention.

Nutritional Support

Nutritional support, like most health topics, is very individualized. That is why it is very important to work with your health care provider to determine what is going to be most supportive for you and your health goals. I'm going to shine a light on four of the most common nutritional topics that come up in the Menopause Chicks Community regularly: magnesium, iron, omega 3 and vitamin D.

Nutritional Support: Magnesium Matters

Magnesium is an essential nutrient and in Canada, more than 40% of adults over 30 do not meet the daily recommended intake of dietary magnesium: 300 mg/day for women and 400 mg/day for men. Other risk factors for magnesium depletion: chronic stress, alcohol and caffeine use, poor dietary absorption and drug-induced depletion.

More than half of our magnesium (approximately 60%) is found in our bones. The rest (approximately 30 to 40%) is found in our muscles and organs. Only 1% of our total magnesium circulates within our bloodstream.

Why is magnesium so important for optimal health? Magnesium is fundamental in countless processes that keep the body running smoothly. This is because magnesium is a cofactor in the myriad of chemical reactions that keep us alive.

Enzymes are proteins that facilitate these chemical reactions—whether that's breaking down food for fuel, or metabolizing toxins before they can do harm. For over 300 of these enzymes, magnesium is an essential partner.

One such reaction, perhaps the single most important, is the production of cellular energy. Every time a cell produces a unit of energy, called adenosine triphosphate (ATP), the ATP molecule must bind to magnesium in order to be biologically active.

In short, magnesium is required for any process in the body that requires energy! In addition to cellular energy, magnesium is also responsible for stabilizing and repairing our DNA, regulating the way our nerves conduct signals, and ensuring that muscles relax after contraction.

How do you know if you're getting enough magnesium? Given that magnesium has such a crucial role to play in nearly all functions of the body, it comes as no surprise that a deficiency in magnesium can manifest in symptoms big and small, from head to toe.

Experiences associated with magnesium deficiency may include: fatigue, headache, low mood and/or anxiety, poor sleep, muscle cramping, acid reflux, constipation, high blood pressure and high cholesterol, poor insulin sensitivity, osteoporosis, and more. You will recall from Chapter 3 some of the experiences from this list are similar to some of the common experiences associated with progesterone fluctuation—a reason to work through the pyramid as you may need magnesium, progesterone or both!)

Magnesium is found in many whole food sources, such as leafy green vegetables, nuts and seeds, and legumes. However, since magnesium is found in small quantities over a large wide variety of foods, it can be a challenge to consume enough magnesium through diet alone.

In Canada, more than 40% of adults over 30 do not meet the daily recommended intake of dietary magnesium: about 300mg/day for women, and 400mg/day for men. In addition to poor dietary intake, many of us have risk factors for increased magnesium depletion: chronic stress, alcohol and caffeine use, poor dietary absorption, and drug induced depletion, just to name a few.

If you are taking long-term medications, your pharmacist is a great resource for checking if any of your medications might be contributing to magnesium depletion.

One complicating factor to assessing for magnesium deficiency is that testing for such is difficult. This is because lab testing evaluates the amount of magnesium in the bloodstream, called serum magnesium. However, only 1% of the body's magnesium is found in the blood. This means that magnesium levels in the blood might not reflect true magnesium levels in the body; your serum magnesium levels might read normal, even when your total body's magnesium levels are low. This means that diagnosing low magnesium requires a careful assessment of your whole-body symptoms, and risk factors for magnesium depletion, as well as lab values.

This is why it is always best to work with a health care provider before deciding to add a supplement to your health routine.

Common questions about magnesium:

Should I be taking a magnesium supplement?

In addition to correcting or preventing magnesium deficiency, there are many other reasons why taking a magnesium supplement may benefit your overall health. Here are some other evidence-based benefits of magnesium supplementation:

Preventing Against Cardiovascular Disease

Studies have linked a higher intake of magnesium to reduction of plaque build-up in the arteries, and a lower risk of heart attack and stroke. Taking supplemental magnesium seems to slightly lower blood pressure. Magnesium may also help to reduce the "bad" cholesterol (LDL) while raising the "good" cholesterol (HDL).

Fighting Type-2 Diabetes

Higher dietary magnesium has been associated with lower risk of developing type-2 diabetes. In patients who already have type-2 diabetes, supplemental magnesium may also decrease fasting blood sugar, and

improve insulin sensitivity.

Preventing Recurrent Migraine Headaches

Magnesium supplementation can help to reduce the frequency and severity of migraines. Migraine headaches can be debilitating. They are often treated with anti-pain medications—but overusing anti-pain medications can, in itself, cause even more headaches. Magnesium can play a crucial role in breaking this feed-forward cycle.

Reducing Chronic Pain

There is emergent evidence to support the use of magnesium in chronic pain management, particularly in nerve pain. Chronic pain is multifactorial and complex, but one of the key players in the pain pathway is the activation of the NDMA receptor. Magnesium acts to block this receptor, and in doing so, interrupts the pain signal.

Improving Insomnia

Studies show that taking supplemental magnesium can help to improve sleep onset and sleep quality, particularly in older adults.

Maintaining Bone Health

We often talk about the importance of calcium when it comes to bone health, but research shows that magnesium is also essential in maintaining bone mineral density, preventing osteoporosis, and reducing fracture risk.

In fact, one study showed that higher magnesium intake or supplementation reduced risk of osteoporotic fracture by 34%.

It is important to note that there is such a thing as taking too much magnesium. Excessive magnesium supplementation can cause side effects and be unsafe.

People with low kidney function are less able to excrete excess magnesium, and thus are at higher risk of magnesium toxicity, which can be dangerous to the heart. Discuss with your healthcare provider

whether magnesium supplementation is right for you.

Which Magnesium Supplement Is The Best Choice For Me?

There are many forms of supplemental magnesium, and not all are made equal. Here are the different types of magnesium supplements available, and how they may best be used:

Magnesium Citrate

This form of magnesium is bound to citric acid, a large molecule with mild laxative effects. While well-absorbed, magnesium citrate can cause loose stools, especially at higher doses. This is a great option for those looking for general magnesium supplementation, who might also suffer from occasional constipation.

Magnesium Oxide

Magnesium oxide is poorly absorbed in the gastrointestinal tract. As such, it will not be as effective for increasing magnesium levels. It is, however, a highly effective antacid and laxative.

Magnesium Bisglycinate (Glycinate)

Magnesium bisglycinate is well-absorbed and less likely to cause loose stools compared to magnesium citrate and oxide. Additionally, glycine is an amino acid that also functions as a calming neurotransmitter in the body—hence, this form of magnesium is particularly useful in promoting sleep. Magnesium bisglycinate is a great option for those not requiring a laxative effect, while still providing optimal magnesium absorption.

Magnesium Taurate

Taurine is an amino acid that, when bound to magnesium, minimizes the laxative effect that magnesium may otherwise cause. Taurine in itself may also be beneficial for cardiovascular health. Hence, magnesium taurate may be beneficial in those taking magnesium for its heart health

benefits.

Magnesium L-Threonate

This form of magnesium is unique in that it crosses the blood-brain barrier. Within the brain, magnesium may be beneficial for improving anxiety, depression and cognition.

Nutritional Support: Iron Deficiency

When I talk with women about their health, I often refer to the "front burner" (things that are most important) and the "back burner" (things that we convince ourselves are unimportant, ok to tolerate.)

Would now be a good time for a friendly reminder that we are not meant to suffer?

Experiences such as fatigue, exhaustion, depressed feelings, brain fog and even hair loss frequently get relegated to the back burner, or sometimes "menopause" or aging will get blamed, when low iron is often the culprit.

Iron deficiency anemia is one of the most common nutritional deficiencies in women, causing things like fatigue, brain fog, cold intolerance, hair loss, and sometimes, not having enough energy to even climb a flight of stairs!

Women are so used to leading hectic lives and feeling tired all the time, they often dismiss their fatigue as "just part of being a woman." It's almost as if someone told an entire generation of women to expect to feel weak, irritable and unable to focus.

Ying Wang is a pharmacist at Pure Pharmacy in Vancouver and she says many women find it challenging to get adequate iron from diet alone, and that simply having a period—or definitely heavy bleeding during perimenopause—are common causes of iron deficiency.

Wang wants women to watch for common symptoms, to have their ferritin levels tested, and to know there are easy supplement solutions.

While iron is one of the most common tests doctors order, the normal reference range for ferritin has been traditionally quite broad,

and varies region to region. In B.C., the reference range for women 18+ can be anywhere from 5-247 ug/L. This means a woman can have all the symptoms of being anemic, but if her level is 30, for example, her lab result may not be flagged, her doctor may not be alerted, and the opportunity to treat and restore her quality of life may be missed.

One of our members, Phyllis R., noticed she was becoming winded while climbing a set stairs, and asked her doctor about iron. Her test result showed her ferritin was at a 2, and I remember Phyllis telling me that her doctor responded with a plan immediately, but that she didn't even realize how exhausted she was until she started to feel better! (Let me insert another reminder here: You deserve to feel amazing!)

Women have a high tolerance for coping with discomfort. And it's easy to assume symptoms are part of the perimenopause-to-menopause transition. More awareness is required, and a greater understanding of what optimal ferritin levels should be—so please tell your friends—especially if they still have a period and/or eat primarily a vegetarian diet.

Recommendations:

- Know the common signs of iron deficiency: fatigue, exercise-intolerance, cold-intolerance, hair loss, dizziness, irritability, brain fog and restless legs.

- Test ferritin levels (on a regular basis), and discuss low thyroid with your doctor too, as many symptoms overlap. Plus, your thyroid requires adequate iron levels to function optimally!

- Know your ferritin level. Ask the lab, your doctor or access your test results online. This will allow you to have an informed conversation with your pharmacist/health team.

Choose a high-quality supplement that will be optimally absorbed (iron absorption requires vitamin C) and one that won't cause stomach upset, nausea or constipation. My daughter and I take Ferapro from PurePharmacy.com/MenopauseChicks

Nutritional Support: Omega 3

I often say "crossing your fingers and hoping for the best" is not a health strategy, but we all do it. We wouldn't be human otherwise! Lately I've been thinking a lot about my own heart health and brain health. What about you? Is there one thing that you are hope you never have to deal with?

Dementia? Osteoporosis? Incontinence?

Of course, I already know the answer. It's *all* of the above.

Ok. Next question. What are you doing about it? *(Besides crossing your fingers, of course!)*

If you said "taking Omega 3s," you are on a good path.

Menopause Chicks was born out of my own frustration while trying to find quality women's health information online, in the media, and even from the medical community.

As my journey progressed, I inevitably found myself in the vitamin aisle—staring down a sea of supplement bottles—without any education or understanding of what my body needed, what ingredients or brands to trust, how much to take or when.

One of the most popular concerns for women in midlife is our brain health.

As we navigate these years, it can be challenging to pinpoint whether difficulty concentrating, forgetfulness, and brain fog are rooted in hormone fluctuations, hormone decline, stress, sleep deprivation, a nutritional deficiency, or cognitive decline.

Once upon a time, I joked I might be showing signs of dementia.

