Episode 122 Transcript

Dr. Jaclyn Smeaton, ND
Welcome to the DUTCH podcast where we dive deep into the science of hormones, wellness, and personalized healthcare. I'm Dr. Jaclyn Smeaton, Chief Medical Officer at DUTCH. Join us every Tuesday as we bring you expert insights, cutting edge research, and practical tips to help you take control of your health from the inside out. Whether you're a healthcare professional or simply looking to optimize your own wellbeing, we've got you covered. The contents of this podcast are for educational and informational purposes only.

The information is not to be interpreted as or mistaken for medical advice. Consult your healthcare provider for medical advice, diagnosis or treatment. I'm so glad you're with me for this week's episode of the DUTCH podcast. And let me tell you, I think this is one of our most helpful episodes. If you are a perimenopausal or menopausal woman wondering about hormone replacement therapy, or if you're a provider who is doing this and wants to really hear from an expert, let's move the needle. Now,

There's been so many changes in menopausal hormone therapy and how it's applied from the 90s where it was given to every woman to the early 2000s when the Women's Health Initiative was published and people pulled back and were so scared. And now we're in a new era with a lot of personalization, both in the lab testing and on the prescribing side. Dr. Deb Matthew has been at the forefront of that. She's known as America's happy hormones doctor. And she's really been at the forefront of menopausal hormone therapy for decades.

She's really thoughtful about how she practices. She's not dogmatic about the route of administration, the type of hormone that she uses. And she really takes an integrative and comprehensive approach that not just thinks about replacing the hormones, obviously that's a critical piece, but really supporting the person that the hormones are going into. What's going on with their HPA axis? What's going on with their metabolism? How's their gut health? How's their stress, their sleep, et cetera? And in this episode, we really lay out the process that she uses.

Dr. Jaclyn Smeaton, ND (01:57.186)

what she considers, what lab tests you might want to think about ordering, et cetera. It was such a jam-packed episode, a lot of myth-busting, a lot of really actionable takeaways. Now, Dr. Deb Matthew, like I said, she's our America's Happy Hormones doctor. She's a best-selling author, a speaker, and a founder of Signature Wellness in Charlotte, North Carolina. She's board certified in functional anti-aging and integrative medicine. And she really focuses her practice on helping men and women

restore their energy and their mood and their vitality through that hormonal support. Really, she'll share her story, but she overcame her own struggle with hormone imbalance, which really drew her to be very passionate about a root cause approach to medicine. And now she does a ton of education through national media, podcasts like ours and more. She's authored a couple of books. One is called This Is Not Normal. I love that one. And also, Why Can't I Keep Up Anymore? And she's really a trusted voice in the world of hormone health. We're so lucky to have her on today's podcast.

So Dr. Matthew, I'm so excited to have you here today to talk about something I know we both love to chat about, which is hormones. And you are not at home right now. Where are you currently?

I am in Amelia Island, Florida. I'm actually at, it's the Georgia chapter of ACOG, of the Obstetrics and Gynecology Association. And I honestly have to say I had a lot of imposter syndrome about being here because I'm not a gynecologist. And so I thought that we would not be well received, but we're actually finding that there's a lot of interest. The gynecologists want to know more. They know their patients are asking for this. So I'm actually really pleasantly surprised.

Yeah, that's really interesting to hear you say because it sounds as though the culture around hormones is changing even in conventional medical spheres. It's different than what you'd expected. So it's so interesting because it makes me think about how culturally things have just shifted to a more open mindedness. And it was just something that wasn't even surprised you when you were there.

Dr. Deb Matthew (03:56.384)

It did surprise me because I guess what I expected is, you my imposter syndrome made me feel like since I wasn't a gynecologist that the gynecologists would feel like they are the owners of this information, they're the experts here. And they didn't really feel that way. Like they felt like they really were interested and they wanted to learn. And they were just excited at having opportunities to learn more and offer this to their patients because their patients are asking. So they're saying, I refer out.

Like sometimes they'd say, I'm okay with prescribing estrogen and progesterone, but I don't do testosterone. I don't know how. So I refer them off to my colleagues.

Which is different than I tell my patients not to do it. Yeah, it's interesting. This is an interesting and fascinating place to start because I had a similar experience. It was in March of this year. I took a certification through Harvard Medical School in Women's Health and Menopause. This is the inaugural year that they did it. They had a class, I think there were probably a few hundred of us, that went through the lectures. I think about Harvard Medical as a pretty

Yes, very different.

Dr. Jaclyn Smeaton, ND (04:56.626)

know, stable medical organization. They're not going to make Yahoo recommendations or they're not the ones, they're more risk averse, let's say. You're going to get more likely to get kind of standardized information. But interestingly, they invite a lot of speakers who were really pushing the boundaries of hormone replacement therapy. Like Heather Hirsch is so intelligent around different prescribing options. They had Rachel Rubin, who's a big testosterone and women proponent. People from Ishwish around sexual health and

Just a very comprehensive training. And it was really nice to see. I wouldn't say they were super open to a lot of integrative therapies, although Anna Kabeca was on faculty. It was great to see her there. She's an OB-GYN, but very integrative in her approach. She taught about oxytocin. She taught about vaginal DHEA. So really, I would say there was more open-mindedness. And it's really interesting, because you have to ask yourself, what are the factors at play for this cultural change? Research is one.

I also think about like maybe aging out of gynecologists who are now retiring, who were like in their prime practice in the early 2000s with WHI and a lot of gynecologists who are aging into perimenopause and menopause themselves maybe looking for options.

And also, maybe even also lot of women in medicine. Because generations, like my generation, I went to medical school in the 90s, so before the WHI, but there are generations before us, and it used to be a lot of women, and so maybe that's another part of it, is the gynecologists themselves are experiencing this.

I think you're totally right. It's really an interesting switch happening in that field. And absolutely, it was a predominantly male. All of medicine was, but even gynecology and obstetrics, which is so interesting. And you look at, I mean, you've probably seen memes and stuff online where it's like, imagine if a man had the following list of symptoms. And they show a couple of perimenopausal or menopausal symptoms. It's like, we'd have a solution right away. So it's nice to think about. It's great to see women in leadership and kind of making these changes and just this kind of cultural.

Dr. Deb Matthew (06:58.446)

Yeah.

So what a nice place to start today. And you're really in the soup right now of hormone replacement therapy at ACOG, which is great. So I want to talk a lot about hormones today. But before we dive into that, I always like to start by giving you the chance to share your story a little bit with our listeners. Because as a doctor who has moved into integrative and functional medicine, there's a story behind that. We've got to know the story.

