Episode 153 Transcript

00:00:00:00 - 00:00:11:14
Dr. Jenn Simmons
If we screened for metabolic dysfunction with the same vigor that we do breast imaging, we would have a very different health status.

00:00:11:16 - 00:00:37:02
Dr. Jaclyn Smeaton
Welcome to the DUTCH podcast, where we dive deep into the science of hormones, wellness and personalized health care. I'm Doctor 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 well-being, we've got you covered.

00:00:37:04 - 00:00:59:16
Dr. Jaclyn Smeaton
The contents of this podcast are for educational and informational purposes only. This information is not to be interpreted or mistaken for medical advice. Consult your health care provider for medical advice, diagnosis and treatment. Hi there! Welcome to this week's episode of the DUTCH Podcast. I'm really excited that you're here with me today, because we're going to dive really deep into menopausal hormone therapy and breast cancer.

00:00:59:16 - 00:01:21:08
Dr. Jaclyn Smeaton
But also talk about the fact that breast health is just health. And we're going to talk about a lot of the underlying factors that might surprise you, that influence your risk of breast cancer and your survival of breast cancer. My guest today is Doctor Jennn Simmons. Now, she used to be a breast cancer surgeon, and she stepped away from that and really sparked a revolution.

00:01:21:12 - 00:01:42:00
Dr. Jaclyn Smeaton
She's the founder of PerfeQtion Imaging. But really she's committed her career to disrupting the fear, the confusion and the medical dogma that's controlled women's breast health for literally generations. On today's pod, we are going to talk about how we got to the point where we have said women with breast cancer or after breast

cancer should never get hormone therapy.

00:01:42:02 - 00:02:06:10
Dr. Jaclyn Smeaton
We're never going to talk about how things have changed. What does a data actually say? And believe it or not, just recently in JCO, the Journal for Clinical Oncology, they just put out a statement in their publication that we should be really talking about hormone therapy for women with breast cancer and not just having a blanket prohibition. This really supports the work that doctors men have been doing for literally decades.

00:02:06:12 - 00:02:24:16
Dr. Jaclyn Smeaton
Now, Doctor Simmons is a really compelling speaker, and we're going to dive right into the research. So let's go ahead and get started. Doctor Simmons, I'm so glad to have you back on the podcast. When we had you live at a forum, it was so much fun. And I remember thinking, gosh, we're just getting into the story and we're out of time and we need to have you back on.

00:02:24:16 - 00:02:25:23
Dr. Jaclyn Smeaton
And so here we are.

00:02:26:01 - 00:02:28:00
Dr. Jenn Simmons
Welcome. I'm so happy to be here.

00:02:28:02 - 00:02:52:04
Dr. Jaclyn Smeaton
Now I want to just remind listeners and kind of get people caught up to what we talked about, and we'll link to the previous recording. I really recommend you guys listen to that if this is the topic that's interesting to you, but I want to just remind listeners and have you start out by talking about kind of the core arguments around estrogen, progestin and breast cancer risk, because you really blew my mind, right?

00:02:52:04 - 00:03:13:14
Dr. Jaclyn Smeaton
Open and really challenged a lot of the assumptions that I'd been taught by kind of the standard approaches to menopausal care, like menopausal society or NAMs at

that time. And now things are really changing. And even since we talked last December. So let's start by just talking about the core arguments around these. What do people believe and what do you think that's different?

00:03:13:16 - 00:04:04:09
Dr. Jenn Simmons
Well, the narrative that has been in place since the early 2000s were there for very intentional reasons. And when we went into the Women's Health Women's Health Initiative study, the primary investigators went into that study with great intention. It was no accident that their findings were their findings, because if you can somehow create a belief that estrogen causes breast cancer, then you create, a situation where women would then actively choose to not have estrogen and estrogen is the hormone of life.

00:04:04:11 - 00:04:34:12
Dr. Jenn Simmons
So without estrogen, women start to lose their mind. They can't sleep. They're anxious, they're depressed. Their joints ache, their bones ache, they become osteoporotic. They gain weight. They, have mood disturbance. They lose their libido. They lose their, vaginal health, their bladder health. I mean, really, all of it. Right. And in that place goes a lot of pharmaceutical medications.

00:04:34:14 - 00:05:04:20
Dr. Jenn Simmons
Right? In that place goes antidepressants and anxiolytic and sleep medications and bisphosphonates and weight loss drugs and, and things for your heart and things for your cholesterol and things for, for pain and on and on and on. Right. So you can easily see a scenario where if a woman is not on hormone replacement, she could easily be on 3456789 pharmaceuticals.

00:05:04:22 - 00:05:44:03
Dr. Jenn Simmons
And this isn't, one and done kind of thing as these pharmaceuticals come on board, they're there forever in the minds of the manufacturers. Right. So they're creating this incredible customer base by having women believe that estrogen is the problem. And it really, really worked. It really, really worked. When they came out with the their position statement, that hormone replacement caused breast cancer, that there was an increased incidence of breast cancer in the women who took hormone replacement.

00:05:44:05 - 00:06:16:19
Dr. Jenn Simmons
And they made that blanket statement. It was kind of like the science is settled, but no one asked for the science, and it wasn't there. And the people that were part of the that original Women's Health Initiative study that said, wait a minute, this isn't exactly correct. What we're putting out there isn't exactly correct. They were just drowned out by the voices that were so willing to believe it.

00:06:16:21 - 00:06:50:06
Dr. Jenn Simmons
And and, and wanted very much wanted to create this narrative. Now, fast forward that that opinion has been completely retracted. There was a position paper that was printed in 2017 that I think, like you, me and maybe five other people read, but they're all of that. All of those findings were completely retracted, and it's only now that people are looking at the real data that came out of that study.

00:06:50:06 - 00:07:25:07
Dr. Jenn Simmons
And the real data is that in the patients that were given estrogen alone now, they weren't given bioidentical estrogens, they were given conjugated equine estrogen, which, you know, I can still argue it was not a good thing to give women. But even even in that we saw a 23% reduction in breast cancer like this should have every single practitioner up in arms.

00:07:25:09 - 00:08:04:21
Dr. Jenn Simmons
And even if they are right, even if we are setting the stage to say, okay, it's not the estrogen. And when we actually look at the data and we look at the data across the board for both pre breast cancer studies and post breast cancer studies with hormone replacement, the only signal that we're seeing that is tied to an increase either primary breast cancer or recurrence are for progestin containing formulations, not progesterone progestin.

00:08:04:23 - 00:08:15:20
Dr. Jenn Simmons
And the biggest problem that we have we have a lot. But the biggest problem that we have is that most providers don't know the difference.

00:08:15:22 - 00:08:18:14
Dr. Jaclyn Smeaton
Yeah. Well, tell us about the difference.

00:08:18:15 - 00:08:56:16
Dr. Jenn Simmons
Yeah. So when you look at the chemical composition, a progestin looks very different than progesterone. And progesterone will, attach to the progesterone receptor and do what progesterone does. Right. So if estrogen is our on button, progesterone is our off button. It's our calm button. It allows us to sleep and think rationally and be calm and not overreact.