Except, I wasn't really joking. I was scared.

- I would forget that I let the dog out.
- I was forgetting the names of my colleagues mid-sentence.
- And one time, I got off a plane and drove straight home forgetting I had a suitcase to claim from the carousel.

I was in perimenopause, my stress was high and my mother was

also showing signs of forgetfulness and confusion. After all that, it's not surprising that I continue to be concerned for how I can invest in my own brain and heart health.

Omega-3 Fish Oil

The pharmacy team at Pure Pharmacy has taught me so much over the years about the importance of key nutrients, in particular, omega 3s. Here is what I have learned:

Heart Health

EPA in Omega-3s helps to reduce inflammation in our bodies—it's good for our joints and our arteries!

In fact, fish oil helps to take the inflammation out of our arteries, which can drop our chance for heart attack and stroke by as much as 47%!

In the absence of inflammation, the heart doesn't have to work as hard. This is huge for women's health, as the leading cause of premature death in women is heart disease.

Brain Function

DHA in Omega-3s assists with cognitive function and to protect the brain. So woman can put their heart health *and* their brain at the top of the priority list with Omega-3s.

While fish oil can help lower high blood pressure and help improve all around circulation, it also feeds the brain. Omega-3 to enhance cognitive function should be part of a protocol to prevent Alzheimer's disease, because 70% of Alzheimer's patients are women.

Other Benefits:

- As we age, inflammation can become a bigger factor in our ongoing well-being.
- Benefits from fish oil are also seen for the joints, the digestive

tract, and the body. Anywhere you're inflamed, Omega-3 can help.

- It's likely not possible to get adequate Omega-3s from our diet. Be sure to shop for a high-quality fish oil that has been cleansed really well. Fish oils can sometimes contain heavy metals and cleansing is essential to the purity of the supplement.
- Omega-3 supplements have improved over the years and there are many great options that do not leave a fishy taste. Vegan options exist too, so be sure to ask a natural health advisor.
- Fish oils can take 6 to 12 weeks of consistent intake to make a difference

Nutritional Support: Vitamin D

Vitamin D is considered both a hormone and a vitamin.

It contributes to bone strength, heart health, immunity and fighting off depression. Vitamin D can be made by mammals when we are exposed to the sun; the challenge is that many North Americans do not get enough sun exposure, so many of us are vitamin D deficient.

As a result, taking a vitamin D supplement is recommended for everyone.

But please don't guess—we don't guess how much gas to put in our vehicles; we use a gauge.

It's even more important to have your vitamin D level tested so your health care provider can recommend the dose that is going to be best for you.

(Note: most provincial health care plans do not cover the cost of testing vitamin D.)

Thyroid

Hopefully by now you are with me on the "find and treat root cause" train, because the next stop in the pyramid is thyroid. Thyroid must be

on this pyramid because I can't even count the number of conversations I've had with members of the Menopause Chicks Community that go something like this:

> She: I'm exhausted all the time, I can't lose weight, everything aches now more than it used to and I'm challenged with _____ (hair loss, low libido, constipation, brain fog.) I went to my doctor but he said we are all just getting to "that age."
>
> Me: Have you had a full thyroid panel done?

The reason this is so important is that the experiences listed above (can't lose weight, constipation, etc.) all fall into a category that fits the social construct of the aging woman. Brushing these experiences off; dismissing the woman who is telling this story is a form of medical gaslighting. Remember that you deserve to feel amazing. If you feel anything less than, get curious—because if it's a thyroid condition, you might be missing the opportunity to address something that's easy to treat, but will not get better on its own.

I like how my doctor, Dr, Kathleen Mahannah, ND, explains thyroid health in this article:

The thyroid is a small gland at the base of your throat that produces hormones that play vital roles in metabolism, growth, mood maintenance, heart health, digestive function, brain and fetal development, among other critical roles in the body. Healthy thyroid function is important for:

- Feeling energized
- Having a balanced, positive mood
- Maintaining a healthy weight
- Proper digestive function

If you have experienced unusual fatigue, weight gain, dry skin, menstrual irregularities, or cold intolerance, hopefully you had your thyroid hormones checked. One of the most common conditions I treat in my practice is **hypothyroidism**, which is a very common hormone disorder involving a low-functioning thyroid gland.

Hypothyroidism affects up to 10% of women in North America. There are several causes of a low-functioning thyroid. The most common cause of hypothyroidism is due to a condition called Hashimoto Thyroiditis, which is what I'll focus on in this article. This particular form of hypothyroidism is autoimmune in nature; meaning the body is attacking its own thyroid gland, resulting in inflammation and an under-functioning thyroid.

Thyroid problems

Hashimoto thyroiditis is the most common form of hypothyroidism in North America, and affects women 5-10 times more often than men. The most common time of life it is diagnosed in is between the ages of 45 and 65, though it can also be diagnosed in children.

Symptoms of Hashimoto typically arise as a slow onset of:

- Fatigue
- Constipation
- Dry skin
- Weight gain

More advanced symptoms may include:

- Cold intolerance
- Voice hoarseness from an enlarged thyroid gland
- Slowed movements
- Memory loss or "brain fog"

- Joint pains and muscle cramps
- Hair loss
- Menstrual cycle irregularities, such as skipping periods
- Depression

Testing and Diagnosis

Hashimoto thyroiditis is diagnosed based on physical exam findings and laboratory blood testing results. Depending on the extent of the disease, physical exam findings may include a puffy face, cold and dry skin, thickened and brittle nails, slowed heart rate, altered reflexes, and increased weight, among others.

Blood testing will involve a thyroid panel, examining TSH (Thyroid Stimulating Hormone), free T4 and T3 in the blood to determine thyroid function. To understand whether the cause of your hypothyroidism is autoimmune or not, specific antibodies are tested in the blood. These are Anti-Thyroid Peroxidase (anti-TPO) and Anti-Thyroglobulin (anti-Tg). The presence of one or both of these antibodies means that there is an autoimmune process occurring. In some cases, a thyroid ultrasound may be used to assess thyroid size or to determine whether or not thyroid nodules (lumps) are present.

Medical Treatment

The most important step in managing Hashimoto is replacing the thyroid hormone that your body is not producing. This comes in the form of thyroid medication, most commonly levothyroxine (Synthroid). Providing your body with this replaced hormone helps to slow the inflammation occurring in the thyroid gland itself, and provides your body with the hormone it is missing. After being diagnosed, you'll start taking medication daily, and your TSH will be re-tested every 8 weeks or so until ideal thyroid hormone levels are observed in the blood. Thyroid antibodies are conventionally never re-tested or monitored.

This is typically where medical management of Hashimoto stops. As a Naturopathic Physician, I always look deeper at other root causes that may be contributing to the autoimmune inflammation in order to support thyroid function, reverse symptoms, and prevent the development of other complications and diseases that are related to the presence of thyroid antibodies.

Addressing the root cause

The reason why this autoimmune thyroid condition arises in some individuals but not others is poorly understood. It appears that the combination of an immune defect in a susceptible person, accompanied by environmental factors seems to initiate a complex immune reaction resulting in the body attacking its own thyroid gland. Due to the genetic component, if you have a family member with autoimmune thyroid problems, you may be at higher risk and should be screened more regularly.

Why is it important to address the root cause of Hashimoto thyroiditis?

Having one autoimmune condition may put you at a higher risk of developing another one! Hashimoto occurs significantly more frequently in patients who are suffering from other forms of autoimmune disease, including: Addison's disease, type 1 diabetes, celiac disease, rheumatoid arthritis, or systemic lupus erythematosus (SLE). By treating the underlying autoimmune process, this may help to reduce your chance of developing other autoimmune conditions.

How to heal your thyroid: specific nutrients and herbs for thyroid function

While we can't control our genes, we can control our environment, food and supplements we put into our bodies. If you've been diagnosed with Hashimoto or hypothyroidism, here are a few top nutrition, herbal and lifestyle tips to help address the root cause of your thyroid problem.

Gluten

Studies have demonstrated a relationship between Hashimoto and celiac disease, both of which are autoimmune disorders. One meta-analysis suggests that all patients with Hashimoto should be screened for celiac disease, given the prevalence of coexistence of these disorders. Whether or not you have a diagnosis of celiac disease, I strongly recommend gluten avoidance for patients with Hashimoto. One small 2018 study examined the effects of a gluten-free diet on serum thyroid peroxidase and thyroglobulin antibodies and found that the group on the gluten-free diet had lower antibody levels at the end of the 6 months compared to the group on a gluten-containing diet.

Vitamin D

Vitamin D acts as both a vitamin and a hormone in the body. Several studies have demonstrated that vitamin D deficiency is associated with thyroid autoimmunity. Ask your ND to check your vitamin D levels in your blood and correct any deficiency with a vitamin D3 supplement.

Selenium

Selenium is an essential mineral for thyroid hormone function. Supplementation with selenium in patients with autoimmune thyroid problems seems to modify the inflammatory and immune responses. Foods rich in selenium include:

- Brazil nuts
- Oysters
- Tuna
- Whole-wheat bread
- Sunflower seeds
- Meat

- Mushrooms
- Rye

You can obtain your recommended daily intake of selenium by simply eating 2 Brazil nuts per day! 3 meta-analyses have demonstrated that the use of a supplement containing selenium called selenomethionine can reduce thyroid antibody levels in the blood. A typical dose is 200 mcg per day. Ask your ND if this might be appropriate for you.

Iodine

Iodine is an essential mineral needed for thyroid function. A deficiency of this mineral was a common cause of hypothyroidism in the past, until this problem was resolved in many countries with the introduction of iodized table salt. If you use Himalayan sea salt rather than table salt, you can obtain iodine in the diet through foods such as:

- Seaweed
- Seafood, such as scallops, cod, sardines, shrimp, salmon and tuna
- Yogurt, cow's milk
- Eggs
- Certain fruits (strawberries and cranberries).

Autoimmune thyroid problems seem to occur more often in iodine-replete countries, suggesting that excess iodine in the diet may be problematic. Work with your ND to assess your supplements to see if you are taking a healthy amount of iodine. The recommended adult daily intake of iodine is 150 mcg, increasing to 250 mcg in pregnancy and lactation.

Cortisol

During periods of prolonged stress over weeks to months, this stress

hormone has a 'dampening' effect on the thyroid gland. One study of non-autoimmune hypothyroidism found that patients with overt hypothyroidism have higher levels of cortisol (as tested in hair samples) compared to patients with normal thyroid function.

Supporting stress resilience in your life is an important part of a thyroid treatment plan. This may involve various tools and practices, such as exercise, meditation, yoga, and counselling or other stress relieving activities.

Your resilience to stress can be enhanced with the use of a family of herbs called "adaptogens" (they help you 'adapt' to stress). Ashwagandha (*Withania somnifera*) is an adaptogenic herb traditionally used to help support thyroid function in Ayervedic medicine. One study found that after 8 weeks of use, ashwagandha helped to improve TSH, T3 and T4 values in patients with subclinical hypothyroidism. Ashwagandha is my number one favourite herb to support thyroid function.