Well, let me really go all the way back and say that I started my career as a pediatrician. And I say that because there's a lot of us that are doing this that came from other places, and there's a lot of imposter syndrome, and feel like it's not the original training. So sort of who

am I to be doing this? And I had a huge imposter syndrome for so many years. But back in 2006, I was exhausted all the time. Napping was my favorite hobby. Like I would just...

would get my kids to bed at night and just completely crash and burn if there was spaghetti sauce slopped all over the kitchen floor. It was just gonna have to stay there till the morning because I had nothing left in me by the end of the day. I was so exhausted and I was so cold all the time. And even though I lived in the South, I would take a sweater with me in July everywhere because the air conditioned movie theaters and restaurants would just make me shiver uncontrollably and it was so miserable. But I had been feeling this way for so long that I just thought I was a cold natured person who needed more sleep than everybody else.

Right around this time, I was in my late 30s. I don't even know if I'd heard the word perimenopause at that point, but I was irritable and I felt so guilty for shrieking at my kids all the time over the silliest little things. I would just lose it at the drop of a hat. And it was my poor husband who had to put up with my wicked witch of the West, know, impersonation all the time, the poor guy. And he actually found a book that was written by Suzanne Summers about women's hormones.

Dr. Deb Matthew (08:51.086)

And he brought me this book and suggested maybe I'd like to read it, which like, we've got to give him some points for being brave, right? Suggesting to a woman that her hormones are on a whack is a little bit dangerous. But nothing in my medical training helped me understand what was going on with me. I didn't know what else to do. And I can assure you, I did not want to get medical information from, know, Suzanne Summers, right? Celebrities, like that's not where we as doctors get our stuff. But I didn't know what else to do. And so I read the book.

And the book changed my whole life because when I read the stories about women who were feeling just like me, and then how much better they felt when they got their hormones back in balance, it really allowed me to open my mind. And suddenly everything made sense. Because I have Hashimoto's, I was on Synthroid, I'd had symptoms for 10 years and always they told me that my thyroid was normal, even though I had an enlarged

thyroid gland. And then finally it got bad enough that I was prescribed Synthroid. So at this point I'd been on Synthroid for 10 years and I felt completely the same.

But then I'd been through medical school, I'd had four babies, my adrenals were shot, my progesterone was tanking, and I wasn't feeling good. And so when I looked at all these things, I'm like, what? Progesterone helps you sleep through the night? I was having panic attacks in the middle of the night for no apparent reason. Like there was nothing going on in my life that would warrant that. And so in this book, she gave some links for places that doctors could go and learn. And I realized it's not woo-woo medicine. There's real science behind this. It's just normal human physiology.

and there's things that we can do to fix it. And so I got my energy back, my kids got their mom back, my husband got his wife back and I got my life back. But I couldn't go back to just writing prescriptions all day long, cause it didn't make any sense. So I completely retrained, I retired from pediatrics, I spent an entire year retraining. So now for the last 18 years, I've been helping men and women get their hormones back in balance so that they can be well, they can get off a lot of those prescription medicines and love the way they feel.

That's amazing. I really appreciate you sharing the details of it. As you go through your story, I there's elements that are so relatable to probably 100 % of our listeners today of those elements of not feeling like yourself or feeling like that change. And life happens to us, right? I think the older you get, the more you realize everyone's been through tough times, everyone's been through stress, and that's not without.

Dr. Jaclyn Smeaton, ND (11:10.456)

health outcomes on the other side of it. And so I commend you for kind of taking an open-minded approach to a solution. And I think a lot of people are in that space where they're desperate. Information's easier to come by nowadays. But yeah, thank goodness for your husband. What an angel. And he must have had to really tread carefully on that introduction.

That's great. Well, tell me a little bit about the impact that you've seen in your patients over that 18 years and a little bit about maybe how hormone prescribing or how the patients that come to you are different than they were when they first started. Yeah, sure.

So when I first started, most people didn't really, like most people never heard of bioidentical hormones. There were almost no cash practices at that time. So a lot of people were sort of hesitant to come in because it wasn't covered by health insurance. And when I first started, the first thing that I learned was how to do bioidentical hormones. I didn't know much about the rest of sort of holistic health and wellness and integrative medicine. And so I would start off by looking at

know, female hormones or male hormones, thyroid panel, and cortisol levels. And I could get my patients feeling so dramatically better. if we could just get people to sleep, like, that's such a huge thing, right? Like, so many things get better. And it impacted their mood and their cognitive function and their...

their ability to stick to their good lifestyle habits that they wanted to do, you know, go for a walk and drink enough water and, you know, chop their vegetables and all the things. So it really did have a dramatic impact on how they were doing. And I do have to say in the beginning, I wasn't like 100 % sold on this whole idea of adrenal health because that like hormone replacement therapy, like, you know, we do.

Dr. Deb Matthew (13:02.334)

learn about that concept in medical school. We're not really taught very much to be competent, but like we know that that exists. Whereas this whole adrenal thing was a big blue new ocean.

And it kind of had some poor branding, to be honest, for the 80s and 90s. Yeah, the adrenal fatigue, like this unscientific concept, and the way we talked about it didn't make any sense. And yeah, I get that.

But I know.

Dr. Deb Matthew (13:24.686)

And so I remember like kind of only sort of addressing the adrenal fatigue and at the time. what I really have found over the years is the more that I dive into that and really look at it with my patients, the better the results we get. Because for some women, they just feel so much better when we put them on hormone therapy. But for other women,

They do, know, their hot flashes are better, like maybe they don't have as many nights so they sleep better, but they're still exhausted all the time. They're still really just struggling and when they have those bad days, they sort of crash and burn or they're still hangry because their blood sugar's dropping. And when I learned better skills at managing adrenal function, it really did make a difference with our patient outcome. So I am really a strong proponent that if you are going to be somebody who says that you are a hormone practitioner, that you help

you know, your patients with bioidentical hormones, or like if you're sort of gonna identify yourself to your patients as you're somebody who can help them with your hormones, I have a really strong bias that that has to include adrenal function too, and not just like hormone replacement therapy, because I've really seen such a big difference.

really love that you bring that up. It's such a nice place to start. Because a couple of things. One, I think the science is really clear around the impact of heightened stress response on not just the reproductive system, but every system of the body. There's a great book, I recommend this so often, called Why Zebras Don't Get Ulcers by Robert Sapolsky. It's old, but it's still such a great read. And the science has come so far since that was published.

