

Hormone Balance For Men & Women Age 35+ ***Jini Patel Thompson Interviews Dr. Wendy Ellis***

Welcome to Hormone Balance After Age 35. I'm Jini Patel Thompson from www.ListenToYourGut.com and I specialize in natural healing for digestive diseases.

Today, we're talking with Dr. Wendy Ellis, a naturopathic doctor who also has a degree in medical biology. Dr. Ellis has apprenticed and continues to work with medical doctor Jonathan V. Wright. He's an integrated physician who is very prolific, and recently, made even more so when Suzanne Somers wrote about him in a few of her books on hormone balance and anti-aging.

Before she joined Dr. Wright at the Tahoma Clinic, Dr. Ellis practiced medicine in Nicaragua serving as primary care physician for a rural community and focusing on women's health, pediatrics and parasitosis. She also practiced medicine in Haiti where she worked extensively with HIV and tuberculosis programs. Dr. Wendy Ellis now serves as focal doctor for Dr. Wright's well-known bioidentical hormone therapy for women and sees conditions ranging from mineral deficiency, thyroid imbalance, multiple sclerosis, chronic fatigue, detox, allergies and various other concerns.

I was just talking to Dr. Ellis before the call and she said that actually there's now two Tahoma clinics, so if you want to get in contact with Dr. Ellis after this call, you can reach her at www.TahomaClinicNorthSeattle.com

Just a reminder to everyone before we get into it, if you have questions that come up as we're talking, just use the question box on the teleseminar webpage. After you click 'Submit' your question will come straight to me in real time and we can get your questions answered or perhaps you have a question about something we're currently talking about, it's all very fast and interactive.

Wendy, Dr. Ellis, welcome!

Dr. Ellis: Thank you. Thanks for having me.

Jini: I'm going to get right into it because this is a question that you had said that you get asked a lot and it also came in on our webcast from Susan in Midland and she says: *Is there any cancer risk with bioidentical hormones like there is with synthetic hormone replacements for men and women?*

Dr. Ellis: Jumping in to the very, very big question right away.

Jini: This might even be a better idea, do you want to start by defining what's the difference between bioidentical, natural, and synthetic?

Dr. Ellis: The description of the hormones is very, very, very important because basically the hormones that you often get from Premarin or Prempro or many of the traditional medication, they're basically estrogens derived from actually horse urine. In our bodies as women, we have about 20 different estrogens in our bodies. Horses

and horse urine has more than 100 different estrogens and so basically they're made for a horse; they're not made for a human and so they're going to behave differently in human bodies.

There is something called equaline in Premarin which is a very, very potent carcinogenic estrogen which is not included in your own hormone production in your body. The biggest definition of bioidentical hormones is it's basically hormones that your bodies produce. It's the exact same hormone that your body is producing and you're basically taking that, it's a synthetic form because it is made in a pharmacy but you're introducing the exact same molecule that your body is used to.

The most important differentiating factor between bioidentical and synthetic or bioidentical in Premarin is whether it's a human-derived estrogen or not and they do come from soy or yam and they actually extract the constituents from those but they are actually estradiol and estrone.

There are some bioidentical estrogens that are available through a regular pharmacy. These are things like the Velpatch or estrace cream, so there are bioidentical pharmaceuticals but Premarin is one of the ones that we hear the most dangerous things about and the Women's Health Initiative study that was done in the early 90s that gave everyone the scare about estrogen was basically done on Premarin and Prempro and not only is it the estrogen that's different, but even more dangerous than estrogen in some cases is progestin and progestin is the synthetic progesterone that has a lot of associations of up-regulating breast cancer risks.

Jini: What I'm taking from what you're saying is that it's like Premarin would technically be a natural hormone replacement because it does come from a horse but that's really not anything we need to worry about in this discussion because as you just explained, just because it's natural doesn't mean it's safe for us, doesn't mean it's not carcinogenic.

Dr. Ellis: Right. There are some studies that show that Premarin binds 1,000 times more strongly to a hormone receptor than your own estrogen would.

Jini: So that can even replace your own supply.

Dr. Ellis: It very well could, yes.

Jini: So with the bioidentical hormones, even though many constituents of them are extracted from natural sources like you pointed out the yams and the soy, then they are processed and the finished product does come out of a pharmaceutical grade facility, right?