Your invitation

If you have a thyroid problem, or suspect you have a thyroid problem, I recommend you do an in-depth thyroid assessment with your ND and identify any nutrient deficiencies discussed in this article and begin a targeted treatment plan to help heal your thyroid.

Hormone Therapy

At the turn of the last century, women lived to be 50. Menopause was a non-event.

Now, we expect to see our 100th birthdays—yet, retirement communities and nursing homes are filled mostly with women, many who are challenged with heart disease and stroke, osteoporosis and dementia-related conditions, incontinence, reoccurring UTIs and vaginal atrophy.

It is not enough for us to have quantity of life, we must aspire to have quality of life as well.

It is not enough for us to explore one rung of the inverted hormone

health pyramid; we must explore all of them.

I often say to members in the Menopause Chicks Community: *It is not my job to convince you to take hormone therapy. It is my job to convince you that you are worth the effort of finding out what the benefits of hormone therapy might be for your current and future health.*

Note: Hormone therapy sits at the bottom of our inverted hormone health pyramid—not because of importance, but because we can't "skip" to hormone therapy, thinking it's a "quick fix" solution without working through the other key questions regarding lifestyle and sleep and stress management, possible nutritional requirements and thyroid health.

This year marks the 20th anniversary since the infamous 2002 Women's Health Initiative Study (WHI) came to an early, abrupt halt and declared hormone therapy dangerous. That headline graced the front page headlines of every news outlet. And almost every member of my community is familiar with or remembers this news at some level.

However, very few members are aware that poor research structure and poor dissemination of the study's findings in 2002 left women (and their health care providers) fearing the potential risks of hormone therapy without fully understanding all the benefits. And without fully understanding all the study's flaws and interpretation of risk.

Before this time, hormone therapy was regarded as the gold standard for women's midlife health. Then in 2002, the Women's Health Initiative (WHI) study was stopped three years early. Researchers had been studying *Premarin* and *Provera* (brand names for non-bioidentical hormone therapy; bioidentical hormone therapy was not studied) and determined they were dangerous.

What the headlines and researchers failed to tell us at the time was that women in the study ranged from age 50-71. Hence, the study's early results: propensity for blood clots, heart disease, stroke and breast cancer—should have been expected! Women in this age range are more susceptible to heart disease and breast cancer based on age alone!

The findings rocked the gynecological world leaving many physicians to discontinue the hormone therapy their patients had relied

on for decades. But the researchers did not allude to any flaws in the study (a public relations nightmare!), so the damage was done.

Ideally, the WHI wanted to enroll 250,000 50 year-old participants, give them randomized treatment vs. placebo, and follow their health for 30 years.

But it was impossible to recruit that many women willing to be part of this experiment for that long. They settled for half the desired participants, with two-thirds of participants already over the age of 60!

This flaw was never communicated with the "hormones cause breast cancer" headlines, and we are still living with the study's misconceptions today—even though in 2017, the North American Menopause Society (NAMS) released an updated positioning statement on hormone therapy declaring it safe when an individualized risk assessment is conducted.

Their guideline recommends women begin hormone therapy within 10 years of menopause (the 12-month anniversary of your final period) and before the age of 60. This is a guideline, not a deadline. And there is no universal guideline for how long a woman should remain on hormone therapy; these are decisions that need to be made on an individualized basis via consultation with your prescribing physician.

While the fallout from the WHI study debacle continues, women continue to fight through a maze of misinformation led by under-informed media, marketers and sometimes, a not-so-well informed medical community.

I want to include these facts—that you can discuss with your health care professional—and that will hopefully help you choose the hormone health protocol that is going to be right for you:

- Hormones are natural. And even though we've been conditioned to treat the word "hormones" like it's a swear word (*i.e. "She's so hormonal!"*), hormones are responsible for hundreds of critical jobs in our bodies. It's just that a woman's body was designed to live to 50. That means, essentially, we are asking our bodies to do those same important jobs for another three-to-five decades without all the same ingredients we had in our 20s, 30s and 40s.

- Hormone therapy is a prescription-based protocol designed to provide relief from disruptive symptoms, as well as serve as an investment in long-term health, by protecting the lining of our uterus, our brain health, our bone health and our vaginal health.

- Because every woman is at a different age and stage, and because our own hormones are constantly fluctuating, hormone therapy requires an individualized approach and the guidance of a hormone balance expert.

- This means that what is right for your friend may not be right for you. The type of hormone therapy, its length, dosage and mode of delivery will vary, requires regular monitoring and often requires tweaking.

I also want to offer a few suggestions for how to navigate any confusing or overwhelming health misinformation. Because it is unlikely to ever go away! The good news is that we can learn to be media-savvy health seekers to ensure we always have a clear understanding of the most up-to-date, reliable research.

- Check the date and source of any information you're consuming

- Don't use Google to fact-check *(even if the creator of the content appears to have done so!)*

- Please don't make any health decisions for you (or a loved one) based on headlines or hearsay.

- Always double-check with a reliable source, such as a member of your health team, for clarification, and then choose the journey right for you.

Hormone Therapy: The Basics

Hormone therapy is an umbrella term to describe all forms of hormone therapy. The birth control pill is a form of hormone therapy; so is the (Mirena) IUD. Tamoxifen, a treatment for breast cancer is also a form of

hormone therapy. And some men take hormone therapy too.

But the kind of hormone therapy we discuss the most is used to support women's health in midlife. The North American Menopause Society calls this Menopausal Hormonal Therapy or MHT.

When prescribing a hormone therapy protocol, your health professional (after conducting an individualized risk assessment) is going to consider three things:

1) What are the best hormone(s) for her age and stage (date since last period)?

2) What are the best dose(s) for her age and stage?

3) What is the mode of delivery that her body will absorb/metabolize/benefit from?

The type of hormones prescribed most often are progesterone and estrogen (there are three types of estrogen: estrone, estradiol and estriol.) Testosterone and DHEA may also be part of someone's protocol. Generally speaking, women in perimenopause may need progesterone but they are unlikely to need estrogen until postmenopause.

If a woman is prescribed estrogen therapy in postmenopause, estrogen cannot go unopposed, so if she has a uterus, she must also take progesterone. But as we have learned, progesterone has many other roles in addition to protecting the uterine lining, so a conversation about the benefits of progesterone—with or without a uterus—is recommended.

Here are some words that frequently confuse conversations about hormone therapy: bioidentical vs non-bioidentical, synthetic, natural, compounded, FDA-approved/Health Canada approved, and progestins vs. progesterone.

Bioidentical vs. non-bioidentical:

The best way to translate the word bioidentical is "body-identical." All hormones are manufactured in a lab, but bioidentical hormones have a molecular structure that's similar to the hormones our own body makes.

Bioidentical hormones are approved by the FDA/Health Canada. Bioidentical hormones that are made by a compounded pharmacy are not.

Synthetic vs natural:

Synthetic used to be the term given to non-bioidentical hormones; the ones used in the WHI study; hormones made from ingredients that are not similar to the hormones made by our own body. The reality is that all hormone therapy products are manufactured and therefore "synthetic," and natural should refer to the hormones women make on their own. I prefer to distinguish by referring to hormone therapy as either bioidentical vs. non-bioidentical.

Compounding:

Compounding is a term that means customizing; a compounding pharmacist can often re-mix a formula and customize it for their patient. Sometimes that means making a medication into a liquid or a gummy, many pet medications are compounded, and often compounding is chosen as an excellent route when a patient requires a specific dose. For example, if a medication only comes in 100 g capsules, and a doctor wants to prescribe 150 g, compounding the dose is a way to customize this protocol. Compounded therapies, due to their uniqueness, are not FDA/Health Canada approved.

Mode of delivery:

Mode of delivery describes how the therapy is administered: orally, transdermal through the skin, or vaginally. The prescribing physician might make this decision based on health research and which mode is more effective or has the safest profile. Or mode of delivery might be discussed as it relates to patient response or compliance.

Hormone Therapy: What about testing?

Testing is a tool that an individual and her health team have available to them to make strong health decisions.

Some practitioners will lean towards a "no need for testing hormones" stance because a) they know testing is only a snapshot in time and hormones are constantly fluctuating (especially in perimenopause and b) they can tell that estrogen, for example, is high(er) and progesterone is low(er) based on their patients presenting symptoms, age and date of her last period.

Some individuals might love testing because they love data and information and it helps them feel empowered as they navigate their health.

Both practitioners and patients can benefit from all testing as tests can: a) confirm or deny a hypothesis i.e. "I wonder if your headaches are from low progesterone or low iron?" Testing will show some insights and b) could uncover something that didn't come up during conversation—which is common, especially if the appointment time is short.

Review

Review. Review. Review.

So many of us are in search of a magic wand or a "one and done" solution, which I understand, but health, women's health and most definitely hormone health does not work that way.

In the case of hormone therapy, make sure you schedule a review appointment with your prescribing physician to discuss both your positive (and any negative) experiences. Tweaks and adjustments are often required. This is important as the only intended side effect of hormone therapy is for you to feel amazing!

Chapter six:
What Women Want to Know

Menopause Chicks research continues to show that 77% of women have questions about their health—sometimes we learn by asking direct questions such as "What is my best option for preventing vaginal dryness?"

Other times, we learn through storytelling. See Chapter 7 for a selection of popular case studies as presented by some of my co-authors in *Mokita: How to navigate perimenopause with confidence and ease.*

In this chapter, I've curated some of the top topics women want to know. While this list is not exhaustive, it does include many of the most popular conversations occurring in the MenopauseChicksCommunity.com on a regular basis.

Perhaps these topics/questions are similar to some of the questions you have about your own health?

Birth Control

Melanie asks :

> I'm recently divorced and I find myself researching birth control methods for the first time in decades. I'm 48, in perimenopause and my periods are still fairly regular.

> How long will I continue to need birth control? What are my options? And where is the course for birth control for the midlife woman?

There is definitely a gap in quality birth control education for women of all ages. There is a tendency to focus birth control messaging on younger women, leaving those of us who are navigating perimenopause-to-menopause (& beyond!) with many of the same questions you have. You are not alone.

How long you require birth control

Ask any woman about the benefits of post-menopause, and you are most likely going to hear: no more worries about becoming pregnant.

But what about women in perimenopause? There is quite a bit of confusion around contraception for women who have passed the family planning stage of life, but not yet reached menopause.

I frequently receive questions such as *"How do I know if I have reached menopause?"* and the answer is: **it doesn't *really* matter UNLESS you are making decisions about birth control!** Every woman needs to know she can still become pregnant in perimenopause, and birth control is necessary.

What the experts recommend

To be clear, when it comes to preventing pregnancy, you are the expert on your own body. Few women 45 and up are interested in becoming pregnant. And their doctors are especially wary of dealing with unplanned pregnancies. That is why the International Menopause Society recommends that if you are over 50 when you reach menopause, you should continue using protection for one year and if you are under 50 when you reach menopause, continue using protection for two years.