But he goes chapter by chapter, organ system by organ system, to talk about, and it's completely evidence-based, what we know about high epinephrine, norepinephrine, and cortisol on downstream systems. And the reproductive tract, what's interesting is not only does it affect hypothalamic and pituitary signaling, but it actually affects target organs, like

receptor function, protein synthesis within the testes, within the ovaries. And so one is we know that it's so critical to keep that.

Dr. Jaclyn Smeaton, ND (15:32.034)

communication system like functioning healthily. But the other thing that I think about is how postmenopausally women shift, like your estrogen comes from the ovaries premenopausally, and then afterward it comes from conversion from DHEA predominantly, which is an adrenal hormone. So when you think about women who have a hard time transitioning through menopause, I always ask, could it be because

that adrenal health is not as great, the signaling within the HPA axis is faulty, they're not making DHEA as effectively on demand or going through the right metabolism with that hormone. I don't know, do you probably think similarly?

Yeah, and even if I just think of my own story, like back in the time when I was feeling really crappy, you know, I'd been through medical school residency, had four babies, hadn't slept through the night, and you know, probably a decade at that point. So clearly my adrenals were way out of whack, and I was on this synthroid, but...

you know, when you have a problem with cortisol, you don't convert T4 to T3 well, so the synthroid wasn't working for me. And then when you're stressed and your adrenals are high, it shuts down progesterone, right? Your body in its infinite wisdom know that you're under stress, it's not time to procreate, so it kind of shuts down progesterone. So now I have more irritability, anxiety, whatever. All the cortisol itself can cause irritability and anxiety. I'm on birth control pills, because you know, I'm a regular doctor at that point. So that diminishes testosterone on top of the effects of cortisol.

shutting down testosterone. so like sort of the root of all evil of all the things that were going on was really my stress. And so if my life had been different and if I had been in a completely different environment, I may not have found myself in the hormone turmoil that I was in in my late 30s. Maybe it wouldn't have happened to me till I was in my late 40s, you know, as my ovaries really did shut down, but it was just such a big piece of the puzzle.

Dr. Jaclyn Smeaton, ND (17:21.378)

Yeah. Now I'm curious about when you first started in practice, did people seek you out for hormone support or did they seek you out because they felt crappy and they didn't know that hormones were their solution for them? And how has that changed to today? I imagine now today you're like, no, no, you don't need the hormones. It's like almost flip-flopped.

Yeah, well, when I first started, one of the very first things that I learned about business was I listened to some lecture at a conference I was at of somebody basically saying, like, you should set yourself up as an expert in something. And that's been such great advice that's helped me over the years. So I sort of declared that I was an expert in hormones. And I've stuck to that over the years. So now I do, like, full functional medicine, right? Gut health and detox, like, all the things. And hormones is just a piece of what we do. But I still...

put myself out into the world as somebody that's sort of an expert in hormones. So the people who came to me were people who came because they thought they had a hormone problem. Like they're hoping, right? They're hoping that I could figure out which hormone is the problem, give me that hormone and fix me. But so back in the day, they would show up because they didn't feel good. They'd...

Just tell me if something's wrong.

Dr. Deb Matthew (18:33.208)

They'd heard Oprah, they'd heard something about hormones. They looked it up, we're like one of the only people in town, and they would come in and we would do a hormone test, give them some lifestyle changes, some supplements, prescribe hormones. And they would feel mostly better, although we weren't able to help everybody. Over the years though, what's happened is I've learned so much more. I've been going so far beyond just prescribing hormones and all the factors that interplay into how...

Toxins mess up our hormones how our hormones are being metabolized because it's not just what your hormone level is It's what is your body doing with the hormone? That's really important So we've gone so so much deeper and I get a mix of people coming still generally the reason that people are searching for something is they generally don't feel good I Don't feel like myself is literally the number one thing that I say and I see a lot of people that they're not sick there They don't have I mean

Sometimes we have people that come in that have mold toxicity and Lyme. know, things that they're technically they would categorize as sick. But most people, they're not sick. They just aren't living a full life. They don't have their spark. They just have lost their joy. They don't feel good. They can't sleep, et cetera. And they're either very educated, you know, they've read the books, they're listening to these kinds of podcasts. Like, they've learned all sorts of things. And now they need, you know, they've probably already done some lifestyle things on their own, but they need some guidance on where to go from here.

or people that are kind of at the beginning of the journey where they don't really know. They've learned somehow that there's another potential way to help themselves, but they're just at the beginning of the path of figuring out what to do.

Now, I want to talk a little bit about some of the nuts and bolts of hormone therapy. And of course, there's so many different products on the market that are FDA approved and then we have compounded as well. Can you start by just describing maybe what's the difference between like bioidentical or body identical versus synthetic?

Dr. Deb Matthew (20:32.238)

And I'm not sure why this has to be controversial either. So bioidentical and body identical both just mean that the hormone is the exact same as the hormone that's in our body. And to me, that's just logical. If we're going to replace a hormone, let's replace the hormone. If we're going to eat a tomato, we want a tomato. We don't want a synthetic thing that's almost exactly the same as a tomato, but not quite. So there are synthetically made hormones that are bioidentical, like levothyroxine, for example, is both synthetically made.

but it is an exact match for the T4 that our thyroid makes. So technically it's bioidentical. So sometimes it's confusing when we say natural, because Premarin is natural because it came from a horse. So we get caught up in these words and I feel like natural, synthetic, like really what we want is we just want whatever your body actually made. We want the exact same thing. And so bioidentical is the word or body identical. It's just the identical hormone.

There are times where you might choose a non-bioidentical hormone.

You know, personally, I don't use non-bioidentical hormones. I know that sometimes in gynecology, like if somebody has a lot of problems with like really severe endometriosis, I've had patients who've had endometriosis like in their lungs where they cough up blood, like, you know, really serious health conditions where they need some kind of a stronger synthetic progestin to really calm that down. we know we already tried with the bioidenticals, we weren't able to do it. I mean, there can be a time and a place, obviously with our bioidentical hormones, they not really function as birth control because we're...

enhancing the hormones, not shutting them down. So, you know, it's not that they never ever could be, but if what we're trying to do is just optimize health and wellness, I don't use them.