00:08:56:16 - 00:09:51:18
Dr. Jenn Simmons
I mean that that is amongst amongst other things that progesterone does. It stops. It stops bleeding. It, it it is actually the balancing hormone to estrogen. Progestin is actually have estrogen like receptor activity. And so it was a double whammy of stimulation for women who were on this drug. So what what no one realized and providers included was that when they were giving these synthetic combined formulations, they were actually creating something that was very un physiologic, and they have the cancer to show for it.

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Dr. Jenn Simmons
So the reason why providers don't know the difference between progesterone and progestin is because they have been used synonymously, both in practice and in the literature.

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Dr. Jaclyn Smeaton
There's so much confusion around that.

00:10:12:07 - 00:10:24:17
Dr. Jenn Simmons
There's so much confusion. And you really have to be a discerning researcher to to know the difference and to recognize the difference. And most providers are not.

00:10:24:22 - 00:10:47:10
Dr. Jaclyn Smeaton

Yeah. So just to summarize it like we have this category of compounds that are called progestogen. That's our umbrella term for your listeners. And then within under that there is just dins which are always synthetic but still bind to the progesterone receptor. And then there are there's progesterone which is what our body makes. There's bioidentical progesterone available. Progestin I always say synthetic progestin.

00:10:47:11 - 00:11:09:02
Dr. Jaclyn Smeaton
Whenever I say progestin I always say synthetic progestin. Yeah. To try to help people avoid that confusion. Yeah. The other thing with progesterone that's interesting. And Mark, I'd love you to kind of talk about this a little bit. And again, this is just some background information. Is that the stage progestin. Progestin is synthetic. Progestin do not break down into progesterone metabolites which also have biological activity.

00:11:09:04 - 00:11:24:00
Dr. Jaclyn Smeaton
And I think that's another thing that's commonly misunderstood. You don't get the benefits of like Ella pregnant alone or the brain coming benefits. You can only get that from bioidentical progesterone. Can you talk a bit about that piece, Mark. And then I want to shift back to talk about breast cancer.

00:11:24:02 - 00:11:47:22
Mark Newman
Yeah. Yeah. And just double down on what you said. It's pretty frustrating when you read I have seen somewhere you read an abstract that uses the word progesterone even in, in an academic setting. And then as you peel down into the paper, then you see that they're actually not talking about, progesterone, but and so when people are drawing conclusions, even sometimes if you just read the abstract, you can actually be, misled, even if you're even if you're well intentioned.

00:11:48:00 - 00:12:07:02
Mark Newman
But yeah, the thing with progestin, too is it's not a thing like when you get the birth control estrogen, you're pretty much always talking about ethanol, estradiol, which you can study. But then with progestin, there are so many of them that of course they have different impacts than progesterone, but then they have metabolites themselves and which, you know, have not been studied extensively at all.

00:12:07:07 - 00:12:40:13
Mark Newman
And progesterone, of course, has, you know, that pathway that it goes down that creates aloe pregnant alone and the compounds around it, like we measure aloe pregnant dial or alpha pregnant dial. And it has some of those, those similar sedating effects. But that whole family of alpha metabolites has that impact. And who knows which, progestin have some of that or some distorted version of that, because some of them do get metabolized the same way, but then they're still chemically different, at different parts of the molecule.

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Mark Newman
And so, you know, assuming that you're going to get those same effects because you do get progesterone effects, but then it also acts as a pro hormone and you're getting those metabolite effects, you know, all of those.

00:12:50:19 - 00:13:27:00
Dr. Jenn Simmons
Also they some of those metabolites will have your alpha, activity as well, which is why we get into trouble with those compounds because of their affect. It's not it's not their effect on the progesterone receptor. Those are the wanted effects but the unwanted effects or their effect on the er alpha receptor. So when we look at r e our estrogen receptor activity we have to talk about this specific receptors.

00:13:27:00 - 00:14:04:18
Dr. Jenn Simmons
And there are stimulatory receptors and non stimulatory receptors. And they work in balance with one another. But when you have these synthetic progestin that have some progesterone activity but some estrogen activity that estrogen activity that they have is the er alpha activity. And so we get into a whole system where we're, we're out of balance because of the decision to introduce a compound that is acting across different receptors.

00:14:04:19 - 00:14:34:06
Dr. Jaclyn Smeaton
I'm so glad we're covering this. So sorry. I didn't mean to disrupt you. I thought you were, but that's so important. I'm so glad we're covering this because I think the the lack of understanding or the amount of confusion that's erupted in this industry and still exists right now with the perceived interchangeability. And I'll even add OCP is in

the mix because, you see, OCP is given to women in perimenopause, which again, you have this synthetic Athena atlas or diol combined with some kind of synthetic progestin.

00:14:34:08 - 00:15:02:10
Dr. Jaclyn Smeaton
And most ob GYNs believe that that's equivalent to like a bioidentical menopausal hormone therapy regimen. There is not a clarity around different impacts of these things, but they truly are different drugs. You know, every progestin, natural progesterone, and then at the lesser dial. And then you have your different forms of natural estrogens. We need to be thinking about these and compartmentalizing them as unique compounds in the body, not conglomerated them all together without question.

00:15:02:12 - 00:15:48:15
Dr. Jenn Simmons
But this is this is the crux of it. And this is the problem that we have and that we're going to continue to have because because of the results of the Women's Health Initiative, and essentially all learning and knowledge about hormones was suspended, frozen in time. We have two decades of providers who are untrained or under trained, UN knowledgeable, don't know the difference between a progestogen and progesterone, don't even know what the native compound is supposed to do or where it's supposed to do it right.

00:15:48:15 - 00:16:29:18
Dr. Jenn Simmons
Like there's still this perception that estrogen is only for, procreation and and sexuality, and there's no reason to replace it afterwards. I mean, there's just a complete lack of understanding of what the of what the purpose of these compounds are. And so even if we decided tomorrow, today that hormones are safe, who's going to provide them? Because what we have out there is a bunch of providers who don't know anything beyond birth control pills and don't even know or understand the dangers of birth control pills.

00:16:29:18 - 00:16:54:13
Dr. Jenn Simmons
I mean, we have a we have a Denmark study of 1.8 million women that shows a linear relationship between birth control pills and the development of breast cancer. All comers, all ages, not just birth control pills, any hormonal birth control, because any

hormonal birth control is going to be progestogen containing, synthetic progestogen containing.

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Mark Newman
It's interesting that you mentioned, some of the progesterone progestin, those metabolites hitting the estrogen receptor. I'm curious, when they teased out the data, then it would have been a shocking finding to say that the progestin is causing cancer and the estrogen isn't. If the estrogen went back to a risk or whatever you call those stats, the risk ratio of zero, that would have been really interesting.

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Mark Newman
So were you surprised that the estrogen alone arm actually had a reduced risk of breast cancer? And given the role of estrogen receptor, potentially in breast cancer, can you just speak to like why would that be like that surprised me. Like I would have been happy with net neutral, right. But the fact that it reduced the risk, my mind still can't quite understand the impact there or why that is.

00:17:39:23 - 00:17:40:23
Mark Newman
Could you speak to that?