Dr. Ellis: Whether it's a compounding pharmacy – compounding pharmacies would be the only ones who are using estriol. Estriol is the very weakest of estrogens. It's a large fraction of our circulating free estrogen and so basically, you can't get estriol in a regular pharmacy and there is something called the estrogen quotient which basically says if you have more estriol as compared to estradiol and estrone in your body, then that's definitely going to decrease your breast cancer

risk and so the problem with some of the pharmaceutical bioidentical hormones is that it doesn't have any estriol in it. So when you're looking at bioidenticals, most people who are taking them are post-menopausal, they carry extra weight around their middle, and it's that extra weight that actually, it increases your breast cancer risk because after menopause, your adrenals take over estrogen production and if you have adipose tissue that's increased around your body, the intermediate adrenal metabolite tends to convert to estrone. Estrone is basically the most potent (to some, considered *the* most potent) estrogen and basically its metabolites are some of the most known carcinogenic hormones.

Jini: Wow!

Dr. Ellis: So it definitely increases breast cancer risk, but also how you metabolize hormones affects your breast cancer risk and so when we do hormone testing, we look at free fractions of estrogen. We look at a 24-hour urine result versus the blood test because blood can't test estriol. Only urine can test estriol. It's a very, very, very complicated web.

As far as getting back to the original question – does it increase your breast cancer risk? Even if it's bioidentical, it's still estrogen and so the fact that the idea of taking hormones that are bioidentical does not increase your breast cancer risk is absolutely a thing that you cannot say. If someone had an existing breast cancer and it had estrogen and progesterone receptive sites on it and you gave it estrogen, it would make it grow, so a lot of the research shows that feeding an existing breast cancer is absolutely contraindicated.

You don't give estrogen to someone with breast cancer, but there are some different types of estrogen like estriol which basically is anti-carcinogenic in culture, so it basically – it's anti-proliferative against those cells and there's also a lot of research on one of the metabolites of estradiol called 2-methoxyestradiol that they're actually using to treat cancer and so it really, like I mentioned, it's extremely complicated but not all estrogens are bad. There are many estrogens that are very good, it's just a matter of how you metabolize them.

Jini: But what about natural progesterone, what is that and how does that play into what we've been talking about?

Dr. Ellis: So natural progesterone is basically – it doesn't not carry the same risks as progestin. Progesterone and progestin – the word is used interchangeably. Progestin is a very carcinogenic. It actually up-regulates breast cancer versus natural progesterone down-regulates breast cancer, so there really – if you have a progesterone-positive receptor on your cancer cells, then you wouldn't want to give progesterone, but progesterone doesn't carry the same risk as estrogen when it comes to breast cancer. It actually tends to have a positive effect as far as down-regulating those breast cancer genes, so that's why it's available over the counter, because it's fairly safe.

Jini: Right. Because I don't know a whole lot about estrogen, is the estrogen only available on prescription or is there an over the counter estrogen product that you can get?

Dr. Ellis: There is over the counter estriol cream and the estriol cream that you get over the counter is generally in a 1 mg dose, so it's like a one pump. Not many places carry it but it is available over the counter.

Jini: Okay, and because of, as you discussed, estriol is probably the safest form of estrogen.

Dr. Ellis: It is. Basically you very rarely see estriol converting to other estrogens.

Jini: Right.

Dr. Ellis: There is one research study that showed that elderly women who took estrogen in estriol form, their estradiol fractions in the blood increased for a two-week period and then went back to baseline despite the fact that they continued to use the estriol. I think an important consideration in hormone replacement is if you don't have symptoms that would-- if you weren't having hot flashes or night sweats or you didn't have severe osteoporosis or you weren't depressed or didn't have vaginal dryness, I'm not a big advocate of giving lots of hormones for anti-aging in women who don't have any symptoms, who don't have the need for it.

And so it's a spectrum and there are so many different doses of estrogens. There are so many different types of estrogen replacements and so I always look at what's your risk-to-benefit ratio here?

There was a meta-analysis, it's called the Million Women Study and it was done in the UK and basically it said, okay, it's not just progestin that's up-regulating breast cancer risks, because the women that were just on estrogen alone also had an increased breast cancer risk and you can't take estrogen alone if you have a uterus. The estrogen stimulates the uterine lining to grow and progesterone keeps it from getting too thick so you don't have proliferation of the uterine tissue which increases a risk for uterine cancer.

Some women take estrogen only if they've had a hysterectomy, but in this study they said actually women who took estrogen alone had an increased breast cancer risk as well, so it's not just the progestin that increases that and then I went further and actually dug up the questionnaires for the women who were a part of this and the great thing about being in the UK is that they have a national healthcare system. So all that information is – they've studied a lot of women and they have all that data and so when pulling up the questionnaire, they had basically at least 20 different estrogens and estrogen-progestin combinations; they just checked the box on which one they were taking, so that's the only information I was able to get so far, so I don't know if people using an estradiol patch also had an increased breast cancer risk. I just don't think it's been broken down appropriately for us to really know at this point.