Dr. Jaclyn Smeaton, ND (22:12.682)

Great. Now you actually bring up a point about oral contraceptives where I think this is another common misconception I hear, so I want to hear you kind of myth bust, but a lot of people in their 20s, 30s, 40s had no issue, in gynecologists had no issue with prescribing oral contraceptives, but a lot of hesitation due to perceived risk for postmenopausal hormone therapy.

Can you talk a little bit about the relative amount of hormone in those products and like, why was there so much concern around menopausal hormone therapy?

So birth control pills are synthetic estrogen with synthetic progestins at relatively high doses. And they work by shutting down our natural hormones, so therefore we're not cycling, but we're not ovulating. It's not really a cycle, it's a withdrawal bleed. When we were using the synthetic form of hormone replacement therapy, it was basically something similar but at a much lower dose. So it doesn't really quite make sense that

We were scared of it, but actually I went to medical school in the 90s and in the early 90s when I was in medical school we were taught that hormone replacement therapy was the greatest thing since sliced bread. We wanted all of our patients on hormone therapy and the patients didn't always like it because we were giving everybody the same dose. So sometimes it wasn't enough, sometimes they couldn't tell much difference, sometimes it was too much and they felt really crappy and sometimes it felt great and they wanted to take it with them right to their casket because you they could tell that it was such a big difference.

We thought it was the greatest thing since sliced bread. It was gonna protect your heart, your brain, and your bones. We wanted every menopausal woman basically to be on it. And we did know that hormones can increase the risk for blood clots. So birth control pills increase the risk for blood clots as hormones go the most because the synthetic estrogen that's oral increases the risk for blood clots and the synthetic progestins increase the risk of blood clots. So then they kinda add together.

Dr. Deb Matthew (24:08.622)

when you're 19, your risk of a blood clot's pretty low, so we don't really worry a ton. But by the time you're 49, that risk is starting to go up. And so if you don't need the birth control pills for birth control, and we're just doing it because you have heavy periods or whatever, there's just other ways to do it that don't carry the increase in the risk for a blood clot. It's just unnecessary. And then what turned everything on its head was the WHI, the Women's Health Initiative trial back in 2002, that basically said,

hormones cause breast cancer. And overnight, everybody collectively lost their minds. The patients panicked, the doctors panicked. And you know, the first thing that we do at medical school, like literally the very first day is we take the Hippocratic oath that says, first

do no harm. So the idea that we were recommending to like every menopausal woman in America, that they needed to be on hormone therapy. And that was something that was driving breast cancer. It was horrifying.

And so just overnight, hormones went from the greatest thing since sliced bread to, you know, bad, dangerous, are gonna kill you, stay off them at all costs. It's just, it's crazy.

It was a huge switch. Now for people who might not be as familiar with the WHI, maybe patients who are listening, obviously the thought around getting breast cancer from hormones is concerning, but you're probably also hearing that they're rising in popularity again. What's happened since that initial kind of media push of the WHI that's smoothed out the rough edges and said, okay, maybe this isn't so dangerous?

So we've gone back over the years and reanalyzed the original study, first of all. And what we see is even in the original study, the women in that study who were given just an estrogen pill, so just estrogen by itself, not only did they not have an increase in the risk for breast cancer, they actually had a 23 % decrease in the risk for breast cancer. There was a 46 % reduction in heart disease, there was less hip fractures, there was less osteoporosis, there was less colon cancer, there was less lung cancer, like...

Dr. Deb Matthew (26:10.7)

really there were significant benefits being on the estrogen compared with not being on estrogen. And we found the best results for women who were within about five or 10 years of menopause. And as women had been without hormones for longer, and then they started hormones when they were, you know, in their 60s or their 70s, we didn't find as much benefit. We still did not find an increase in the risk for breast cancer. But then they started to have an increase in the risk for blood clots, because of course we're giving them an oral estrogen that

that carries with it a known increase in the risk for blood clots. The real problem was that in the other arm of the study, these are women who got estrogen along with a synthetic form of progesterone. So it wasn't real progesterone, it was the synthetic version. And in that

arm of the study, there was a teeny tiny increase in the risk for breast cancer. So for women who were on no hormone therapy, the risk was about four in a thousand. And if we gave them this combo pill, the risk was five in a thousand. And we're rounding up, it was actually a little bit less than that.

but so one extra in a thousand, that's not even 1%. And that difference could have been due to chance. It didn't even quite meet statistical significance. There's literally nothing else in medicine where we take one study that did not meet statistical significance and change our entire policy. Nowhere in medicine would we ever do that. But in this case, the whole policy changed an entire generation of women.

considered very rare.

Dr. Deb Matthew (27:37.592)

were told they shouldn't be on hormones. For the last 20 years, doctors weren't taught how to manage menopause. We were taught to be afraid of hormones. And women are suffering. Now we have a whole generation of women with osteoporosis and dementia. They're frail. They are having heart disease. It's just really a shame. since then, more and more studies are now starting to be done on the bioidentical form of the hormones, on the body identical form.

So when we use estradiol, which is the estrogen our body makes, when we use progesterone, which is what our body makes, what we're finding in the studies is more and more positives. We're finding more and more benefits. We're not seeing breast cancer. We're not seeing the same kind of blood clot risks. We know that if we use estrogen through the skin, it doesn't increase the risk for blood clots. And even if we're using estrogen in a pill, if it's estradiol, the risk for blood clots is not the same thing as when we were using our synthetic versions.

So now because more and more research, before all the research used to be done on the old synthetic pills, and so we just reinforced the same findings over and over again. But since now we're doing it on the more natural, the bioidentical form of the hormones, we're

finding more and more benefits. And since the science is coming out showing the benefits, now the tide is changing. One really important study that came out was a study that was done on a million...

Was it a million or 10 million? I don't even remember now. But an enormous study of women on Medicare. So that means they were 65 and older. They were still on hormones, because that was another myth that you have to stop the hormones because you hit your birthday of 60 or 65. So these are women over 65 still on hormones. And again, it found lots of benefits from staying on the hormones. And that's an enormous study. Those kinds of numbers just can't usually be done.

We're having more and more benefits. It's changing the tide. Thank goodness. Finally, women are more likely to be open to being on hormones. they're hearing things like this. They're learning. They're no longer as scared. So now they're looking for providers to help them and their doctors don't know how to help them because we never got taught.

Dr. Jaclyn Smeaton, ND (29:50.478)

Yeah, I was in that group. mean, I was in medical school when WHI was published. So I was taught either don't do it or lowest dose, shortest amount of time possible. And it had to really relearn after graduation.