Birth control options: some old; some new

There have not been that many new developments in birth control options for women since the pill made its debut in 1960. To answer

your question, here is an overview of some of your current options (best discussed with your health care professional so you can choose the option that is best for you):

Non-hormone birth control:

- **Vasectomy:** This is my personal favourite, and I realize it is not an option for everyone, especially women starting new relationships. Con: Doesn't protect from sexually transmitted infections (STIs).
- **Condom:** Covers the STI concern and can be used in combination with other methods. When using a lubricant, choose water-based as oil-based may cause latex condoms to break.
- **Non-hormonal vaginal gel:** Evofem BioSciences recently introduced a new "on-demand" form of birth control called *phexxi*. It's a hormone-free, prescription gel known as a vaginal pH modulator. And it prevents pregnancy by maintaining a woman's natural vaginal pH within the normal range of 3.5 - 4.5 which is an acidic environment that is not hospitable to sperm. Similar to condoms, it is designed to be used in-the-moment, but it can be administered up to one hour before intercourse.

Hormone birth control:

- **Birth-control pill:** Probably the most common choice, the birth control pill is a form of hormone therapy used by three-quarters of Canadian women at some point in their lives between ages 15 and 49 to prevent pregnancy. Advice as to whether the pill is right for you if you are over 49 is going to vary depending on your overall health, if you are a smoker/non-smoker and best left to an individualized conversation between you and your health care provider.

Both:

- **IUD:** Stands for "intauterine device." It's a "T-shaped" copper wire that fits inside your uterus and prevents sperm from reaching any egg. An IUD can contain non-bioidentical hormones or be hormone-free. Some women find that a hormone-based IUD in perimenopause (the *Mirena* is popular) helps manage heavy bleeding.

How to decide what's right for you

It's a personal decision. Make a checklist before discussing with your health care team. It's important to first decide where your personal values and preferences lie so you are prepared to either ask for what you want, or to say "no thanks, that won't work for me." For example:

- Am I at risk of getting pregnant?
- Do I need protection from STIs?
- Have I reached menopause?
- Am I under 50 or over 50?
- Am I seeking short-term protection or a longer-term strategy?
- What is best for me at this point in my life—hormone-based or hormone-free?

It's important to note that some practitioners look to the hormone birth control options as ways to manage hormone imbalance during perimenopause, regulate periods, or manage acne. Personally, I'm not a fan of this approach—especially if you don't need birth control protection or the pill is not already your preferred contraception method.

The pill, for example, is a uniform dose of non-bioidentical hormones—whereas a woman's natural hormones are fluctuating (sometimes wildly!) in perimenopause. It's rarely a perfect or personalized match. Women should also be sure to weigh all the pros and cons of

their decision and be aware that the birth control pill is known to cause vaginal dryness (how ironic!) and deplete women's bodies of some essential nutrients, especially vitamin B.

Bleeding/Heavy Bleeding

Heavy bleeding is the most common experience of perimenopause. And the least talked about.

This leaves women waiting for hot flashes (because that's pretty much all media, marketers and the medical community talk about) while waking up in their mid-to-late 40s or early 50s surprised by heavy (and/or irregular) bleeding and immediately assuming something is seriously wrong.

While it is true that many women will experience hot flashes as a result of fluctuating hormones in the final year of perimenopause (the 12 period-free months leading up to menopause,) **the most common perimenopause experience is irregular bleeding.**

When women are unaware of this probable change, it causes concern. Women sometimes believe they have a serious health condition, like cancer, or head to the emergency room.

Perimenopause is defined by age and hormone fluctuations. It is a time in a woman's life when her body is preparing for menopause. Generally speaking, in perimenopause, the ratio of estrogen-to-progesterone can become further apart than when our cycles were regular; estrogen can be high and progesterone low. When this happens, the first change women might notice is changes to their monthly periods. Sometimes periods get heavier, lighter, shorter, less predictable or more frequent.

What's interesting is that this is a common experience, but it isn't commonly talked about. In fact, according to the International Menopause Society, 70% of gynecological visits are due to heavy bleeding.

I am not saying don't consult your health team to discuss any concerns regarding bleeding. In fact, that is the best thing to do—if for no other reason than to rule out something serious!

I am saying conversations about irregular bleeding are important to

raise more awareness about perimenopause so that women might be less worried, more prepared and know what to expect.

Most women don't know what a "normal" period bleed should be. The most common amount of menstrual flow is about 1-2 Tbsp (15-30mL) per period, and a period that lasts 4-6 days.

- For reference, each soaked sanitary product (tampon or pad) contains about 5mL (1 tsp) of blood.
- That means it is common to soak 2 to 7 normal-sized sanitary products per period (not per day!)
- A "heavy period", which in medical terms is called "menorrhagia", is defined as more than 80mL menstrual blood lost per period. This is the equivalent of 16 soaked sanitary products (tampons or pads) per period, or a period that lasts longer than 7 days.

Three important things to know:

1) **The Ibuprofen Protocol:** Dr. Jerilynn Prior of the Centre for Menstrual Cycle and Ovulation Research in Vancouver, advises women with heavy flow to keep track of their experience, to **take ibuprofen (200 mg every 4-6 hours which decreases flow by 25-30%)**, to treat blood loss with extra fluid and salt and to increase iron-rich foods, or take a high-quality iron supplement, like Ferapro. Ibuprofen doesn't address the root cause of heavy bleeding, but it can help to manage especially if you are at work or travelling.

2) **There are more ways to manage heavy bleeding than the birth control pill!** Speak with a hormone balance expert about the benefits of progesterone therapy.

3) **Consult your physician regarding any concerns about bleeding--if for no other reason than to rule out other**

serious health concerns. This includes:

- when bleeding is so heavy it requires a new pad every hour,
- bleeding that lasts more than two weeks,
- any bleeding after menopause (12 months after your final period.)

Brain Fog/Difficulty Concentrating

Suffering from brain fog or lack of concentration is common. But that doesn't mean it needs to be chronic.

Over time persistent brain fog can negatively impact social, family, school and work life. In most cases, a natural and integrative approach to health and wellness works to improve concentration and minimize brain fog.

What is brain fog?

While brain fog has yet to be fully recognized as an official medical condition, it is a common and persistent problem experienced by many. Brain fog is described as a clouding of the consciousness or a mental dampening.

It is a persistent inability to think clearly and affects people of all ages. This mental fatigue may develop over time or may arise quite suddenly following a life event, such as a heart attack or highly stressful time period.

Brain fog can be best described as:

- Lack of focus
- Lack of ability to concentrate
- Poor memory recall
- Reduced mental acuity
- Inability to perform basic mental tasks

- Lack of clarity
- Forgetfulness

Factors that influence brain fog are interrelated. When one factor is present it is likely to stem from, and may also contribute to, other factors. For example: stress can lead to poor eating habits which can lead to iron deficiency which leads to brain fog. Or: fluctuating progesterone in perimenopause can lead to sleep disruption which leads to brain fog.

Ultimately, the brain does not get the nutrients required. This damages the brain cells and neurons, resulting in reduced mental functioning.

Other factors may include:

- Poor circulation
- Antioxidant activity
- Lack of sleep
- Nutritional deficiencies
- Food sensitivities
- Biochemical imbalances
- Neurological diseases
- Stress
- Hormone imbalance during perimenopause-to-menopause (& beyond)
- Diabetes
- Toxic metals
- Digestion

There are many natural remedies that can help to regain mental

stamina. Here are a few to ask your health care provider about:

Omega-3 Fatty Acids – In particular, fish oil supplements help in cognitive impairment by slowing brain shrinkage and even increasing brain volume. They also decrease inflammation, which can be a leading cause of brain fog.

Magnesium Bisglycinate – Increasing magnesium intake works to alleviate brain fog by balancing copper, which in abundance contributes to feelings of fogginess. It is also important for proper nerve functioning and for neutralizing stomach acid, both of which play a role in brain fog.

Iron – Iron transfers oxygen within the blood, regulates metabolism, and is needed to synthesize brain chemicals. It is a significant factor in cognitive performance, especially among women, who also happen to suffer more from iron deficiency.

Vitamin B12 – Arguably, B12 is one of the most important vitamins when it comes to alleviating brain fog. It protects the brain and nervous system, promotes a healthy immune system, regulates sleep, produces energy, and slows cognitive decline. B12 on its own, or as part of a B-Complex vitamin supplement, can improve concentration and mental clarity.

Maintaining optimum brain function involves taking a comprehensive an integrative approach to health. Balancing good health practices with natural supplements can help to alleviate brain fog, but please be sure to speak with a nutritional expert before starting on a supplement plan.

Dry Skin, Itchy Skin & Other Skin Changes

"What used to work is no longer working!"

This is a common sentiment—particularly when it comes to skin health. Members will often share that the products they used to use on their skin no longer have the same benefits.

This makes sense when we take into consideration our age and stage of hormone fluctuation or decline.

When it comes to dryness, introduce hyaluronic acid into your routine. Hyaluronic acid is a naturally-occurring, super-strong molecule

produced by our own body, but it starts to decline in our 30s and 40s and then more dramatically postmenopause. Around 2003, hyaluronic acid began to be included in beauty and skincare products because our skin loves it and misses it!

Itchiness (sometimes extreme!) is reported often by women in perimenopause. I invite you to get curious about this with your health team—because the itchiness might be related to hormone fluctuations, but it could also have other causes—so it's worth investigating!

The same thing can be said about other new/noticeable changes to your skin—such as acne or rosacea: find a health care professional who will work with you to find and treat the root cause.

As for your regular skin care routine—understand that this is a good time to review your current products and switch to ingredients your skin now needs in perimenopause or postmenopause (the Neovadiol products by Vichy.ca, for example)....and remember hyaluronic acid... and sunscreen!

Hot Flashes

Even though I want to write the world a big, giant memo stating that hot flashes are indeed NOT the hallmark sign of menopause.

Even though some members of the medical community continue to think they can placate women with reminders to dress in layers (p.s. we're smart enough to figure this out on our own, thank you.)

And even though, google searches for perimenopause and menopause continue to only depict midlife as gray-haired women holding fans...learning about hot flashes and night sweats is very important to our health.

The most common and most talked about experience of perimenopause, menopause, and postmenopause continues to be hot flashes and night sweats. There are a couple reasons for this.

First—hot flashes, in many ways, are the only "visible" symptom of hormone imbalance. (Other disruptive symptoms—such as irregular bleeding, mood swings and sleep disruption—may get less airtime because they are "invisible" and under-discussed.)

There are a number of hormone therapy products, approved by the FDA/Health Canada for the treatment of hot flashes aka vasomotor symptoms. The ones that include estrogen are primarily for women postmenopause.

Endocrinologist & BC researcher, Dr. Jerilynn Prior, has been studying hot flashes and night sweats in perimenopause for decades, and she has specifically highlighted the success of progesterone therapy (oral micronized progesterone/Prometrium is the brand name) on hot flashes, as the majority of women, if they experience hot flashes, do so in the final year of perimenopause. (A smaller percentage continue to experience for longer if they do not choose a hormone therapy protocol.)

Dr. Prior is quick to also include recommendations for anything that decreases stress! She believes that any hot flashes/night sweats that impact your sleep should be treated. But during the day, she also recommends what is called "paced breathing," which is a kind of meditation or relaxation therapy that uses slow, deep, controlled breathing. Sit in a quiet place with your body relaxed and your eyes closed, and first become aware of your breathing.