So there's always a risk when using hormones. It's just a matter of trying to be as conservative as you can be and try to use the safer hormones like estriol versus straight estradiol.

Jini: But what about thyroid, because most of the women I know, they're not on estrogen; they're on thyroid supplements. Armour Thyroid used to be available and then I guess the FDA got really involved with that.

Dr. Ellis: Well, somebody got involved and then the FDA and the Armour became unavailable and then it became available again about a year and a half ago, so it is available again now.

Jini: Oh it is. I didn't know that.

Dr. Ellis: It is. And it's interesting because people want the natural thyroid. They come in and they want natural thyroid and when it comes to thyroid, there is basically in the natural thyroid T1, T2, T3, and T4 and the number after the T indicates how many iodine molecules are attached to it.

What natural thyroid is, is it's desiccated pig thyroid, so you're basically taking a pig thyroid gland and you're desiccating it and you're putting it in a tablet.

Pigs are pretty close to humans as far as genetically speaking and so when we take the pig thyroid, it works very well for many people, but at the same time, you always have to test their T3 and T4 values in the blood because basically there's only receptors for T3 in the body and so your body takes the T4 which is the storage form and slowly converts it to T3 throughout the day to give you thyroid stimulation without giving you this big load of T3 because it's got such a short half life, you've got to take it all day.

The new thyroid has a little too much T3 and not enough T4 so people are having a lot of heart palpitations on it and they might have a good activity for it for a couple of hours and then all of a sudden the T4 is gone.

Jini: Do you mean the new Armour Thyroid or the new...?

Dr. Ellis: Yeah, well the new Armour, the new Nature-Throid, the Westhroid, they all seem to be having the same problems, so I'm using – sometimes it's great and it depends on the person, but very frequently I'm using some dose of Armour Thyroid and I'm combining some synthetic T4 like Levoxyl or levothyroxine or Synthroid with that in getting sort of the best of both worlds.

As far as thyroid goes, the thyroid is a gland and as we age, our glands decrease their function and plus we're living in an environment where there are things like chlorine and fluoride and bromide and all of these things that displace our iodine and so our water has all these things in it and I think that a lot of people are becoming thyroid deficient because of those chemicals displacing our iodine and the fact that our iodine levels are very low as compared to what they used to be.

So I think that definitely has a role and a lot of women too are getting thyroid cancer in their 20s and so we know that certain chemicals in the environment have a large affinity for our thyroid and so chemical exposure and the fact that since the industrial revolution started and we're introducing a thousand new chemicals into the environment a

day, they have a huge affinity for our hormone receptors and for our glands. So I think a lot of our cancers and a lot of our low-functioning thyroid levels and 30-year-old women going into premature ovarian failure and I see guys who were in their 20s who have very low testosterone and so I think that something is going on with the environment that is far greater than we can even begin to – we have the tip of the iceberg on that I think.

Jini: Yeah, that's kind of what I was wondering because if you look at say like Dr. Weston Price's work on traditional cultures and the people - the Hunza, they're not having these problems that we're having. I was trying to think, is it our environment, is it our lifestyle, is it the food we're eating; like there's obviously some serious, serious challenges that all of our thyroids go out of balance and we all need some sort of, it seems to me, just about everybody I talk to is on some sort of hormone support.

Dr. Ellis: Right. It's a little bit scary.

Jini: It is, but at the same time if you don't get with that, then you're going to feel really yucky for a long time, right?

Dr. Ellis: Right, I know and people say 'I'm too young to take hormone replacement, it's not normal to take hormone replacement, it's not natural.' Our glands naturally decrease their function and we shouldn't have to take them, but we're not in a natural environment any longer.

Jini: That's a fact right there.

Dr. Ellis: There's a really good book called *Hormone Deception* by D. Lindsey Berkson and that book, it's a little daunting but it talks specifically about the fact that the whole word 'endocrine disruptor', meaning a chemical that disrupts our endocrine system, was just introduced in 1993, so it wasn't until that time that we realized-- so that's not that long ago.

Jini: That's a problem.