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So I mean, think we've moved now into this era of personalization, which is really exciting. And I want to talk with you a little bit about your perspective about that and then how you implement that in practice that might be different from.

Dr. Jaclyn Smeaton, ND (31:01.014)

you know, into your OB-GYN's office and getting a, you know, very brief visit to get on hormone therapy. First, with the question around personalization, you'd mentioned that kind of in the early days of hormone therapy, there was just kind of a standardized dose that you would utilize, and it worked really great for some women and was too much or too little for others. Where are we at now with, the options that are available?

Yes, so now we have lots of options, which is really nice. We've got lots of options for testing hormones. We have lots of options for forms of administering hormones. We're having more and more bioidentical or body identical hormones that are FDA approved.

we still can get lots of options from the compounding pharmacies. So it's really nice that we have a lot of choices. I think that one of the main things that's different about how I do it now in terms of personalization is when somebody comes in to see me, I'm not only thinking about their hormones because I want to think about the body that the hormones are going in. We want to put the hormones in the healthiest body that we can because we want all the benefits. We don't want the risks and the side effects. So I want to know about

their gut health because if they have a problem with their gut microbiome, that's going to impact how their body clears hormones, how their body metabolizes hormones. It's also going to impact how well they can digest and absorb vitamins and minerals in their food, which are important for either producing the hormones or metabolizing the hormones. Most of the immune system is in the gut. So if their gut's unhealthy and their immune system is activated, that triggers cortisol production and cortisol interferes with

how a lot of the hormones work. So I want to think about their gut health. I want to think about how their body is able to detoxify. genetically, there are certain genes that impact how our body detoxifies from toxins in the environment and also how our body processes hormones. There are lots of things that we can do to help that process, to minimize exposure to some of the toxins without, you we don't have to go completely.

Dr. Deb Matthew (33:09.614)

but there are some really simple things that we can all do to at least decrease our body burden of toxins and then things that we can do in order to help our liver to be able to process some of these toxins away so that our hormones can do what they need to do. then lifestyle habits are so huge because if we're just living in a stew of stress all the time, there's just only so much that our body can deal with.

And whether your body's still trying to make some hormones or whether we're trying to give you some hormones, we're not gonna get, you're not gonna feel all the way where you need to feel if you constantly are under stress. And it's not even how much stress you have in your life. It's really about how you allow the stress to affect you. It's trying to have some ways to balance out the stress in order to try to help protect yourself from the potentially negative, harmful effects of stress.

We really do a lot. look at vitamin and mineral levels. We look at gut microbiome. We look at hidden food sensitivities. We're looking at inflammation markers, along with a really comprehensive look at hormones, including hormone metabolites, in order to know where we need to start. Because sometimes it's not even hormone therapy. Sometimes we just need to correct a lot of the other things that are going on, and the hormones, depending on the age of the woman, the hormones can kind of solve themselves a little bit.

Yeah, I love that kind of more comprehensive approach because there is a readiness, know, that can help you optimize how someone will respond to hormones by helping them kind of achieve the best state of readiness, you know, that they're exercising, that they're eating well, that they're getting enough sleep, that stress is in check.

And maybe if I can back up and just say for people who are new, that sounds pretty overwhelming. And it took me, like I did not start there. Like I started with measuring hormones, looking at what I found, writing prescriptions for hormone therapy, and then giving them some basic lifestyle advice. And it worked for lots and lots and lots of people. So I think that starting, like if you're dipping your toe into this sort of approach to medicine,

Dr. Deb Matthew (35:17.742)

I feel like starting with hormones is a really great place to start because if you're gonna, you know, open a practice, start to practice in a new way, identifying yourself as a hormone practitioner is a really great way to start because women are looking for practitioners that do that right now. And then there's so much that you can do with hormones. It's almost like, it's almost, I'm not gonna say that it's easy, but like it's a quick win, right? Like you can prescribe somebody some hormone therapy, they can sleep better, they feel better.

and simple lifestyle habits go so far. mean, if we could just take the general population and get them to cut back on sugar and get enough sleep and move their body and maybe do some breathing exercises and eat some vegetables, right? Like we could really help people feel so much better just from really doing the basics. So learning some basic lifestyle, learning how to do hormones and then over time,

we add in other things. Like once you start drinking the Kool-Aid, you you wanna learn more and more. But I do think that for practice. love the Kool-Aid. Yeah, but hormones is really a great place to start.

Yeah, the other lifestyle things I love focusing on for women at this phase of life are circadian rhythm, like exposure to light in the morning and darkness at night. And that's not one that I think is a little bit easier for people to implement compared to like a nutritional overhaul. And the second thing is, this is kind of a newer problem, but the addiction to screens and like the fact that we are never present. mean, that alone, that modification in life alone is transformative, let alone like the

the problems with the light in your eyes and scrolling in bed at night and the lack of sleep and unrealistic expectations for life. Just putting that down and trying to just be present with your family, with your kids. mean, it's even not alone can be so transformative.

Dr. Deb Matthew (37:11.448)

Sometimes the simple things really matter. because as practitioners, we're so caught up geeking out on the fancy stuff, like we overlook the importance of the basics.

Yeah, definitely. I want to talk a little bit about when you're getting started with that personalized approach you mentioned, lab testing. Of course, we love lab testing here on this podcast. Tell me a little bit about what types of lab testing you sometimes turn to.

So we do blood testing on virtually everybody. want to know their thyroid panel. I want to know more than just a TSH. I want to look at their free T3 and free T4. We look at a reverse T3, which isn't so much a function of their thyroid gland function, but what their body is doing with the thyroid hormones. We look at thyroid antibodies. We're looking at things like vitamin D and some basic nutrients. Ferritin is a marker for iron.

and B12 levels. look at a homocysteine, which helps us to get an idea, are they methylated well, which is you have to methylate estrogen in order to clear it from your system. We're looking at lipid panels and C-reactive protein as a marker for inflammation. I'm sure there's a lot more that I'm not thinking of. Blood sugar markers, fasting insulin, A1. So a really nice comprehensive lab panel. Depending on the patient,

is how I decide how I'm gonna measure their hormone levels. So if I have a woman who is say 45 and she's having heavy periods and PMS or maybe she has fibroids or fibrocystic breasts, like there are clues in her history that I think that she's probably estrogen dominant, that her body may not be processing estrogen really in a favorable way, then I really like to do DUTCH testing. So the dried urine testing because

Dr. Deb Matthew (39:00.32)

It's not just the level of the hormones, but it's how the body is processing the hormones. So we can look at the different estrogen pathways in order to see whether she's effectively clearing the estrogen. And then it guides us to what kinds of things can we be doing in order to help because it may not be that she needs more hormones. It may just be that she needs to help clear the estrogen more effectively.