Then slowly take a deep breath in, and equally slowly let it out. You might count as you breathe in, perhaps up to ten. Let your breath out without any effort, say to a count of five or six. Focus on your breath and nothing else.

Alternate methods of relaxation are to sit in the same quiet place and relaxed manner, and to visualize yourself in the most calm, secure, and lovely place you can imagine. If you practice, you will be able to smell the air, feel the breeze on your face, and see the whole full-colour environment. For these relaxation and breathing methods to be effective, you will need to do them for ten to twenty minutes twice a day. One good time to do this is just before going to sleep. If you practice, you will be able to capture the same calm in the middle of a busy day.

For more information, please visit Dr. Prior's website at The Centre for Menstrual Cycle and Ovulation Research (CeMCOR.ubc.ca). CeMCOR is not-for-profit and relies on donations to carry out critical research on women's health.

Hair Loss

Before you assume that hair loss is something you have to endure, know this:

The top two reasons for hair loss are iron deficiency and thyroid imbalance (and adequate iron levels are required to produce optimal thyroid!)

Get curious about your ferritin level and request a full thyroid panel so you can address with solutions with our health team.

Please spread the word on this because it's overwhelmingly sad to think of how many women might be suffering and think (or have been told) they have to put up with it.

See chapter five for more insights into both iron and thyroid health.

Sexual Desire

Reduced interest in sex or fewer sexual thoughts are two examples of low sexual desire—a term used to describe something one in three women experience at some point in their life.

The culprit? Often it's stress.

That's according to a recent initiative from the University of British Columbia (UBC) Sexual Health Lab, where a team of researchers studied women's sexual desire, the impact that mindfulness can have on sexual desire and then turned to social media to raise awareness and debunk myths.

The objective is to share quality resources and to help women understand they are not alone, and that there are solutions for those who want to increase desire and sexual enjoyment, or simply to give their love life a boost.

I sat down with Dr. Lori Brotto who leads the UBC Sexual Health Lab, and asked her to help explain sexual desire.

What is the difference between "libido" and "sexual desire"?

Dr. Brotto: Libido is an older, somewhat outdated term—it implies that sexual desire is an "either/or" equation; something you have or you don't, something you could lose. I prefer the term **sexual desire** because the truth is, desire is a sliding scale—just like happiness or sadness. Some days you might be a 3 and other days you could be a 9.

What does a woman mean then, when she says "I have no libido... ummm...I mean low sexual desire?"

Dr. Brotto: Up to 40% of women may experience low sexual desire at some point in their life—at any age. A woman who has low desire might describe her experiences as: reduced interest, no sexual thoughts, reduced pleasure, things that used to trigger desire no longer work, or just plain avoiding. **Sexual desire is different for everyone. It's not an on-off switch like some people may think. It's more of a sliding scale; something that can come and go, similar to happiness or sadness.**

What types of things impact sexual desire?

Dr. Brotto: We know life's stressors can significantly impact a woman's sexual desire. This can show up as a result of many things including relationship challenges, fatigue, mood changes—even financial worries. Women told us they often have trouble turning off the many to-do lists running through their heads.

Stress—it is the root cause of so many things!

Dr. Brotto: Yes, stress triggers a cascade of hormonal reactions to help our body and mind adapt to perceived threats. The more this happens, the less effective the body is at responding. So, the more chronic the stress, the harder it is for the body and mind to adapt to it. As it turns out, this can impact different hormones in the brain and body, resulting in a decrease in sexual desire.

What do you want women to know about sexual desire?

Dr. Brotto: Oh, so many things! Sexual desire is different for everyone but if I had to pick one thing, I would say I want women to know they can't multi-task sexual thoughts with making grocery lists! Also, it's very important to me that every woman gets this message: low sexual desire does not mean something is wrong, or that you are broken!

Lower desire is sometimes associated with hormone fluctuations in perimenopause and postmenopause, but women of all ages can experience fluctuating sexual desire.

However, most women with sexual concerns will never speak to a healthcare provider.

Instead, they go online or help. We created the DebunkingDesire.com campaign for that reason--because social media/online media plays an important role in sharing quality health information and empowering women to have more informed conversations with their doctors, partners and each other.

And finally, I want to tell women this: you are not alone, and there are proven strategies you can work on, on your own, to increase desire.

Do you mean better sex through mindfulness? Suddenly I have a reason to meditate!

Dr. Brotto: Exactly! Our research over the last 15 years has shown that mindfulness practices are one of the most effective ways for women to manage their overall stress, and positively improve sexual desire and arousal.

You might have heard this and immediately imagined formal meditation.

But mindfulness can be defined, quite simply, as present moment, non- judgmental awareness. It involves the practice of moving one's attention to the here-and-now and focusing on sensations of the body and breath.

For some, this might be a walk in the woods or a bath or simply stepping away from their desk and taking a few deep, long breaths.

It is well known that women can be quite judgmental of themselves, especially when it comes to sex. Mindfulness is a skill that helps women to be less judgmental, to observe sensations as they arise, and accept them for what they are.

We have found mindfulness practices help women to be more present during sexual activity, and ultimately to have improved sexual desire and arousal.

Sexual desire waxes and wanes over the years, over months, and even over days. Sexual desire is "responsive" just like other emotions. We feel happy when good things happen in our lives or we think, see, or do something that elicits happiness. Sexual desire works in much the same way in that it is responsive to triggers. We feel sexual desire when something triggers a sexual response and those triggers might include: seeing an attractive partner, feeling sexually aroused in your body, having an erotic thought or sexual memory, or being touched in a way that feels good. Sometimes there may be no triggers that elicit sexual desire in our environment, or we may have distractions and preoccupations that get in the way of responding to triggers. For women across ages and reproductive stages, ups and downs in sexual desire can be entirely normal.

Many people believe that there is a 1:1 relationship between how much you love a partner and how good your sex is. Sometimes very happy and compatible couples experience sexual problems, and sometimes incompatible partners or conflicted relationships have great sex.

For many women, managing stress is key to improving their sexual desire. A myriad of studies have shown the strong link between chronic stress and sexual dysfunction in women, and stress can interfere with both emotional functioning and also thought patterns to decrease a woman's motivation for sex. And it turns out that mindfulness meditation is one of the most effective ways of managing stress, and in turn, improving sexual desire.

Sex drive, or sexual appetite, is not the same for everyone. It can be difficult to determine what your "normal" is because we are constantly bombarded with messages that tell us we should be wanting sex all the

time, no matter the circumstance. But the reality is what your friends, partner, or the media view as a "normal" level of sex might not be "normal" for you, your lifestyle, or your relationship and there is nothing wrong with that.

Sexual pleasure is the physical and/or psychological satisfaction and enjoyment from sexual experiences. This can be through partnered or solo sexual activities, and can include thoughts, fantasies, dreams, emotions, and feelings.

The goal for DebunkingDesire.com is to share evidence-based information about low sexual desire in women to create and amplify lasting dialogues with women, their partners, their health care providers, and the media.

Chapter seven:
Case Studies

Learning through the experience of others:

Case Study: Kathy, 42

Kathy worked with a medical doctor who is a hormone expert and certified by the North American Menopause Society

I met Kathy when she was forty-two. She was a successful realtor who also supported her husband with his busy renovation business. A high achiever with a remarkable ability to "cope" with whatever life threw her way, Kathy arrived in my office almost at wit's end. She complained of being irritable and experiencing unmanageable, angry outbursts towards her kids and her husband. She had noted in her calendar that the outbursts seemed to be much worse ten to fourteen days before her period. Kathy was also experiencing night sweats a couple of days before her period but didn't think too much of it, even though it was interrupting her sleep. She told me she was having headaches for the first time in her life, and her period was heavier than it used to be.

I asked Kathy a series of lifestyle questions and learned she smoked ten to fifteen cigarettes a day and usually drank three cups of coffee each morning. She exercised occasionally but found it hard to squeeze in amongst her stressful and demanding job and her kids' schedules.

Kathy came to see me because her sister suggested she may be feeling this way due to fluctuating hormones. Her first question was whether or not she is too young for perimenopause.

I explained the common roller coaster ride also known as perimenopause; how estrogen peaks, but that sometimes progesterone can't keep up with it.

As a result, women often experience breast tenderness, cramping, and PMS in the luteal phase (last two weeks of her cycle). I also explain that some women will experience a more severe roller coaster if they have a poor lifestyle.

In Kathy's case, we did not immediately jump to hormone therapy. Instead, we chatted about the benefits of stress management and exercise and the downsides of sleep deprivation and smoking. I encouraged her to try taking melatonin and reducing her sugar, caffeine, and alcohol intake as well as her smoking. We decided to test her hormones, including her cortisol.

When the tests came back, her cortisol was very high, her progesterone was very low, and her estrogen was quite dominant (as was also evidenced by her sore breasts, heavy period, and clotting). I shared her test results with her, which showed Kathy was "tired-yet-wired."

I explained how she is wired because her stress is so dominant that it's pushing on her cortisol pathways. As a result, her adrenal glands can't keep up with the demand, so they are starting to steal progesterone from her ovaries to compensate.

Our goal was to get Kathy's hormone "symphony" under control. My first recommendation was to try taking evening primrose oil, vitamin B, and magnesium, but this wasn't enough to right Kathy's ship. We added progesterone for the last two weeks of her cycle, and Kathy reported back that this helped immensely.

I wanted Kathy to understand that she didn't have to quit her job, but that her stress hormones were at their maximum. We discussed self-care, relaxation techniques, and ways to set boundaries.

When I saw Kathy three months later, her situation had improved significantly. She had had a heart-to-heart with her husband and her

teenagers. Her PMS was better, and she was down to three cigarettes per day. The progesterone therapy was helping with her bleeding and she was no longer anemic.

Case Study: Anna, 54

Anna worked with a medical doctor certified by the North American Menopause Society

I met Anna when she was fifty-four and running her own wellness centre. Her last period was three years go. Her family doctor had prescribed oral Estrace, which is a natural, bioidentical estrogen, but she had stopped taking it due to the conflicting controversies she had heard about hormone therapy in the media.

Since then, she had tried herbal remedies, black cohosh, and acupuncture. Her primary ongoing complaints were foggy brain, insomnia, pelvic pain, vaginal dryness, and bleeding with intercourse. Anxiety and hot flashes had also started to make an appearance, and she felt that her quality of life was dropping.

Anna was under a lot of stress. Her aging mom wasn't well, her marriage had dissolved recently, and her son had been managing his mental illness poorly.

Anna was at a healthy weight, didn't smoke, drank three to four glasses of wine per week to help her relax, and exercised and practiced yoga daily. She had a family history of osteoporosis, and her risk for heart disease was high. She was already wary of hormone therapy before we began.

We performed some testing, along with a thorough risk assessment. Her tests showed her estrogen and progesterone were both low, while her FSH was very high. DHEA was low. Testosterone was low. Cortisol was low.

Anna's lifestyle was good. She could maybe reduce the amount of wine she was drinking, but her blood pressure was good, as was her cholesterol and stress management. Her estrogen ratio quotient was also pretty good, which is an important part of any risk assessment for breast cancer.