00:17:41:01 - 00:18:24:11
Dr. Jenn Simmons
Yeah, I think it's because of the er beta activity. So what while we measure er alpha because we know that that is the stimulatory estrogen receptor, the er alpha receptor, we are not measuring er beta but there's really no other explanation for me other than conjugated equine estrogen has a considerable amount of er beta activity. And so by virtue of that it is lowering proliferation and we know that, you know, the more proliferation you have the more likely you are to make a copy error, a copy mistake.

00:18:24:12 - 00:18:51:18
Dr. Jenn Simmons
So that is that the cells zero, right. That's the original cancer cell that if that goes unchecked then two daughter cells and two daughter cells and two daughter cells. And before you know it, you have a mouse, right? If you are instead not stimulating the alpha receptor, but stimulating the beta receptor, that is going to be anti

proliferative.

00:18:51:23 - 00:18:58:02
Dr. Jenn Simmons
So that's going to turn off growth and decrease the risk of breast cancer.

00:18:58:04 - 00:19:20:15
Dr. Jaclyn Smeaton
There was actually a really interesting study that just came out I will send it to you. It was published in March in Nature Aging. You may have seen it. It was basically looking at aging of the human breast tissue, and it went beyond like mammographic density and looked more at what's happening at a tissue level. And it was really interesting because they identified, a couple of key things.

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Dr. Jaclyn Smeaton
One was that what we really saw was there were massive changes, particularly in that what I read to be that like perimenopause, that kind of 12 months before the last menstrual period, where the withdrawal of estrogen causes massive changes to the breast tissue at a tissue level, where there's a lot of immunologic changes, where the ability to kind of surveil for these aberrant cells really declines, it's almost like it becomes lazy without the estrogen there.

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Dr. Jaclyn Smeaton
And it was really thoughtfully looked at because we look at breast cancer in younger women, which is growing right now. Rates are growing and breast cancer in older women. And the types of tumors that happen are quite different, you know, more aggressive in younger women. And more likely to be er, negative, right. Compared to older women. This is your expertise, not mine.

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Dr. Jaclyn Smeaton
But I just found that really interesting because again, it speaks to that importance of that continuous supply of estradiol too. And, and what got me thinking about all the work with AI. And the other thing with AI is remember the average age of women in the study were in their early 60s. So these women had a withdrawal from estrogen for like sometimes upwards of a decade before it was reintroduced.

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Dr. Jaclyn Smeaton
And you think about all the tissue changes. I always tell Mark the issue was the tissue, right. That's like my new favorite slogan. It's the change in the cells that impact the way hormones are used. And I really liked that. I'll put the link to it in the show notes. For those of you who are interested, it's open access.

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Dr. Jaclyn Smeaton
But, really interesting to be looking at how that withdrawal from hormones and menopause changes in breast cancer risk. When you reintroduce hormones later. Absolutely.

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Dr. Jenn Simmons
And the thing that we don't talk about enough, because everyone has been trained to think that breast cancer is somehow a disease of hormone excess, it's not. It's a disease, a form of deficiency.

00:21:08:08 - 00:21:09:18
Dr. Jaclyn Smeaton
Okay. Let's talk more about that.

00:21:09:21 - 00:21:55:20
Dr. Jenn Simmons
Yeah, absolutely. First of all, this whole concept of estrogen dominance, we're not suddenly making more estrogen. Yes, there are xeno estrogens. And that is contributing to disease states for sure. But estrogen dominance isn't really about estrogen dominance. Estrogen dominance is about progesterone deficiency. And the less healthy we are, the less progesterone we have. And the whole reason I believe that we are seeing cancer younger and younger and younger is because in in a normal life span, a normal hormonal lifespan, we expect to see the loss of progesterone approximately ten years before we lose our estrogen.

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Dr. Jenn Simmons
And all we're seeing now is an accelerated timeline, because the less healthy we are, the less progesterone we're going to produce. And so we are looking at the effects of a loss of progesterone.

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Dr. Jaclyn Smeaton

00:22:12:02 - 00:22:28:21
Dr. Jenn Simmons
Because progesterone is protective. It is anti proliferative. So if you don't have that protection around and you're losing your safeguard, you're going to have more cancer without question. And at a younger age.

00:22:28:23 - 00:22:53:16
Dr. Jaclyn Smeaton
Can we put this in context. Also like I'd love for you to share what we know about a woman's reproductive lifespan in breast cancer. So things like the age of men arc or the number of pregnancies, because I think it's helpful to put it in perspective with our natural production of exposure of hormones. You know, for example, in pregnancy your hormones are very, very high, high progesterone, high estrogen for this period of nine months.

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Dr. Jaclyn Smeaton
And we know that, you know, well with women have pregnancies, it can change breast cancer risk later on in life. What do we know. Like what it can take away is.

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Dr. Jenn Simmons
It actually decreases it.

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Dr. Jaclyn Smeaton
Exactly as right. So the more pregnancies the more protection you have. Yeah. That's the situation with very high hormones. Yeah. So when we can we can you share a little bit about what the takeaways are about. Just natural.

00:23:15:09 - 00:23:40:07
Dr. Jenn Simmons
Well, so I think that when we were saying that women who got their started their cycles earlier, that that is a breast cancer risk, I honestly think that that was tied in to

that whole mentality of hormones are bad. Okay. Right. And so if you have hormones at a young age, it's it's bad. And it must be tied to breast cancer.

00:23:40:09 - 00:24:10:05
Dr. Jenn Simmons
If you think about it, a woman who is menstruating longer, right. She that that is probably a significant mark of health and an ability to to menstruate for longer. So I and I would love to really look at the data with the critical eye that I have now because as I, I, I wrote a breast cancer risk analysis program.

00:24:10:05 - 00:24:34:05
Dr. Jenn Simmons
This just this last week and I kind of put into Claude, I am I missing anything like I named all of the things that I thought were important and am I missing anything? And it said, you know, early menarche and late menopause. And I came back to Claude and said, let's, let's really talk about this. Is that true?

00:24:34:07 - 00:25:09:19
Dr. Jenn Simmons
Because I think that that is another thing that we were sold in, that hormones are bad. And so the longer you have high hormone levels, the the higher your risk is of developing cancer. But I don't know that that data really exists. I don't know that that's true. And we and when you look at the times in a woman's life where she has the most hormones, teenagers, pregnancy, you have ten times the amount of circulating estrogen and progesterone.

00:25:09:21 - 00:25:27:00
Dr. Jenn Simmons
These are not times that are associated with high incidence of breast cancer. And breast cancer is a disease of women who are hormone deficient because hormones aren't innately protective.

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Dr. Jaclyn Smeaton
This story gets complicated when we start to talk about what happens to estrogen when it's in the body. Mark, can you talk a little bit about what we know? Also around breast cancer risk and estrogen metabolism. And I want to also layer in the fact that these studies are mixed. But when we look at the good data which would be LCMs data, they are not mixed.

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Dr. Jaclyn Smeaton
And I'd love you to touch upon that.

00:25:48:04 - 00:26:08:09
Mark Newman
Yeah, it's I mean, it's a confusing topic that I have to go back and like re refresh yourself all the time because there is a lot of old data that's analytically not as good. And then, you know, when you look at the estrogen metabolism, you've got those three pathways of the two hydroxy, the four hydroxy, and then the 16 hydroxy.