On the other hand, if somebody is say 60 years old and they haven't had a period for 10 years and they've got all the symptoms of low estrogen, then I know that their estrogen level is almost certainly going to be low. And when estrogen levels are really low and we're trying to look at those estrogen metabolism pathways, it's harder to distinguish with accuracy how their body is processing the little teeny tiny drop of estrogen that's in their system. So in that case, I might just start with blood work.

just to confirm that the, you what I think, that the hormone levels are low for the estrogen. And then once I've got them on hormone therapy, then do the metabolism testing in order to understand how their body is processing and make sure it's going the right way.

is a really great point. I'm not sure we've talked about that on the podcast before, but...

One of the things, and I'll just kind of put a plug in for DUTCH here, because it's something that our owner Mark cares so much about. We do mass spec, like it's LCMS in the lab. a lot of hormone assays are immunoassays or EIA or ELISA measurements. That's really tough to detect hormones accurately at low levels. Even in certain times of the menstrual cycle when you're doing it in serum, we know that LCMS is better for serum too. So I'd like to call that out, because a lot of practitioners don't know that. You can select LCMS versus

Dr. Jaclyn Smeaton, ND (40:43.088)

EIA when you're ordering serum estradiol, for example. But you're totally right that when you get into postmenopausal females and levels are lower, if estrogens are low, they're tougher to measure with accuracy. One thing that's really cool with DUTCH is we do a lot of

know, seriously diluted samples to make sure that even in very dilute urine we're able to get a good measure. And if we feel like we don't, because it's too dilute, we notify the practitioner on the test. Like, this is at a point where we feel like we're not in the sweet spot for testing, but we can get really low. But a lot of practitioners don't know that once you're on the hormone replacement therapy, if you're on estrogen therapy, then you can measure those.

the metabolites more accurately. So that's a great, I'm so glad that you bring that up. So I don't think anyone's ever raised that on the podcast, but it's a little bit of a surprise to a lot of people.

Yeah, because we want to know, but maybe it doesn't have to be the first test we do. Maybe it could be the second test that we do. And then I always want to look at cortisol levels. And cortisol levels in blood work just don't do it because what we're really looking at is not so much is their cortisol high or is their cortisol low. What we're looking at is the diurnal rhythm of the cortisol production because it's supposed to have, it's supposed to go up.

in the morning, that's our cortisol awakening response so that our eyes pop open and we leap from the bed ready to start our day. And then it's supposed to go down so that we're calm and in the evening it's nice and low so we're relaxed and we fall asleep when we sleep through the night. But for so many people, that's not how it goes. And it's not necessarily that it's low all the time or that it's high all the time if they're stressed out. Sometimes what happens is...

Dr. Deb Matthew (42:22.68)

they don't have a good cortisol awakening response. It stays low in the morning, so they're exhausted. It's so hard to get out of bed. They gotta press sleep three times. They need caffeine to function. But then like 10 o'clock at night, then their cortisol is up when it's not supposed to be. And then they're wide awake and they can't fall asleep and they're popping the ambience and the melatonins and all the things. And so if we can see what's going on with their HPA axis.

and we can see what's happening with their circadian rhythm, we can intervene in different ways depending on the pattern that we see. And so either we can do that, I mean, it's not practical for somebody to go to the lab like multiple times in the day and the lab's not open in the evening, but we can do it with saliva testing, we can do it with urine testing, we see slightly different things depending on the test, but it's so much more information and it's actually relatively common.

that I'll see somebody who has lots of symptoms that make me think, my gosh, this person has HPA axis dysfunction. But maybe somebody ran an 8 a.m. cortisol and it's normal. But then if we do a diurnal test where we're measuring multiple times in a 24 hour period, we can see that their curve is completely out of whack. And it's just such an important piece of the puzzle.

Yeah, it really is. We are actually trying to look through our data now because we have, of course, tens of thousands of samples to take a look also at the CAR, the cortisol awakening response, which is what happens in the first 30 minutes from the moment you wake up to 30 minutes later because you should get a nice spike in cortisol. It's well-documented literature. To see whether the CAR, like what percentage of the time is the CAR dysfunctional where even the diurnal curve looks okay. So we're trying to take a look at that to see

you know, how essential is that car piece of it as well. But there are so many different measures, like you said, that it's really easy to do in saliva or urine, certainly easier than going to the lab four times in a day for a blood drug.

Dr. Deb Matthew (44:20.29)

Yeah, and you know, sometimes understanding how to treat it can be a little bit tricky, but there's sort of some basic things that like, you know, if you're a beginner, you know, giving them some concrete things that they can do to deal with stress. You know, there are some supplements that sort of can be generally, adaptogenic herbs, you almost can't really go

wrong. Like, you know, generally speaking can be really helpful for people. But what I really find,

interesting is it's very validating. Like if we show somebody on a piece of paper, sometimes like I'm trying to explain all the nuances of the curve and using words like, know, cortisol awakening response and metabolized cortisol, all this kind of stuff. And at the end of the day, like we can just boil it down to listen, your adrenals are out of whack. Here's what I need you to do. And, but it's validating. my adrenals are like, and a lot of times it's the chicken and the egg, right? Like.

Are their adrenals out of whack because they've got toxins, they're not sleeping, the things that cause their adrenals to be, their HPA axis to be out of whack, because it's not really their adrenal glands, it's the signaling system that's out of whack. But if we, sometimes if I can just say, listen, your system is out of whack, they're so relieved to know that there's something wrong that validates why they're so tired, why they're like crashing in the afternoon, why they can't sleep.

Yeah.

Dr. Deb Matthew (45:47.886)

And so it's just, it's really interesting even in a way that like when they look at their hormone levels, they sort of expected their hormone levels weren't, you know, if you're menopausal or whatever. But that adrenal testing is, the HP axis testing has been very validating to a lot of people.

Be a bit of an eye-opener. I I did mine when I first, I mean, I've done it before, but like right before I started working with DUTCH, but I did it again earlier this year. And I am like, you know, a mom, we have five kids at home, my work, my husband works, like very busy lifestyle, but.