I explained her risk assessment, as well as the most current research on hormone therapy, and recommended to Anna that she might benefit

from hormone therapy. I performed a complete physical and sent her for a mammogram. I recommended that she take estrogen transdermally. I prescribed bioidentical estrogen, Prometrium (the brand name for oral micronized progesterone) at bedtime, and some compounded estriol vaginal cream to address her vaginal dryness and recommended she also moisturize her vulva and vagina with hyaluronic acid. We stressed the importance of vitamin D and calcium in her diet as well as resistance straining to keep her bones strong. We also ordered a bone density test.

When I saw Anna three months later, her hot flashes had diminished, she was sleeping better, her brain fog had cleared, and her vaginal dryness had improved significantly. She no longer had pain with penetrative sex, and she was starting a new relationship. When I asked her how she felt and what she thought of her current health plan, she said that the speed at which her symptoms improved was much faster than she thought it would be. Anna was very grateful that we were taking steps to prevent osteoporosis, continued on her hormones safely and enjoys an excellent quality of life.

Case Study: Gayle, 53

Gayle worked with a Registered Acupuncturist (and later with a naturopathic physician)

Gayle is fifty-three and works in a high-stress environment as a legal assistant. When I meet her, I quickly realize she doesn't like to talk about her work whatsoever. She is bothered by hot flashes and sleep deprivation. Gayle had a hysterectomy when she was forty-nine; she isn't taking any hormone therapy and indicated that her doctor didn't even discuss with her what her quality of life might be like post-operation. A work friend recommended acupuncture to her, and that is how she found me.

My recommendations included acupuncture treatments twice weekly for two weeks because she was in an acute state of stress. My first priority is to see if we can restore Gayle's sleep, but I know hot flash reduction is also important as hot flashes are impacting her ability to do her job and function normally. I learn that Gayle has already started magnesium, lavender oil capsules and apple cider vinegar to help manage her blood sugar.

Given that Gayle was 53 and had had a hysterectomy, I wanted to ensure she had a plan for investing in her health for the next few decades. While we continued treatment, I recommended a local hormone expert so Gayle could get curious about the potential benefits of hormone therapy for her.

After a few weeks, Gayle told me her work stress is still there, but her sleep was improving and her hot flashes had all but disappeared. The most surprising part? She was not only enjoying the after-benefits of acupuncture, she was also really enjoying the in-treatment time itself. She told me she was actually scheduling "me time." She had never imagined that something like acupuncture, which involved the insertion of fine needles and took her away from her hectic schedule, would be so relaxing and meditative!

Case Study: Elizabeth, 41

Elizabeth worked with a naturopathic physician whose practice focuses on women's hormone health

When I meet Elizabeth, she is forty-one and her primary concerns include heavy periods, more pronounced PMS, fatigue, difficulty sleeping, stress and anxiety, and low libido.

As usual, I perform a comprehensive medical intake, order bloodwork, and we discuss the opportunity for hormone testing. Hormone testing is not always required for treatment, but it can be helpful—especially as an opportunity to highlight any underlying conditions or surprises. For her blood work, I am looking at her vitamin B12 and iron levels, her thyroid profile, and a marker for hemoglobin A1C (blood sugar).

What we learned was that Elizabeth's iron was low, while her blood sugar and her vitamin B12 levels were fine. Her thyroid profile was not too bad, but her cortisol was low during the day and spiking at night—which is the opposite of what is should be.

We learned her progesterone-to-estrogen ratio was low, which is common in perimenopause and is usually responsible for heavier periods and more severe PMS.

My recommendations included taking an iron supplement and including more iron-rich foods in her diet. I also performed lifestyle counselling for cortisol management. This includes carving out more time for herself, eating regularly, following a Mediterranean diet, moving more, and ensuring she incorporates the things she loves and is passionate about into her life.

To improve her progesterone-to-estrogen ratio, I recommended cyclical progesterone (oral, before bed) on the days when she gets her period. This is used to slow down the menstrual cycle and will help with sleep. For her adrenal function, we talk about lifestyle tweaks, exercise, and herbs to improve cortisol levels and help the body cope with stress. These include rhodiola, ginseng (which she takes in the morning) and

magnolia bark (which she takes at night). For her heavy periods, I also recommend a tincture to take during her period that contains cinnamon essential oil, which helps to curb the heavy bleeding.

Since her thyroid was borderline, I chose not to treat this right away. This can be caused by adrenal fatigue, which she has, so if we opt to treat the adrenals first, it may not be necessary to treat the thyroid.

Case Study: Jayne, 53

Jayne worked with a naturopathic physician

Jayne is fifty-three, and she is in postmenopause. It's been a year and a half since her last period, and she didn't seek any support during perimenopause. This is common with many women—they often don't seek help until the hot flashes get really bad and/or vaginal dryness begins to significantly impact quality of life, and then they are really motivated to find solutions.

Jayne is experiencing ten to twelve hot flashes during the day, and she is only getting two to three hours of sleep per night. Overall, she is not feeling well, either mentally or physically.

She has vaginal dryness and pain with intercourse. Not surprisingly, her libido is also low.

Jayne describes her thinking as "foggier than it used to be," and she is experiencing more stress and anxiety than normal. She says her energy level is low, and she knows that her issues with sleeping are likely contributing to her general feeling of not being at the top of her game; it's impacting her ability to cope at work and exercise the following day.

Together, we decide to look at her four-point cortisol and test her estrogen, progesterone, and testosterone levels, along with her thyroid, iron, blood sugar, vitamin B12, and cholesterol.

We learn from Jayne's blood work that her iron levels are okay, as are her vitamin B12 and thyroid function. Her blood sugar and cholesterol levels are borderline. We are not surprised to learn ger estrogen and progesterone levels are low, and her testosterone level is low to normal, given where she is at in postmenopause. Her cortisol doesn't look too bad—it's within the reference range, but on the low side of normal.

To help Jayne improve her quality of life, I gave her information around diet for management of her cholesterol and blood sugar. I go over the benefits of a Mediterranean diet with a lower carbohydrate option. I suggest eliminating refined carbohydrates and give her a handout that explains her options. We discuss wine, and my suggestion is that limiting

wine is always a good idea. However, if Jayne is going to have wine, I advise that it is better to have one glass per day rather than saving it all up for the weekend. I also recommend more exercise and regular movement to offset Jayne's mostly sedentary lifestyle and recent weight gain.

To address her foggy thinking, we introduce an omega-3 fatty acid. We often see good changes with lifestyle tweaks alone; however, omega-3 has so many other benefits, including managing things like anxiety and inability to concentrate, that I still choose to recommend it. For cortisol management, I offer Jayne a choice of either lifestyle tweaks and a herbal remedy, or lifestyle tweaks and IV nutrient therapy. Herbal remedies include rhodiola, ginseng, licorice root, and withania, which she would take daily for three to six months. IV nutrient therapy is another option that would include receiving weekly treatments for four to six weeks.

We discuss her options for low estrogen and progesterone. Because Jayne is a healthy, symptomatic woman in her early fifties with no apparent health history or health risks for breast cancer, heart disease, or blood clotting, we talk about bioidentical hormone therapy and decide to pursue it. I prescribe Bi-est, which is a bioidentical estrogen cream containing estradiol and estriol, and we combine this with an oral micronized progesterone to take before bed and prescribed to address Jayne's hot flashes and to support her sleep. For vaginal dryness, Jayne is going to moisturize with hyaluronic acid and we will review at her next appointment. If she needs localized estrogen therapy down the road, we will add that to her protocol upon review.

Case Study: Rebecca, 53

Rebecca sought health guidance from pharmacist, Bob Mehr

Rebecca is fifty-three, and she walked into my pharmacy back in 2015 with symptoms of fatigue, low energy, hair loss, feeling cold, weak and brittle nails, and brain fog.

Many of these symptoms can be indicative of low thyroid function or hypothyroidism, and some of the symptoms can also be related to hormone changes in perimenopause or postmenopause. But the most common thing I see in women who walk through our pharmacies on daily basis is iron deficiency.

Many people don't understand the connection between iron and thyroid health, but optimal iron is required to produce optimal thyroid hormone!

Testing iron levels is one of the most common tests doctors run, and they do so by looking at ferritin levels (a measure of iron stores in your body). The normal reference range for ferritin is anywhere from 10-291 ng/mL for women (yes, it's a wide range!) Most often, if women are not clinically anemic and their ferritin is within a lab's reference range, doctors won't be alerted to abnormal/low ferritin levels. However, recent studies show that women have improved energy and feel best with ferritin levels that are greater than 60 ng/mL.

To say this another way—you can experience symptoms of iron deficiency such as hair loss, fatique, depression and brain fog (25-55 ng/mL)—without being diagnosed as anemic (below 22 ng/mL.)

With this in mind, the first thing I asked Rebecca to do was to ask her doctor to check her ferritin level and her thyroid function. A week later, she came back and told me that her doctor said her ferritin level was 7 ng/mL, and she urgently needed to start iron supplementation. Her tests showed her thyroid was also low, and she was given a prescription for thyroid medication.

A common issue with iron supplementation is that it can cause a lot of stomach irritation and constipation, which will lead some women

to skip doses or stop taking it entirely. However, there are some iron supplements which are easier on the stomach and do not cause too much constipation. I gave her one of my own formulations (Ferapro; formerly Bob's Iron) which I developed back in 2001 because it is easy on the stomach, doesn't cause constipation, and has a very low side effect profile while still delivering enough elemental iron to bring ferritin levels up. She started taking one capsule every morning.

Within three weeks, Rebecca came back to report she was feeling great again, her energy level was much better, and she had noticed her hair was not falling out as much. She continued taking the iron for another six months, and eventually her ferritin level went up to 65 ng/mL. At that point, the recommendation for her was to continue checking her ferritin level every six months to ensure she was getting enough iron, and to monitor her thyroid function.

Chapter eight:
Why Is This So Important?

This is important because it's about you.
This is important because it's about your health.
It's about taking care of your health now.
And, it's about investing in your future health.
This approach to women's health is like the Chinese proverb:
When is the best time to plant a tree?
100 years ago.
When is the second- best time to plant a tree?
Today!

I believe this approach is the opposite of how most of us grew up thinking about menopause and women's midlife health; many of us were led to believe that either we should expect discomfort, or that if we experienced any adverse health experience, our doctor would know what to do.

I am writing this to tell you (again!) that you are not meant to suffer.

And there is no guarantee that your current doctor is trained in women's midlife hormone health (but there are many educated, experienced hormone health experts who can support you!)

That said, the majority of medical professionals are familiar with the glaring statistics facing the future of women's health—things like:

- Heart disease and stroke being the #1 reason for premature

death in women

- The prediction is that 1-in-3 of us will break a bone due to osteoporosis
- More women than men will be diagnosed with Alzheimer's and dementia
- The disposable incontinence pad market is expected to be $16 US billion by 2025 with the majority of their marketing budget aimed at women
- Reoccurring UTIs (urinary tract infections) account for more than 8 million doctor visits per year
- Over 80% of us will experience vulva and vaginal dryness in postmenopause, yet less than 4% of us are currently receiving a solution

So, thank you for reading this far. I want you to consider this book your invitation to do two things: take care of your health now AND invest in your future heart, brain, bone and vaginal/pelvic health. It's time to develop our investment strategy!