00:26:08:11 - 00:26:45:13
Mark Newman
You know, the two hydroxy definitely seems to have some protective properties when it comes to breast cancer. That's my understanding. And then when you look at the four hydroxy, it's got the I was actually just looking at one of the kind of older papers that has this beautiful pathway that breaks down, you know, that pathway from estrogen to four hydroxy, and then it can get methylated or it can move on towards that active quinone where it can, you know, attach to the pureeing the DNA and make those DNA attacks where you're actually seeing sort of a physical DNA damage from the estrogen metabolites that four hydroxy that specifically has that, the nature of

00:26:45:13 - 00:27:06:18
Mark Newman
that. And so, so the relationship between the two and the four and the importance of methylation, we talk about that a lot. I'll be honest with you, I'm still a little bit confused. And maybe, maybe Doctor Simmons, you can you can add your perspective on the role of the 16 hydroxy. We know that it has a unique relationship in that it can create covalent bonds with the estrogen receptor.

00:27:06:20 - 00:27:23:09
Mark Newman
And some of the older studies show that there may be some breast cancer risk associated with the 16 relative to the two. And look at the at the ratio there. But that is one where the studies are mixed depending on which one you're looking at. And I wouldn't I wouldn't state that it's real clear on that one.

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Mark Newman
But the, the mechanism of, you know, for hydroxy and DNA damage and the, the, the, the cancer rates, you see, particularly people who have the, the, genetic defects of making the for not methylated and then not detoxing. When you stack those, those three up you definitely get the higher breast cancer risk. So, you know how your body deals with deals with estrogen in terms of phase one and phase two?

00:27:51:07 - 00:27:59:23
Mark Newman
Metabolism definitely plays a role, but it is complex. I'd be curious to know just kind of what your perspective has been on how the literature has kind of evolved with that over the years.

00:28:00:01 - 00:28:50:13
Dr. Jenn Simmons
Yeah, I'm going to agree with you in that I think it's very easy for us to picture and understand how the four hydroxy pathway can directly damage DNA and set the stage for cancer. Right. And that that seems very clear to all of us. And then the 16 hydroxy pathway is not so clear. And I also don't know that in vivo studies are entirely possible with isolating these, these pathways, because all of this is really in the face of is this person inflamed and metabolically unsound, or is this person metabolically sound?

00:28:50:13 - 00:29:24:17
Dr. Jenn Simmons
Because I think what we're seeing are the downstream effects of metabolic dysfunction and inflammation. And when you correct them, do you at the same time correct some of this metabolic findings? Right. In terms of estrogen metabolism. So I don't know that we can tease them apart or blame something like 16 hydroxy when that is just there as a result of metabolic dysfunction.

00:29:24:19 - 00:30:00:03
Dr. Jenn Simmons
And I have long said that if we screened for metabolic dysfunction with the same vigor that we do, breast imaging, we would have a very different health status, right? If we if we instead screened for metabolic dysfunction and corrected that, we would we would see very different things, including what the downstream metabolites of our estrogen, metabolism are.

00:30:00:05 - 00:30:08:09
Mark Newman
Could you define metabolic dysfunction there, which are. Yeah, I'm just before you in terms of what you specifically would measure to to separate. Absolutely that well.

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Dr. Jaclyn Smeaton
Let's talk more about that for sure.

00:30:10:01 - 00:30:46:14
Dr. Jenn Simmons
Yeah. So instead of everyone going and getting the kind of precursor labs that they get every year at their doctor, like maybe they get a CBC and maybe they get some electrolytes and a and, what they call a complete metabolic panel, which is anything but, and, you know, your basic lipid panel, what we should really be looking at, because by the time your, let's say, glucose, your fasting glucose is elevated, you're already far down that pathway, right?

00:30:46:14 - 00:31:13:04
Dr. Jenn Simmons
Your body will work really, really hard to keep that in an acceptable range because being hypoglycemic is so very toxic to your cells. Right. So there's going to be a lot of comp compensation before that happens. So instead of measuring fasting glucose why aren't we measuring fasting insulin. You're right. We need.

00:31:13:06 - 00:31:14:00
Dr. Jaclyn Smeaton
Indicators.

00:31:14:00 - 00:31:46:06
Dr. Jenn Simmons
Yeah early indicators. And why are we allowing people to walk around with hemoglobin A1 C's in the mid fives for years without saying what's going on here. Why is their average glucose well over 100 enough to make your A1 c in the mid fives. So we are not looking for metabolic dysfunction. And at PerfeQtion Imaging. This is part of your basic screen.

00:31:46:06 - 00:32:07:17
Dr. Jenn Simmons

When you come in to screen for breast cancer we're not just imaging your breast because that has nothing to do with prevention. If we find something on your imaging, the cat's out of the bag or the horses out of the barn, or I forget which one is the one that you say and or maybe both, right? Yeah, like it is.

00:32:07:18 - 00:32:41:07
Dr. Jenn Simmons
It has already happened. And what I'm looking to do is to actually prevent disease. So we're looking at your fasting insulin. Yes. We're also looking at your triglycerides your HDL and major measuring a triglyceride to HDL ratio. We're looking at some body composition metrics. We're looking for a high sensitivity C-reactive protein. I'm also incidentally looking at vitamin D because vitamin D levels are highly predictive of who does and who does not develop disease and dysfunction.

00:32:41:09 - 00:33:16:06
Dr. Jenn Simmons
We're looking at a waist to hip ratio, waist circumference. We're looking for the things that tell us are you metabolically sound or are you not metabolically sound? Because if you're not metabolically sound, this is just setting the stage for dysfunction. And it's going to lead to dysfunction across the board. It's going to lead to hormonal dysfunction. And then it's it's going to lead to some end point that we readily recognize, but rarely talk about where it came from or why it's there.

00:33:16:08 - 00:33:50:17
Dr. Jenn Simmons
Right. So diabetes, hypertension, coronary artery disease, peripheral vascular disease, overweight, obesity, cancer, autoimmune disease, any of these diseases, they're starting off as metabolic dysfunction. But we're just not looking for it. We're not measuring it. And I think we're not doing it because we don't know as a as medical providers, most people don't know what to do with that input information.

00:33:50:18 - 00:34:02:22
Dr. Jenn Simmons
They don't know how to optimize people's health. So they're not looking for health optimization. They only know what to do when you failed. And their what to do is suppress the symptom.

00:34:03:00 - 00:34:32:01
Dr. Jaclyn Smeaton

It's not an important conversation, and I'm so grateful for you raising it because I think one we hormones never work in a vacuum. You know, there's the hormone in the bloodstream, but it's the cells response to it. And I think people get this when it comes to glucose and insulin. I like to use that as an example, where now everyone knows the term insulin resistance and what that what that means at a 50,000ft view is that the cell is changing the way it responds to hormones first.