I'm like, yeah, I'm handling it, no big deal. And then you take a look and I'm like, you know. Okay, I guess maybe I need to hit a couple more yoga classes and like meditate a little bit more or get more sleep at night. Like it can be really eye-opening. And I think particularly on HPA access testing, it's really can be a shocker for a lot of high functioning women because they think we can do it all. I'm one of those people too.

Wahaha

Dr. Jaclyn Smeaton, ND (46:44.622)

I got this, I got this under control. You want me to take on another project? Pile it on, it's no big deal. And I think functionally, we walk through life like anyone who's a physician, like you've been through it and you had kids in med school, like residency, all that stuff. You handled it and you got to where you are and kind of took it in stride. So I think that you're right, that recognition of maybe your resilience, your tolerance of that level of stress, I really think that changes as you shift into perimenopause and postmenopause.

What you used to be able to do, you can't do anymore. And that's okay. You just need, or maybe you can, but you need to think about like the yin side of life as well, to the yang and finding a way to get a little bit more balance.

Yeah, and I think using that word resiliency too is really important because really that's what this is all about. Like it's not that the stress system is broken, it's just not functioning as well as it needs to and it impacts our resiliency. And so when people can see that on a piece of paper, I find that they're much more open to the idea of listening to me when I'm trying to recommend.

breathing or meditating or the things that we really want them to do. People are really open to, everybody knows they're supposed to eat, Everybody knows they're supposed to exercise, but doing some ohms or, that just feels, it's not valued in our culture.

time. Let's be honest, it feels like a waste of time.

Dr. Deb Matthew (48:09.038)

Yeah, we're busy, we have stuff to do. I can't turn my brain off, my brain is busy. But people like us kinda need that more than anybody else because we don't turn our brain off. That's right. And it can be hard for us to meditate. So it's a good tool to help women especially really understand so that they'll be more open to listening to the recommendations.

Yeah, I love that. We should do a whole episode just on how to actually, with lifestyle, manage stress better, because I think that's something we all could kind of learn and learn different ways that we could connect to things that we'd be willing to do.

Yeah, it's such powerful medicine. Like if only we could just package it in a pill or give you a shot in your butt or something like that, that'd be awesome.

It needs to be like the next GLP one. It's like the CHL one, the two. So, know, the next, when we talk about personalizations, we've talked about testing and kind of all the additional info you need. And I love that whole person approach that you're describing. Another area that I think there's been a lot of development that I'd love to hear you speak on is personalization on prescribing. Now we have different forms of hormone. We have routes of administration. And I think a lot of people assume that if you want bio-agenical, you need to go with compounded.

Yeah.

Dr. Jaclyn Smeaton, ND (49:17.792)

medications, but there's so many great insurance covered FDA approved medications. So can you talk a little bit about how personalization and like the options today affect women or give opportunity to women?

Yeah, so there's so much more opportunity now than we had before. But you're right, compounded means that a compounding pharmacy, which is a specialty pharmacy, is gonna personalize the prescription into a cream or a capsule or a lozenge that goes under your tongue or whatever form is prescribed. So they are literally personalizing the prescription. We can say we want estrogen and progesterone and testosterone. We can say we want a pinch of testosterone and a bigger dose of estrogen. Like we can...

the sky's the limit basically in, we can do any dose that we want, we can do almost any combination that we want in all sorts of different forms, which is lovely. But the problem is we cannot FDA pass those because testing works is every dose, like every dose of Tylenol has to get FDA approved separately. So here we have infinite possibilities. We couldn't possibly FDA approve every single one of our infinite possibilities. But there are

are more and more bioidentical hormones or body identical hormones available that are FDA approved. There's patches, we have capsules, we have vaginal creams, we have choices. But because a lot of sort of mainstream doctors sort of misinterpreted bioidentical to mean compounded, and honestly, I still hear practitioners say that, even the practitioners that practice this way, they talk about how you get bioidentical hormones from the compounding pharmacy. So just like...

we want to be clear about it's not your adrenals that are broken. It's the signaling. It's the HPA axis is a problem. Bioidentical does not mean compounded. You can get bioidentical hormones from the compounding pharmacy, but you can also get them from the regular pharmacy where they're FDA approved. So it's not that unusual that I hear women say, I went to my doctor, asked for bioidentical hormones and they said, no, no, we don't do that. But then they gave her a prescription for an estradiol patch, which is bioidentical and a progesterone capsule.

Dr. Deb Matthew (51:26.05)

which is bio identical. And so the problem with the FDA approved products is that they only come in certain doses. So like for progesterone capsules, we have 100 or 200 milligrams and their immediate release, which means you swallow them at bedtime. They get quickly into your system, which is great. You sleep well overnight. mean, women love them, but

then when you wake up, it's kind of already out of your system. Whereas if we got the capsules from a compounding pharmacy, we can get them in an extended release.

form in a capsule so it lasts longer. We can do lozenges that dissolve right into your bloodstream so they don't have to be digested and go through your liver. So we just, it's nice that we have all of these different options because we do things differently for different people. If we have younger women who, you let's just say that for some reason they had to have a hysterectomy and have their ovaries removed and they've just been flung right into menopause and they're only, you 35.

their body is used to having a pretty decent dose of hormone. And so even the highest dose of a patch just might not be enough for them to feel really good. Whereas if we have somebody who is 65 and they haven't had a period for a year, but now they've learned about hormones and they wanna try something, we may wanna start with something that's sort of a lesser dose and kind of be more gradual in our approach. Sometimes we have people who...

are really cost sensitive and they really want something covered by insurance. So that would need to be one of the FDA approved forms of the hormones. Sometimes we have people that, know, one of the things that happens as we kind of get into perimenopause and menopause is we start to feel like we have ADD. So if you really have ADD, it can get worse. And if you never had it before, you can start to feel like you're kind of losing it. And so sometimes it's hard to remember to do things all the time. So.

the more we can simplify things, if we can combine everything all into one cream, so it's just one thing that you have to do once a day, there's lots of options. One of the things that I do sometimes in my practice, which is even more controversial that not everybody agrees with is hormone pellets. And hormone pellets are just the same bioidentical hormones, just in a different form. It's just that when we put the...