Heart Health

Our risk of dying from heart disease is seven times higher than dying from breast cancer.

I hope this statistic takes you back to the pyramid in chapter five to review what you can do to prioritize your heart health starting today.

Please consider how you eat, move, sleep and manage stress, any missing nutritional support—and have a conversation with your health team about your heart health goals. Review your risk factors (for example, a woman's risk of cardiovascular disease may be higher if she has a history of endometriosis, polycystic ovarian syndrome, gestational diabetes or high blood pressure in pregnancy.)

And also—if you can embrace one more paradigm shift—make it

that you decide to stop thinking of hot flashes, night sweats or other symptoms of hormone fluctuations as a nuisance—and start regarding them as a friendly "tap on the shoulder"; an invitation from your body that it needs something. And then respond with an informed plan for your heart health.

Answering this invitation is one of the ways we are going to decrease some of the glaring statistics women face in our next 50 years.

Bone Health

If you think that getting women excited to have more conversations about menopause is challenging, try getting women excited to talk about their bone health.

We need more awareness of osteoporosis, and osteoporosis prevention, because the statistics are staggering. But even more frightening are the unmeasurable impacts to a woman's health and her family/caregivers if she falls and breaks a bone—which could lead to lack of mobility, loss of independence, dementia and more.

Here are a few bone-related thoughts to consider:

- We reach our peak bone mass in our 20s
- The earlier you reach menopause, the higher the risk of fracture. So if you are wishing your period away but it's still sticking around, know there are benefits to your bones!
- Alcohol affects our bone mass and fracture risk
- Quit smoking
- Focus on strength-building and balance exercises and do whatever you can to avoid falling
- Things to review with your doctor:
    - Any current health conditions: arthritis, diabetes, thyroid disease and more

- All medications and cannabis use
- Genetics and any past health experiences that could impact your bone health (i.e. eating disorder)
- Nutrition—especially calcium and vitamin D
- The potential benefits of hormone therapy for preventing osteoporosis

Brain Health

Research for how to prevent and treat dementia and Alzheimer's disease in women is very much in its infancy stage—even though two-thirds of all Alzheimer's patients are women!

There is a hypothesis that estrogen therapy can play a role in protecting a woman's brain from Alzheimer's disease, and so far, still only a small amount of conclusive data.

While I'm encouraged by the number of organizations taking on the challenge of research and education to combat brain-aging disorders that disproportionately affect women, it is important as individuals that we have some actionable steps to take today.

Again, this is one of those opportunities, where there is no magic wand, but an incredible opportunity to put our own name (and brain!) at the top of the to-do list regarding how we:

- Eat, move and sleep—we must prioritize quality, restorative sleep!
- Play Scabble and Sudoku if you want to—just know there is even greater potential for brain health benefits from:
  - prioritizing laughter
  - maintaining strong social connections
  - seeking support for depression

- Manage stress by practicing regular mindfulness exercises and walking in nature
- Supplement—especially quality Omega 3s
- Be sure to have a conversation with your health team:
    - if you need support for your sleep and
    - to understand the potential health benefits hormone therapy may have for you

Bladder Health & UTI Prevention

Urinary tract infections (UTIs) are the second most common type of infection and account for approximately eight million doctor visits every single year! Women in postmenopause are more susceptible to UTIs because after estrogen declines the vaginal walls can become thinner, dryer and/or more inflamed, the urethra gets shorter and thinner, and sometimes the bladder takes on a mind of its own. All of these factors can lead to bacteria overgrowth and UTI.

What is a UTI?

A UTI occurs when bacteria enters the urinary tract, overstays its welcome, and multiplies.

Most UTIs happen in the bladder, but if left untreated, they can spread to the kidneys and wreak havoc. Both women and men get UTIs, but the female anatomy makes women 8 times more susceptible.

Women are more susceptible to UTIs because their urethras are shorter and closer in proximity to the vagina and anus. This means bacteria can spread easier and move up the urinary tract faster. Frequent UTIs are especially common in postmenopause because hormone changes (estrogen decline postmenopause) and physical changes can impact the bacteria in the vagina and bladder, making it easier for infection to spread.

60% of women will have at least one UTI in their lifetime and 25% of women will experience a recurrent UTI within one year. About 10% of all women in postmenopause experience at least one UTI per year.

Older people are highly susceptible to UTIs because of their weakened immune systems. In fact, older adults often develop silent UTIs, which can cause life-threatening damage without any of the usual UTI symptoms.

UTI signs and symptoms can include any of the following:

- Sudden urges to pee
- Burning sensation when you pee
- Cloudy or bloody urine
- Your pee has a not-so-cute smell
- Abdominal pain

Once a urinary tract infection is diagnosed, the most common form of treatment is antibiotics. These powerful prescription drugs battle the bad bacteria in your urinary tract and stop it from spreading. Antibiotics are a quick fix. But when repeated, in the long run, they can stop working and even cause potential harm.

Here are some ways to proactively prevent urinary tract infections:

- **Water is Key**

  The first step to preventing UTI during menopause is simple: drink more water. While your body goes through all these changes, it's crucial that you continually flush out the system.

- **Pee Well**

  Don't strain while you pee. Stay relaxed and empty your bladder completely so that no urine is leftover. If you're

sexually active, always pee before and after sex to get rid of any bacteria that might be hiding in your urinary tract.

- **Moisturize Your Vagina**

  Hyaluronic acid is a naturally occurring molecule that our body makes on its own—and it also declines postmenopause. Moisturizing the vulva and vagina with hyaluronic acid (MoisturizeYourVagina.com for example) helps to restore natural moisture, keep the urethra healthy and helps keep bacteria away. Working with a pelvic floor physiotherapist is also important for prioritizing bladder health.

- **Localized Estrogen Therapy**

  Speak with your doctor about the benefits of localized (vaginal) estrogen therapy. In addition to treating dryness, his can stop bacteria from spreading and soothe skin irritations caused by the loss of estrogen. Vaginal estrogen is available as a topical cream, vaginal insert, or a flexible ring that is placed inside the vagina for 3 months.

- **Cranberries**

  For decades, scientists have been searching for natural remedies to treat UTIs. The most popular? Cranberries. But most of us are not drinking 32 oz. of pure cranberry juice per day! The real power of cranberries comes from their bacteria-fighting compound called proanthocyanidins (or PACs). This all-natural ingredient prevents bacteria from sticking to the walls of the urethra and bladder. You need at least 36 mg of PACs per day at a high concentration, such as 15%, to effectively prevent UTIs. A daily dose of 36 mg of PACs (UtivaHealth.ca for example) can keep the urinary tract

free from bacteria. And the supplement d-mannose can target E. coli (the most common UTI-causing bacteria) specifically. Speak with your doctor or pharmacist about what will be best for you.

Vaginal Health

Vulva and vaginal health is important to our overall health because we want to be able to sit comfortably, move comfortably, enjoy penetrative sex comfortably—and ensure we can prevent UTIs, incontinence and pelvic floor prolapse for the next three-to-five decades**.**

Vulva and vaginal dryness occurs most often in post menopause (12 months period-free) after estrogen (the hormone responsible for keeping our eyes, mouth, joints and vaginas lubricated) declines, and after hyaluronic acid (a naturally occurring molecule in our skin cells) also decreases significantly.

Vaginal dryness can occur at other times in our life too—one of the biggest culprits is the birth control pill, which changes our hormone balance. Other reasons include postpartum, overuse of pantyliners and other absorbent pads, side effect from cancer treatments, certain medications or other health conditions.

The bad news is vaginal dryness, if left untreated, is the one midlife experience that will not get better with time.

This is really important because many women have been conditioned to think hormone changes are something we have to "get through" without realizing there are longer-term implications if action is not taken.

The other really bad news is that of the 80% of women currently trying to deal with vaginal dryness, LESS THAN 4% are receiving treatment!

The good news is there is a menu of options for preventing and treating vaginal dryness. And, what women really need to know is this: prioritizing vaginal & pelvic health improves a woman's overall quality of life—it positively impacts sexual health, confidence, how active we can be and even our cognitive function. Yes, we need to make certain

nothing impedes our physical movement; therefore prioritizing our vagina helps take care of our brain!

How to prevent or treat vaginal dryness

Engage in sexual activity (with or without a partner)

A "use it or lose it" approach to vaginal health is not a myth. Sexual activity (with or without a partner) and regular orgasms keeps blood flow and energy directed to our pelvic region and that helps to produce natural vaginal lubrication. *(Note: this is a prevention strategy. If you already experience dryness and find penetrative sex uncomfortable or painful, this is not a recommended approach. Continue reading for your treatment options.)*

Practice regular pelvic floor exercise

See a pelvic floor physiotherapist at least once per year. Our pelvic health must be a priority as it is responsible for our bladder health, bowel health, sexual health and more. It's important for all women to exercise their pelvic floor correctly and consistently, and this requires the guidance of a professional.

Moisturize your vagina

As part of a regular routine, you can prevent and treat vaginal dryness by moisturizing your vagina with hyaluronic acid—just like you moisturize your hands, face, feet and elbows!

Hyaluronic acid has been a popular ingredient in beauty and skincare products since 2003. In 2013, researcher & gynecologist Dr. Petra Stute showed how hyaluronic acid is as effective for treating vaginal dryness as localized estrogen therapy (a physician-prescribed form of hormone therapy--often in the form of a cream, suppository or ring--applied directly to the vagina delivering estrogen back to the body.)

In May 2021, the International Society of Gynecologists recommended vaginal moisturizer as the first line of treatment for

vaginal dryness. This is because hyaluronic acid is a naturally-occurring compound made by our own bodies, but it starts to decline around age 30-40 and then more significantly in post-menopause.

A vaginal moisturizer is not the same thing as a lubricant or coconut oil. Lubricants provide a temporary barrier to friction and should be used for pleasure and fun, but they do not offer any long-term benefits. A vaginal moisturizer works as an "investment" to restore natural moisture back into the cells of the vulva and vagina wall.

In 2019, members of the Menopause Chicks community asked me to research new options for treating vaginal dryness as they were frustrated by the lack of vaginal health education, the lack of conversation with their health care professionals, and too many women were assuming vaginal dryness was something they had to tolerate.

Other members were frustrated by the lack of over-the-counter options as they were spending money on products that had great marketing, but the ingredient lists were long and full of preservatives and additives.

We took our members' concerns to an integrative pharmacy to co-develop a non-prescription vaginal moisturizer (MoisturizeYourVagina.com) that contains hyaluronic acid and a little vitamin E which thousands of women are now reporting effective.

Don't give up

Everyone is at a different age and stage of dryness. The only option not on the menu is giving up. Many women choose to moisturize and use localized estrogen or DHEA therapy. A lot of members of the MenopauseChicksCommunity.com do well with both—some alternate either every other day, or between morning and night. Speak with your doctor about the potential benefits for you.