00:34:32:04 - 00:35:14:22
Dr. Jaclyn Smeaton
That's the first step, first stage of disease development towards diabetes type two. Then what you have is you eventually have hormonal changes that follow that. So I think that it's like the cart before the horse. And when we are only looking for the hormonal changes, you are missing the opportunity for early intervention. And I love that you phrase that because in America, when we talk about preventive medicine, what most people mean is preventive screening or early detection, screening, pap smears, mammograms, colonoscopy is what they are not doing is what you are doing, which is looking at the foundational layers that drive, in your case, breast cancer development.

00:35:15:00 - 00:35:43:13
Dr. Jaclyn Smeaton
You know, we know that chronic inflammation, oxidative burden, even sleep disruptions been identified by the World Health Organization as a human carcinogen, a possible human carcinogen. You are upstream from the detection to true prevention. And I want you to talk some more about that, because one, I think for other people especially like, you know, other breast surgeons maybe, who follow you, breast psychologist, if you've never heard you, Doctor Simmons, speak before, this could be a very new concept.

00:35:43:13 - 00:35:52:02
Dr. Jaclyn Smeaton
But can you talk a little bit about, like before a woman gets on hormones? What would that work up look like? I mean, you've described some of those cardiovascular pieces.

00:35:52:02 - 00:36:20:20
Dr. Jenn Simmons
Yeah, absolutely. Well, what we all need to understand is there is no magic pill or potion or anything, right? Hormones can be extremely helpful. And life enriching, but they are not the be all, end all in that they are the bow on top of the box, and the box

is filled with all of those foundational things that we all need, and we need them first.

00:36:21:02 - 00:36:56:14
Dr. Jenn Simmons
Now, can you always optimize people's metabolic health before putting them on hormones? No, because part of our metabolic health is tied to having hormones. But at the same time, I'm not giving hormones to someone who hasn't tried to optimize their sleep, who hasn't tried to optimize their diet, who isn't moving and is sedentary, who isn't lifting weights, who is still using alcohol or drugs as their escape, or as their self-care.

00:36:56:16 - 00:37:24:12
Dr. Jenn Simmons
Right. As my kids would say, mom, that's not it, right? It's not. It's not how it works. And if you want hormone replacement to work, and if you want hormone replacement to be safe and to be part of your longevity plan, then you have to lay it on top of a foundation that sets up for health and longevity.

00:37:24:14 - 00:37:47:13
Dr. Jenn Simmons
And that is, you know, eating in a way that's nourishing. Having a fasting practice, make sure that you're moving your body and not just being an exercising couch potato, but someone who is moving their body throughout the day. Because we are nomadic, people were meant to move our body, or we lose our body and we have to lift heavy things, right?

00:37:47:13 - 00:38:15:01
Dr. Jenn Simmons
The water didn't come to us. We had to go get the water right. So were meant and built to lift heavy things. And that's how our bones become strong. So you can't have any expectation of strong bones if you're not demanding your bones. Be strong. Right? Bone follows muscle, so you got to work those muscles so that you build strong bones and you have to prioritize sleep.

00:38:15:01 - 00:38:42:04
Dr. Jenn Simmons
Sleep is where the healing happens. And if you're not sleeping, you're not healing. Which is why it is a known carcinogen to not sleep. Right? Because if you can't do the tissue repair, then you're just going to have a lot of broken cells, a lot of rogue cells.

And we unquestionably live in a toxic world, and you're never going to be able to escape all the toxins.

00:38:42:06 - 00:39:14:08
Dr. Jenn Simmons
But you got to try. You got to do your part. And the easy things, like not drinking out of plastic and not cooking in plastic and not storing in plastic. And like the easy things, you just you just have to do it. You have to do it. You have to eliminate as much as you as you can. And having detoxification practices and some of that, you know, I'm not saying that everyone needs to sit in their sauna and meditate all day long, but I am saying that you got to take the trash out, right?

00:39:14:08 - 00:39:47:23
Dr. Jenn Simmons
And sometimes that means you got to break off that relationship or get out of that situation. Like whatever the garbage is that surrounding you, you got to figure out how to get rid of it. You have to, and we all have to live life with purpose. Because if you're not doing that, if you're not motivated by whatever you're out there doing, then that that is not a path to longevity.

00:39:48:01 - 00:40:17:01
Dr. Jenn Simmons
And so when I'm working with someone, we're tackling all of these things first before I even get my no one has prescription pads out anymore. But but before I ever get my virtual prescription pad out, we're working on all of these foundations because, again, hormones are wonderful. They're life changing, but they are not the thing. They are the bow on top of the box.

00:40:17:03 - 00:40:46:16
DUTCH Podcast
We'll be right back with more. If you're already running DUTCH tests in your practice or thinking about it, there's never been a better time to become an official DUTCH provider. Why? Because we go beyond lab testing. Our provider community gets exclusive access to clinical education, in-depth report interpretation, training, monthly case reviews, and one on one clinical support. Whether you're just getting started or looking to sharpen your functional hormone expertise, we give you the tools to grow.

00:40:46:18 - 00:40:54:00
DUTCH Podcast

Join thousands of providers already making a difference. Visit DUTCH test.com today.

00:40:54:02 - 00:40:57:12
DUTCH Podcast
Welcome back to the DUTCH podcast.

00:40:57:14 - 00:41:14:22
Mark Newman
Yeah I would I would love to roll up what you were talking about as it relates to sleep. Well there's a there's an interesting study that looks at breast cancer patients and some of the markers that we look at well, a combination of studies. So we look at the melatonin metabolite in the waking sample, which is essentially a pool of of what you've made over the night.

00:41:15:03 - 00:41:34:17
Mark Newman
And you can see substantially lower in people who get breast cancer. And then if you switch your focus to the marker, that happens to be right next to that on our test, which is the oxidative stress marker, and you look at breast cancer patients, it's substantially higher in those people. And if you look at studies where they've looked at each other, they negatively correlate with each other.

00:41:34:17 - 00:41:58:02
Mark Newman
So this all makes like a story that makes sense. And then they also tie in in terms of correlation with cortisol. And when you look at cortisol in breast cancer survivors, people have those flat cortisol patterns don't do as well in terms of survival. So I've got this sort of triangle of data of oxidative stress melatonin and just kind of crappy cortisol results.

00:41:58:04 - 00:42:27:06
Mark Newman
And they all interrelate. But most of those studies are on people who already have breast cancer. Right. That's an easier way to ask that question. So I was wondering if you could take that story of sleep which relates to cortisol and melatonin, and both of them relate to our oxidative stress marker. So if you move that story back to a prevention story, how do how how do those relate to each other of melatonin being, you know, an antioxidant but related to cortisol and oxidative.

00:42:27:06 - 00:42:33:16
Mark Newman
So could you sort of tie those together in terms of not once you have breast cancer, but in terms of of risk?

00:42:33:18 - 00:43:19:10
Dr. Jenn Simmons
Yeah. Well, if you think about melatonin instead of, you know, most people think that melatonin is what makes you sleep. That's not it. Melatonin is what you make when you sleep. And if you think of melatonin as your repair hormone, the last melatonin you make, the less repair you do. So breast cancer is this intersection between cellular damage, DNA damage, and an immune system that is supposed to be surveilling for these damaged cells and kind of destroy them, or take them out of circulation in their infancy before they can reach mass proportion and become a tumor.