Dr. Deb Matthew (53:43.448)

pellets in, just, they look like a little tic-tac. We make a little incision, they slide under the skin, and then they just slowly dissolve over the next three or four months or so. So they give a nice stable level, but we can't take them out. So we have to not put too much in in the first place. And so I feel like that should be, in order to do pellets, practitioners need to know how to really manage hormones and then add pellets. Not that's the only thing that they know how to do.

because otherwise what ends up happening is they keep kind of going higher and higher on the pellets to try to make their patients feel better when the real problem is probably their cortisol or their gut health or their stress or other things. And then they just end up with side effects. The doses become really, really high. They don't have a good experience. And so then it kind of ruins it for everybody. you know, it's just an option. the reason that sometimes, the reason that women who choose the pellets choose the pellets is usually just the convenience. They don't have to think about it.

Just another option.

Yeah, I love that you bring up all those options and there's so many for women now, even like I think about.

You know, I know our preference, same with us, we are clinicians on our team are talking to providers and they're getting started with HRT prescribing, menopausal hormone therapy prescribing. We generally recommend like estradiol plus oral micronized progesterone. So like Pat or gel or compounded cream if you want plus oral micronized progesterone or maybe vaginal if the patient's not tolerating oral. But the realm of other options available if those aren't working is huge. Like I was actually just talking with a friend today who was struggling.

Dr. Jaclyn Smeaton, ND (55:14.542)

recently, she's 52, she had gone on a Mirena, she's in the UK, but they did like a Mirena coil for her because she was getting heavy bleeding and perimetapause. It worked great. Six or

seven years later, and she went on estrogen therapy at some point, then six or seven years later,

she had that coil removed to have an hysteroscopy and they didn't put her back on progesterone because she was post-menopausal. But then she's had all these issues. And so even talking about like, she's like, I don't really want to have to take a pill every day. Like even you could go back on an IUD. Like there's so many options depending upon what matters to you about bioidentical or not.

administration that you can stick with that's easy. Some women love patches. It's once every seven days for estrogen. Other women hate them because they peel or they cause it. Yeah, they're itchy. There's so many different options now that really that personalization is really unique. One of the things that's so interesting when we were doing a putting together our course last year, there's a study from 2001 in Maturitas by a researcher named Jarvanin.

Yeah.

Dr. Jaclyn Smeaton, ND (56:17.804)

where it was really small. There were only about 30 subjects, but they put them on patches and gels and monitored. And there were some women who showed like completely varied response. Some followed the normal pharmacokinetic pattern you'd expect. Others had an opposite pattern. Some responded fine to patches, but not to gels. Others were fine to gels, but not to patches. And it just got me into thinking really the importance of that personalized approach.

I like to bring that up because if women try something and they feel like it's not working, sometimes our inclination is like we're doing it wrong or we're broken, but that's not the case. We're just all unique and different.

Yeah. Which is so important about what we do. And you know, like a lot of women just feel like they should be able to go to their primary care doctor, their gynecologist, get a prescription, like be done with it, like that, you know, just like they would for their blood pressure pill or whatever. And they don't really understand that there's so much that goes into it that is very personalized. And so we,

What I think is important as practitioners is that we're sort of agnostic and we don't say like this is the best way. Because that's a lot of practitioners, what I find is they wanna know what's the best way? What's the best test? What's the best prescription? And there's not one best way to do anything, it depends. But so we want to give our patients choices like.

here's the hormones that I recommend for you, we could do it this way, this way here, this one's covered by insurance, this is not, this is daily, this is whatever, and let them choose because then they also, I we don't wanna make it super complicated, because then it's overwhelming. But so what they hear from that is, I have options, I'm gonna pick this option, and then if they go home and it's not working so well or they don't care for it, they know they can come back and ask for something different. If they go in and their practitioner just says, okay,

Dr. Deb Matthew (58:08.214)

Here's what you need to do. This is the best way to do it. Here's your prescription, off you go. And then they get home and they don't really like it, then they sort of feel like these hormone things aren't really working for me. I don't wanna do it anymore. Or that doctor wasn't able to help me. I'm gonna go find another doctor. that conversation and giving, you don't have to give every option, because that's overwhelming. But kind of talking about how there's some choices and letting it be a partnership in helping them choose what they like. I think that's really, really important.

for patient loyalty, for protecting yourself, like for our medical legal defense, because if the patients feel like we're on their team and we're working with them in partnership to help them, then if things go south, you know, if something goes wrong, they're much less likely to feel like we did this to them, you know?

That's particularly important earlier in the menopausal transition. Like if you're starting women on hormones, maybe when their cycles are changing or they're not one year out without a menstrual cycle, which is fine. The guidelines are kind of gray with when to start. But there can be fluctuations and change. I completely agree with you. If you start on something and then it's not working anymore, it may not be a problem with that prescription. It's just that your body's shifting and how it's using hormones and being in good collaboration and partnerships.

with your provider is so important through that because your provider might have made the right prescription at the time, but it just needs adjusting. How often do you recommend follow-up with patients when they're on a menopausal hormone therapy?

When we first start, we're checking in with them monthly for the first couple of months. usually recheck levels about three months into it. And then if we're making some adjustments, we might check again three months later. But once we've kind of got them on a dose where they feel pretty good, we're typically monitoring them every six months. so at...

Dr. Deb Matthew (01:00:01.422)

But I would say we're monitoring them about every six months. At some point when they're post-menopausal, they've been on the same hormones forever and nothing's really changing and then maybe we just see them once a year.

That's great. Well, I've really loved our time together. We've covered a lot of nuts and bolts, but also a lot of like really interesting nuances to hormone therapy and menopausal hormone therapy. So thank you so much, Dr. Matthew. One more question that I have for you is just like, when we take a look at this and we really zoom out beyond labs, beyond the variety of hormone therapy options available for women, like what is it about hormones and working with hormones that you think makes it worth women pursuing this option?

Hormones play such a dramatic role in how we feel on the inside, how we relate to other people, how we react to the world around us. And so literally the most common thing that they say is, I just don't feel like myself. Like this isn't me. One of my patients said, I just want Lori back. And they're not sick, but yet they don't feel right. And so if they march into their doctor and they say like, I know I'm tired, I wanna exercise, but I'm not. we just.

their medical practitioner does not have the tools to deal with it. And the antidepressants and the sleeping pills are fixing the wrong problems. So it's just so rewarding to just help to give people their spark back and their joy back. Like husbands are so happy that they get their wives back. I mean, my husband and I laugh about how I was such a ding dong before and how I was so hard to put up with because we can laugh about it now because it's old news, but it was not funny at the time. it just, it really transforms people's lives.

Wonderful. Well, thanks Dr. Matthew for taking your time out of your ACOG sessions and coming to spend some time with us at the DUTCH test. I really appreciate it.

Dr. Deb Matthew (01:01:49.656)

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