Other options for treating vaginal dryness include at-home red light therapy (the v-sculpt from Joylux.com, for example) or laser therapy (Mona Lisa Touch, for example) by a qualified physician/gynecologist.

Prioritize the Pelvic Floor

Incontinence is the #2 reason (after dementia) why women are admitted into long-term care facilities. The disposable incontinence pad market is expected to reach $16 US billion by 2025. Incontinence impacts the quality of women's lives more than men—affecting our ability to exercise, socialize, maintain healthy sex lives and more. And it's expensive.

Incontinence is any unwanted loss of urine at any time and any amount. So, if you are not sitting on the toilet, wanting to go pee and urine comes out of you, that would be termed "incontinence".

Urine is stored in the bladder and our bladder signals our brain that it needs to empty and we then go to the washroom. What should happen when we sit down on the toilet is our pelvic floor muscles should relax and our bladder should contract to empty. 150 mil is usually when you get your first signal – a gentle hint that you may want to start thinking about a bathroom in the next hour or so.

It continues to fill and will signal strongly between 200-300 mls. With a truly full bladder, the stream should be steady for about 10 to 15 seconds. Anything less than that, it's probably not full or it's not emptying properly.

Stress Urinary Incontinence (SUI)

If you're laughing, coughing, sneezing, running, exercising, jumping, or doing any sort of exertion where a little bit of urine leaks out, that is stress urinary incontinence and is typically due to a lack of synergy between the pelvic floor, the bladder, and managing intra- abdominal pressure. The pelvic floor muscles must contract 200 milliseconds before an increase in intra-abdominal pressure in order to maintain continence. Stress urinary incontinence is when there is not enough tone to close off the sphincter and/or the sphincter doesn't close in time and therefore a little bit of urine leaks out.

Urge Urinary Incontinence (UUI)

Urge urinary incontinence is when all of a sudden you feel an

overwhelming urge to urinate and may not make it to the bathroom in time which can result in a bit of urine leaking out or a complete release of your bladder. This can happen even if the bladder is not full. Urgency occurs when there's too much activity in the muscle and it's signaling the brain to empty more often than it should. The bladder is a muscle that can be trained and oftentimes it starts to signal more often because of habits or behaviors.

Mixed Urinary Incontinence (MUI) would be a combination of the SUI and UUI.

The good news is that incontinence can be prevented and treated—without medication or surgery. It's essential for everyone with a pelvic floor (that's everyone: Women and men!) to work with a pelvic floor physiotherapist—at least once each year. We need to think of working with a pelvic floor physiotherapist the same way we think of going to the dentist; both help us invest in our quality of life now, and our future health.

Online programs and app-based training are also helpful. The VaginaCoach.com has an app with a ton of information and education, plus high-quality pelvic floor exercises that can be done in 10 minutes per day and they are easy to incorporate into a regular routine.

Prioritizing our pelvic health and working with a pelvic floor professional means more than bladder health and incontinence prevention. Pelvic health also includes preventing and treating pelvic organ prolapse (when the bladder, uterus or rectum descends into the vagina), chronic back pain, constipation and sexual function and satisfaction. It's worth putting your pelvic health at the top of our to-do list!

Chapter nine:
Who Cares?

So, who cares about women's midlife health?
(This "double entendre" is intentional.)
On one hand, given the vast amount of frustration and disappointment many women face when trying to address their midlife health, it can sometimes feel as though no one cares.

But that is not true. I can assure you there are many highly educated, experienced hormone experts who do care; who specialize in women's midlife health, who invest in continuing education (certification from the North American Menopause Society or The Confident Clinician program, for example) so they can support women who want to navigate perimenopause-to-menopause-to-postmenopause with confidence and ease.

But, it might not be your family doctor, and that's important to know in order to prevent disappointment.

It's also important to highlight that there isn't one specific designation (medical doctor, naturopathic doctor, functional medicine doctor, gynecologist, nurse or nurse practitioner) that guarantees education, experience or expertise in women's midlife health. We have to ask!

The InHerWords.ca study highlighted women's experiences with their primary care provider. One-third of women surveyed did not feel

their needs were being met or treated effectively by the current healthcare system. 51% of surveyed women felt that a physician had diminished or overlooked their symptoms. And 59% of women age 45-54 reported leaving their health appointments feeling dismissed or disappointed.

The top two reasons for those visits? Menstruation and menopause. I hear thousands of stories of how a woman's health concerns has been met with a "wait and see," "you're just getting older," "that's normal," or "have another glass of wine" from their health professional. It's called medical gaslighting and it shines a big light on the glaring gap that exists in the lack of awareness, prioritization and value our society puts on women's health.

These statistics are even higher for Indigenous women and women of colour.

And that's too many.

Because women deserve quality health care.

And it is not that all doctors do not care.

They do care.

But family physicians and general practitioners go to medical school to study all the diseases and chronic conditions and treatments for such. Menopause and women's midlife hormone health is not taught in medical school because it is not a disease. They might learn to prescribe hormone therapy, but no time is devoted to the prevention of symptoms or impact to a woman's quality of life.

They graduate into a system that rewards 10-minute appointments. And all of us know that is impossible to discuss heavy bleeding, hot flashes, sleep deprivation, mood changes and mental health, vaginal dryness and sexual health concerns in 10 minutes.

What can we do?

Add a hormone expert to our health team

If resources (financial, health insurance benefits) allow, add a hormone expert to your health team. That is a health professional who has taken

additional continuing education in women's midlife hormone health and who is successfully working with a patient panel of women navigating perimenopause to postmenopause. This could either be a health care professional who is going to be your primary care provider, or it might be someone you discuss your hormone health strategy with, and then return to your doctor/primary care provider to help you execute (order tests, prescribe a supportive protocol.)

Options include:

- Searching for a NAMS-certified (North American Menopause Society) practitioner in your area at Menopause.org
- Asking your naturopathic doctor or nurse/nurse practitioner about their education, experience and expertise in women's hormone health
- Asking for recommendations in the MenopauseChicksCommunity.com. One of our roles is to ensure you have a health team who can support your journey
- Asking friends for a recommendation or referral

Work with your existing doctor

Many women are without a family physician, and that is a challenge unto itself. But whether you are discussing hormone health with your family physician, or speaking with a telehealth or walk-in clinic provider, there are "script tips" that can really enhance the communication experience and health outcome of your appointment.

- Practice telling your story and make notes or draw out a timeline as a way of preparing for your appointment. Doctors should know how to take a good history. It's your job to describe your health concerns—as if you were telling a good friend. For example, instead of saying "I just don't feel like myself anymore," say "I used to be a good sleeper but now I wake up every day at 3

a.m. and it's impacting my ability to do my job/care for my aging parents/exercise."

- Use a rating scale. "The pain I was experiencing with penetrative sex used to be only a mild concern, but now it is an 8 out of 10!"

- Share both your expectations and your surprises. "I'm getting used to having irregular periods. However, the bleeding has become so heavy and erratic—it has really caught me off guard, and for 2-3 days each month, I can barely leave the house. This has never happened before!" Relating what's surprising to you will help make sure the doctor pays attention to this part and address it. And who knows; it might surprise your doctor too, and completely change his or her thought process.

- State your health goals and ask for what you want. I realize this might sound obvious, but a 2012 study in the Journal of Health Affairs showed that people don't ask their health care providers questions out of fear of being perceived as difficult. It's an interesting construct when we are so good at asking for what we need in other corners of our life. *(Imagine going to the mechanic or hair stylist but not actually saying why you are there!)*

My invitation to you

Midlife women are holding up the world.
We are 50% of the population.
We influence over 90% of all consumer and health decisions.

Yet, society has tried to convince us we are "over the hill."

Marketers make it sound as if we need fixing.

And we continue to leave medical appointments feeling dismissed or disappointed.

My invitation to you: don't accept "grin and bear it," "you're getting older," or "it's just part of being a woman" as an answer. Investing in your health takes work. And you are worth it!

Somehow the negativity of menopause has become ingrained into our culture.

Women's health has been on the backburner for far too long.

What if instead of telling women to "suck it up"...we HELD them up?

What if instead of telling women to "cross their fingers & hope for the best"...we convinced them that they are the BEST?

What if instead of suggesting women "power through"...we empower them to become their own best health advocates?

Can we shift your thinking from "symptoms" to "solutions?" From "suffering" to "celebrating?"

I understand change IS hard!

And it can be messy in the middle.

But we are smart. And savvy. And we can learn to navigate any health concern...especially if we have access to QUALITY information, trusted health care professionals, and a community who has our back.

Our time is not up. This is our time to SHOW UP.

And it's our time to **feel amazing.**

Thank You

To all the members who show up regularly in the MenopauseChicksCommunity.com to ask great questions and prioritize your health: THANK YOU.

To the many women's health experts, brands and organizations who share my passion for women's health, lend their time, talent and expertise so that I can do this work: THANK YOU.

To you—for picking up this book and reading it today; for committing to sharing this important information and having more informed conversations about women's midlife health: THANK YOU.

Your name looks amazing at the top of your to-do list! Xo

Let's continue the conversation

Private Online Community:	MenopauseChicksCommunity.com
Facebook (Public)	Facebook.com/MenopauseChicks
Instagram:	@MenopauseChicks
Twitter:	@MenopauseChicks
TedX Talk:	TinyUrl.com/ShirleyWeirTedTalk
Email:	shirley@MenopauseChicks.com
Website:	MenopauseChicks.com

About the Author

Shirley Weir introduces herself as a Menopause Chick and defines "chick" as anyone who is smart, savvy and wants to be proactive with her own health!

Now 55, Shirley's perimenopause journey began in her 40s. Sore boobs, sleep deprivation, depression and brain fog led Shirley to her doctor's office, the book store and "Dr. Google," but she was left feeling confused, overwhelmed and alone.

Ten years ago, she launched MenopauseChicks.com & her private group, MenopauseChicksCommunity.com, onto the world stage to provide clarity and quality health information to what can be a very confusing time in a woman's life. Her personal mission is to invite women to get curious about their health—leading with a reminder that we all deserve to **feel AMAZING!**

As a fierce advocate for women's health, Shirley teaches women about their hormone health, and how to be their own best health advocate. With over 40,000 members, the award-winning MenopauseChicksCommunity.com is regarded by members as the "go-to" place to get health questions addressed. Last year, the group generated more than 2.2 million site visits—but that doesn't surprise Shirley, as her research shows 77% of women have questions, and more than 80% say they don't have anyone to talk to about perimenopause or menopause!

In 2019, after members repeatedly asked for a solution for vulva and

vaginal dryness, Menopause Chicks co-created a hyaluronic acid vaginal moisturizer at MoisturizeYourVagina.com

Shirley is a TedX Speaker, a recipient of the YWCA Women of Distinction award, has tweeted for Oprah and speaks regularly to media. Her first book, *MOKITA: How to navigate perimenopause with confidence & ease* is an Amazon bestseller in women's health.

Shirley is a communications graduate from Wilfrid Laurier University in Waterloo, Ontario and holds a certificate in Peer Counselling from the University of British Columbia. She lives in Port Moody and is the mother of two young adults and one golden doodle.

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