00:43:19:12 - 00:43:55:10
Dr. Jenn Simmons
Right. So if you think of melatonin as something that is allowing your body to make the repairs, not make so many mistakes, or at least do the repairs once you've made the mistakes. If you don't have that repair serum, you can see how this can easily lead to an increased incidence of cancer. But it's not only just cancer that's associated with these low or depleted melatonin levels.

00:43:55:12 - 00:44:33:21
Dr. Jenn Simmons
It is being overweight. It's obesity. It's heart disease. It's any chronic disease, autoimmune disease, any inflammatory condition is going to be more prevalent in the population of people who both have low melatonin and are short sleepers, insomniacs. And what's even more interesting is that you can sleep the right amount of time, but if you're sleeping at the wrong time, you're also going to be melatonin deficient.

00:44:33:23 - 00:45:09:05
Dr. Jenn Simmons
So if you are a night shift worker and you are dutifully sleeping during the day, it won't work. You still have increased risk of chronic diseases. And if you are sleeping, but it's not dark in the room, you're also going to make less melatonin and have more chronic disease. So my my question is, is it purely that you're not asleep so you're not making enough melatonin?

00:45:09:05 - 00:45:35:11
Dr. Jenn Simmons
Or is there something else that's going on that is not allowing you to make enough melatonin in order to do the repairs that you need to do? And I think that that's that's the unanswered question, at least for me. Is it the lack of sleep leading to a lack of melatonin, or is there something else that's going on that are you over consuming?

00:45:35:11 - 00:45:57:20
Dr. Jenn Simmons
Are you not able to make enough? I, I'm not sure that I understand the total picture, but I do know that low melatonin levels and low sleep levels are absolutely, without question, directly correlated with chronic disease states cancer being kind of the end of that spectrum.

00:45:57:20 - 00:46:10:22
Mark Newman
Yeah. When you talk about repair and then that oxidative stress marker also going up when your melatonin is low, and in people who get various types of cancer that like connect some of those dots. Yeah, I think so.

00:46:10:22 - 00:46:24:08
Dr. Jenn Simmons
That oxidative stress marker is just a reflection of the repair that didn't happen. Right? Right. Because it directly it's a direct result of DNA damage.

00:46:24:10 - 00:46:43:00
Dr. Jaclyn Smeaton
Now Mark, a lot of people order the DUTCH test. A lot of clinicians order it because they want to take a look at estrogen metabolism ratios when they have breast cancer in mind. But given everything we've talked about today, that's obviously an incomplete use of the markers on DUTCH. Now, before we answer before I like ask you this question.

00:46:43:01 - 00:47:00:05
Dr. Jaclyn Smeaton
DUTCH test is not a diagnostic task and does not diagnose risk of cancer. If there is no data, correlate it to breast cancer risk. It's not a screening tool, so I want to get that out of your head. We're not making any kind of claims that the DUTCH test can

diagnose risk of cancer or active cancer or anything like that.

00:47:00:06 - 00:47:25:14
Dr. Jaclyn Smeaton
However, what the concept that we've talked about today, metabolic health, oxidative stress, inflammation, estrogen metabolism, like, let's put estrogen and herbalism aside because we've talked about that. What other markers are important for clinicians to look at on the DUTCH test for this group of patients? When we're thinking about prevention and we're thinking about, how to assess some of those underlying functional contributors.

00:47:25:19 - 00:47:56:16
Mark Newman
Yeah. Well, the odds ratio for just that melatonin looking at the lowest quartile versus the highest quartile, that's 0.6. You know, so that's a pretty significant, you know, change in terms of risk of those that don't make, very much melatonin and those that have nice healthy levels. So that's, you know, that trifecta of cortisol dysfunction, oxidative stress marker high and melatonin low, is it I mean, the data on that's pretty strong in terms of the risk between the sort of haves and have nots in terms of, of those levels.

00:47:56:18 - 00:48:17:08
Mark Newman
And then of course estrogen. And we talked about progesterone, as well. I think those would probably be, you know, on the, the top of the list for me in terms of not just having a theoretical like conceptual relationship, but also that there's like solid data that shows that there's a difference. I'd be curious for you, Doctor Simmons, when it talks about like, are you making enough progesterone?

00:48:17:14 - 00:48:37:10
Mark Newman
Is your estrogen metabolized? Well your cortisol dysfunction, melatonin insufficiency and oxidative stress. If you were to put those in sort of a hierarchy of, of your expectations of how tightly those would be related to breast cancer, what's, what sort of comes at the top of the list for you? In that.

00:48:37:12 - 00:49:16:14
Dr. Jenn Simmons
Yeah. So I am almost directly flipping to where is the progesterone and what is the

adrenal function. Yeah. Because that that is kind of the tell for me of where are you in terms of your reserve, in terms of your plasticity, where are you? If I'm being honest, most women who have a breast cancer diagnosis and think that the DUTCH is somehow going to tell them something about their estrogen, that is going to be enlightening.

00:49:16:16 - 00:49:30:19
Dr. Jenn Simmons
Nearly not 100%, but nearly all of my breast cancer patients. When they take the DUTCH, we can barely measure their estrogen. There's there's virtually none people on and.

00:49:30:20 - 00:49:33:18
Mark Newman
Or that are on treatment.

00:49:33:20 - 00:50:01:15
Dr. Jenn Simmons
Well, most people come to me after they've already been diagnosed. Right. And as we said before in this podcast, breast cancer is not a disease of hormone access. It's a disease of hormone deficiency. So they have minuscule levels and these aren't people on aromatase inhibitors. These are these are just the population of postmenopausal women that get breast cancer.

00:50:01:17 - 00:50:44:20
Dr. Jenn Simmons
They have almost immeasurable levels of hormones because as I hope we very clearly stated, hormones don't cause breast cancer. That's not the thing. It's not why you got breast cancer, right. And if anything, estrogen is an innocent bystander in this entire story. And while a tumor will alter the environment around it and upregulate what we call aromatase, which is the enzyme that converts testosterone to estrogen, so it will do its best to create an estrogen rich environment.

00:50:44:22 - 00:51:20:04
Dr. Jenn Simmons
But estrogen is just the innocent bystander there. That's just the tumors. Last dipped ditch attempt to survive, right. It's just trying to create an environment that it can live in because the whole reason that the tumor got there in the first place is cancer's a normal response to an abnormal environment, and there was some global

environmental shift that allowed these cells to to feel threatened enough to go into survival mode.

00:51:20:06 - 00:51:57:07
Dr. Jenn Simmons
That's all that's happening there. So when I when I get a DUTCH on a patient, although if I'm being honest, so many of them come to me with their DUTCH in hand, saying, here, tell me why I got breast cancer, right? And the answer is not there. But I do. I see the signs of it. Yeah. And so when I see someone who has low melatonin and I think the more the more dangerous profile for me are the ones that also have very low cortisol and cortisol levels.

00:51:57:12 - 00:52:05:10
Dr. Jenn Simmons
Right. This is someone that is well beyond their ability to acclimate, right? They're tanked.

00:52:05:12 - 00:52:06:02
Mark Newman
Right?

00:52:06:04 - 00:52:33:20
Dr. Jenn Simmons
They're tanked. So these are the things that I'm looking for and I'm looking for that that oat at the end. Right. I'm looking for, signs of DNA damage, signs of increased lipid peroxides like if I'm looking for signs of imbalance in the system that I know. Well, this isn't the thing, but this is someone who. Maybe we can help them.

00:52:33:20 - 00:53:10:12
Dr. Jenn Simmons
Maybe there are touch points there. But I'm. I'm looking for ways to help them improve. And I think that the DUTCH test is a really good indication of that, but I'm not necessarily looking for how you're breaking down your estrogen, because usually there's so little estrogen that we can't we can't really make that that assumption from the, from the information and also I don't think that's anyone's primary problem.

00:53:10:14 - 00:53:28:12
Mark Newman
Right. Yeah. And to kind of finish off the other part of that question, Jacqueline, terms

of, of what we see, I think you talked about inflammation and when you've got long term inflammation that that really lights up a lot of different areas on the DUTCH test, as far as having kind of high kind of running kinder nic acid.

00:53:28:14 - 00:53:53:04
Mark Newman
You know, that tryptophan metabolism shifts when there's inflammation. And then, you know, you get high cortisol with acute inflammation. But with that long term inflammation, the pattern that you described as much more often seen in terms of having low cortisol, oftentimes we'll see higher levels of, cortisol metabolism because that long term inflammation can kick up your body's, processing of cortisol.

00:53:53:06 - 00:54:13:01
Mark Newman
And then the other marker, this sort of that plays into that a little bit indirectly is if we see high power glutamic acid, because if you've got a glutathione deficiency then that's, you know, that's not going to that's related. Maybe not causative but related in terms of just if you're not doing well on the glutathione side of things, then, you know, getting rid of those bad estrogen metabolites is going to be a little bit harder.

00:54:13:01 - 00:54:25:05
Mark Newman
So there are a number of those things that we're we're looking at, not as much, on the cause side, but just tying that all into together with inflammation and, and some of that metabolic picture that you're, that you're describing.

00:54:25:07 - 00:54:47:08
Dr. Jenn Simmons
And just proof that someone struggling. Right. Like it's, it's a, it's an indication that they've kind of exceeded their body's ability to deal with their environment that that they've used and overused their resources and their body is just tired. Right.

00:54:47:10 - 00:55:13:12
Dr. Jaclyn Smeaton
Well we've been on we've talked about so much but I have to wrap by sharing with you that I was thinking about you so much this last month because on March 31st the Journal of Clinical Oncology or JCO, which is the American Society of Clinical Oncology journal, published a commentary titled Menopausal Hormone Therapy After Breast Cancer Personalization, not prohibition.

00:55:13:14 - 00:55:30:18
Dr. Jaclyn Smeaton
So you can search this. It's partially open access. But what I want to read a quote from that because I just I think it's like a pat on the back to all the work you've done. Doctor Simmons says the contemporary management of cancer focuses on effectiveness of treatment while aiming to maintain quality of life. They go on to kind of talk about a little bit about that.

00:55:30:20 - 00:56:04:23
Dr. Jaclyn Smeaton
And while there are therapies available like antidepressants, the use of vaginal hormones, which are, you know, providing localized absorption to mitigate symptoms related to genital urinary syndrome of menopause, menopausal hormone therapy has been considered contraindicated. But for women in whom quality of life is sufficiently compromised because of menopausal side effects, such blanket prohibitions against menopausal hormone therapy deny breast cancer survivors a treatment option that's less costly than many alternatives and highly effective with benefits beyond addressing menopausal symptoms.

00:56:05:01 - 00:56:31:10
Dr. Jaclyn Smeaton
And get this part the totality of data not supporting its absolute contraindication after a breast cancer diagnosis. And I want to just pat you on the back because I think this is a song you've been singing for a long time, and I think this is going to shake the industry, to maybe start to look at some of those studies and realize, I mean, with the Women's Health Initiative, we have said that was a faulty conclusion and let's move on.

00:56:31:16 - 00:56:52:15
Dr. Jaclyn Smeaton
But I feel like breast cancer survivors were kind of the last remaining subset of women where we've said, absolutely not. It's kind of like the last lingering piece that's holding on to Y. And so I'm so excited to hear this. Like, let's look at the evidence approach. So what do you think about that?

00:56:52:17 - 00:57:37:05
Dr. Jenn Simmons
Well, I'm not at all surprised because this evidence was sure to come out. And even

when you look at, the book estrogen Matters, which I think was first published in maybe 2018, where, Doctor Abraham Blooming looked at all of the studies in the breast cancer population and of the 20 studies done between, 1999 and 2015 or something like that, there was only one study that had negative outcomes for women who had breast cancer and took hormone replacement afterwards, and that was the habits trial.

00:57:37:06 - 00:58:22:02
Dr. Jenn Simmons
And the habits trial used a very high amount of, of one of the progestin genes, like one of the synthetic process tens and all. And even in that trial, only the women that also took tamoxifen were did did they show an increased risk of recurrence. And everyone else and the other, other 20 trials showed a either no increased risk of recurrence in women who had breast cancer and took hormone replacement afterwards, or a decreased risk of recurrence.

00:58:22:04 - 00:59:09:13
Dr. Jenn Simmons
And if you think about it, if you are taking a woman who had breast cancer and instead of depriving her of hormones, you are providing her with hormones. You can protect her heart, protect her blood vessels, protect her bones, protect her brain, protect her mood, protect her sleep, protect her bladder, protect her vagina. And when you protect her joints and when you do all of this and you diminish suffering, you're going to have better health, which is going to result in less recurrences, longer longevity, and better quality of life.

00:59:09:15 - 00:59:41:09
Dr. Jenn Simmons
So it's just logical that hormones are only protective. However, does that mean that we should be putting everyone on hormones? No. Absolutely not. This needs to be an individual conversation without question, and it needs to be done thoughtfully, safely and individually. Right? And we are not giving hormones to everyone, and we're certainly not giving the same hormones to everyone, and we're not giving the same dose to everyone.

00:59:41:11 - 01:00:14:03
Dr. Jenn Simmons
Because again, as my kids say, mom, that's not how it works, right? And we need to approach everyone as an individual and meet them where they are. And if you are in

the throes of breast cancer treatment, now is not the time. But there is a huge distinction between have breast cancer and had breast cancer. And if you had breast cancer, what we were telling people is you should be grateful to be alive.

01:00:14:05 - 01:00:38:22
Dr. Jenn Simmons
But it is very hard to feel grateful when you can't think and you can't sleep and you're nervous and you're anxious and your bones ache and your joints ache, and you've gained weight and you don't recognize your body anymore. And you have urinary tract infections. You have yeast infections, you have no libido. Your is sex is unwanted. Sex is painful.

01:00:38:22 - 01:01:10:06
Dr. Jenn Simmons
Your relationship is either strained or absent. It is very hard to feel grateful. And yet this is how we are leaving most women after breast cancer treatment. And it's the wrong thing to do. And it is high time. It is past time for us to start to acknowledge these women and say, I hear you, and we can offer you the same thing that we are offering to everyone else and not put you in danger and in fact, enrich your life.

01:01:10:08 - 01:01:30:18
Dr. Jenn Simmons
And this is what we need to be doing. And now we have the evidence. We've always had it, but no one was saying it loudly enough. Now we have the evidence to stand on, to say, this is what we should be doing. We should be meeting everyone where they are and say, what do you need right now?

01:01:30:20 - 01:01:54:09
Dr. Jaclyn Smeaton
I mean, and the other piece of this is, I love what you're saying, and the other piece that's really jumping out at me is that, like, women are not just breasts, right? That's what I'm hearing. You say after breast cancer. Even still, women are not just breasts. They are a whole human being that deserves to feel great. And, you know, we can talk about the medical risk, but I think we need to think about women as women, as whole people, even after breast cancer.

01:01:54:09 - 01:02:19:22
Dr. Jaclyn Smeaton
So thank you so much. So one final question for you today is that I've just we've been

hearing so much about the use of testosterone in women, and I feel like we can't leave this podcast today without talking at least a little bit about testosterone in breast cancer. A couple of things. Like, we're one, we're seeing a kind of a debate in the scientific community, in the clinical community around testosterone use in women.

01:02:19:22 - 01:02:49:13
Dr. Jaclyn Smeaton
You have some prolific researchers, like Professor Susan Davis, who continues to support, like, given all the body of research she's been a part of, libido is really the most statistically relevant application of testosterone in women. You have other researchers who are looking at it from a broader point of view, because women are reporting feeling better on testosterone. And and actually, April 7th of this year in menopause, Sarah Glenn published a small study in breast cancer survivors.

01:02:49:15 - 01:03:14:16
Dr. Jaclyn Smeaton
It's called use of transdermal testosterone to treat menopausal symptoms in Women with a History of Breast Cancer, a small, retrospective, open label study. And it really looked it was at 47 women UK. They use the menopause symptom questionnaire to like ask about how women felt. They evaluated fatigue, cognitive symptoms and reduced libido, night sweats, anxiety and panic, depression and palpitations, and a lot of other symptoms.

01:03:14:21 - 01:03:35:16
Dr. Jaclyn Smeaton
What they found was that there were a lot of improvements in many other symptoms beyond, libido. And so I think fatigue, libido and cognitive symptoms were the ones that were most improved. But libido was by far the best. However, I think the thought is like, could testosterone therapy be a safe addition for women with breast cancer?

01:03:35:16 - 01:03:42:14
Dr. Jaclyn Smeaton
Do we know that yet? And what are your thoughts or your experience maybe working with testosterone and women in this group?

01:03:42:16 - 01:04:14:15
Dr. Jenn Simmons
Well, I think that Rebecca Glazer has published her 20 year data on the topic and and

for from my perspective, this is an area where the science is settled. And she has she has 20 years of the use of testosterone with or without an aromatase inhibitor, because I think there was a time when she did believe that estrogen was bad, probably as a result of working in a system that accepted the findings of the Women's Health Initiative.

01:04:14:17 - 01:04:48:11
Dr. Jenn Simmons
So for for at least a portion of her population, and she worked with women both with and without a diagnosis of breast cancer. So she either gave testosterone alone in the form of pellets, or she gave testosterone and an aromatase inhibitor in the form of pellets. And her data is staggering. She has an 87% reduction in breast cancer as compared to the general population.

01:04:48:13 - 01:05:24:09
Dr. Jenn Simmons
Now, if this doesn't scream that testosterone is protective against breast cancer, I don't know what does. And I am universally using testosterone in my patient population. Both my previous ers and my survivors. And even my women with active disease, with metabolic, with metastatic disease. And it's because one of the properties of testosterone in the breast is that it is anti proliferative.

01:05:24:11 - 01:05:59:23
Dr. Jenn Simmons
And so I very confidently use it. And yes, I'm using it for libido, but I'm also using it for cognition for metabolic health, for confidence, for people to continue to feel like themselves and have the desire to really live this life because that is highly predictive on how you do, on how long you live, how long you live, by and large, is how long you want to live.

01:06:00:01 - 01:06:03:01
Dr. Jenn Simmons
And testosterone makes you want to live.

01:06:03:03 - 01:06:04:00
Dr. Jaclyn Smeaton

01:06:04:01 - 01:06:16:15

Mark Newman
I think there are a lot of people in our industry, and particularly individual women, that are indebted to Doctor Glazer for that work that gives people the confidence to be able to, to to have that in their toolbox specifically for those women.

01:06:16:17 - 01:06:40:06
Dr. Jaclyn Smeaton
Yeah. Yeah, I, I was hoping you'd bring that up. Well, what a wonderful note to end on today, doctor Simmons, thank you so much for joining Mark. And I, for the pod and Mark for providing all the additional insights on the DUTCH test as well, because I think this is an area where there's so much opportunity for us to really look at this from a more comprehensive point of view, for both in the overall clinical picture and when you're looking at a DUTCH report.

01:06:40:08 - 01:06:41:21
Dr. Jaclyn Smeaton
I thank you both for joining me.

01:06:41:23 - 01:06:44:22
Dr. Jenn Simmons
Thank you. Thank you for having me. It was wonderful.

01:06:45:00 - 01:06:49:21
Dr. Jaclyn Smeaton
Doctor Simmons, if people want to connect with you, what is the best way for them to do that?

01:06:49:23 - 01:07:12:00
Dr. Jenn Simmons
Yeah. So if you're looking for breast cancer screening, and when we screen for breast cancer, we screen for your overall health. So that's happening at PerfeQtion Imaging and PerfeQtion is spelled with a QT in the middle. If you're on a breast cancer journey go to Jenn Simmons md.com. And my Jenn has two ends. I have a podcast myself.

01:07:12:00 - 01:07:54:10
Dr. Jenn Simmons
It's called Keeping Abreast with Doctor Jenn. And there we talk about all things as it relates to women's health. You can find me on all the social media channels. I'm at Doctor Jenn Simmons. And again, my Jenn has two ends and I have a bestselling book

called The Smart Woman's Guide to Breast Cancer, which is not only what everyone who has a breast cancer diagnosis needs, but it's also how to prevent a breast cancer diagnosis, because at the end of the day, breast health is health and the same things that you're going to do to have healthy breasts, you are going to give is going to give you a healthy brain and healthy bones

01:07:54:10 - 01:08:00:12
Dr. Jenn Simmons
and healthy joints and healthy heart and healthy gut, healthy mood, healthy libido, healthy everything.

01:08:00:14 - 01:08:21:05
Dr. Jaclyn Smeaton
Thank you so much. And thank you, all of you for listening and joining us today for this really important conversation. If you like what you heard and you want to hear more about women's health and hormones, definitely follow Doctor Simmons podcast. And you can also listen to us at the DUTCH Test. We release a new episode every Tuesday, so be sure to hit subscribe wherever you're listening today so you can catch every podcast episode.

01:08:21:05 - 01:08:26:12
Dr. Jaclyn Smeaton
And you can follow us on socials at DUTCH Test. Thanks so much. See you next week.

01:08:26:14 - 01:08:39:07
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