Dr. Ellis: Another thing, and I know I mentioned this in an email to you earlier is that gluten-sensitivity, gluten intolerance, a lot of people think it's a fad that everyone wants to be gluten-free; however, if you have a gluten intolerance, it is having an autoimmune condition. Basically, when you eat gluten and you have a gluten intolerance, those antibodies produce in response to your eating gluten, they have a huge affinity for glands and they definitely attack the gland and decrease its function meaning decrease its ability to produce whatever it produces whether it would be thyroid or estrogen or progesterone or cortisol in regards to the adrenal glands and it has a huge affinity for the parietal cells in the stomach that produce stomach acid, so 50% of people who have a gluten intolerance have very low acid production, so then as you know, that increases a lot of – it opens a door for many, many, many infections and overgrowth of certain bacteria like *C. difficile* and *Enterobacter cloacae* and all these crazy bacteria that have never been an issue, but how many people have Crohn's and IBS now? It's a lot of people.

Jini: And the other thing that I've noticed with the gluten intolerance is you'll get some people – I mean if it's an actual allergy, that's pretty definitive and people will then be very careful, but there is a huge growing sector of people who are just gluten intolerant and that can range from pain and bloating after eating to constipation, but none of these are really what I call heavy handed, stop-you-in-your-tracks kind of symptoms.

What I've seen is you get a lot of people and especially with kids, they have an intolerance, but it's so hard to control children. Especially when they go to other people's houses, right? Like if they've got a peanut allergy and it's anaphylactic shock, that child will control themselves. They will make sure they never come into contact with peanuts. But if you have a child who's just gluten intolerant, they're going to sneak a cookie, they're going to sneak a piece of pizza and the parents are kind of like I need to teach him to self-regulate, and it's not really taken as seriously. But what you just talked about is the reason why it needs to be taken seriously, because if your body has shown you 'if you eat this substance, I'm going to start producing antibodies'. It's going to touch off a whole cascade reaction. It's going to blunt your microvilli, your whole absorption is going to be affected. Now, we're into a whole other range from 'it just bloats me,' 'or 'it just gives me some pain after eating.'

Dr. Ellis: And usually what I do is I never just say, 'Okay, you're gluten intolerant. You have to avoid gluten because you have bloating.' Usually, what I do is I do a very comprehensive metabolic panel with lipids and the complete blood count and oftentimes, their triglycerides are very low. Their vitamin D is very low. They're iron-

deficient. They may have high uric acid because high uric acid is a side effect of having a gluten intolerance. There are so many things you can see. Oh, their white blood cells might be low. You can see many, many things on the blood work and that's a really – it's a very good tool to show them that paper and say, 'Hey, look what gluten is doing to your blood chemistry.'

It's not stomachache. It's definitely affecting your physiology and so I had a 17-year-old patient in yesterday and gluten intolerant, diagnosed years ago, didn't really follow it. About 260 pounds, was maybe 5'10' and so I showed him his blood work and said, 'Hey wow, look at your blood work. This is the blood work of someone who's much older than you.' 'You know, you're anemic. You have uric acid.' He was like, 'Yeah, my toe hurts.' Yes, that's gout. Basically showing him that and educating him on that is a lot more effective than saying, 'You need to avoid gluten because it can increase autoimmunity.'

Jini: Exactly.

Dr. Ellis: It's challenging but it's important. Actually there was a really good article in either the *Wall Street Journal* or the *New York Times* on March 15th on the difference between gluten sensitivity and celiac disease and it was a really great article outlining the fact that gluten intolerance is very serious and has very, very potent physiologic effects.

Jini: Why do you think gluten intolerance is escalating so rapidly?

Dr. Ellis: Basically we're eating a lot more processed foods than we ever did. We look at Weston Price, they all had big beautiful teeth and very wide arches in their mouths because they were eating whole foods. As soon as processed foods were introduced there, our jaws are becoming smaller, our teeth are a mess, but also basically what's happening is that gluten is one of the second highest ingredients in foods outside of sugar. It's in everything because they use it as a binder and its maltodextrin, it's modified food starch, it's caramel coloring, it's many things. There's not only that it's in many things, but it's also because we so highly genetically modified it to increase the gluten content, that it's no longer sugar and natural substance. It's weird – as Dr. Wright would say – "a space alien creature in our food" and our bodies are saying 'I'm not really sure what this is and so I'm going to release antibodies against it because it doesn't belong.'

Jini: Right. That makes a lot of sense.

Dr. Ellis: In Europe, they don't allow genetic modification the last time I checked and basically people who have celiac disease here or have severe gluten intolerance have told me, and I've heard this from more than one patient, that they ate gluten there because they were in Italy and they were going to eat pasta and they didn't have any side effects at all. So I do think the genetic modification is the biggest problem.

Jini: Very interesting. All I had heard was that well, they've manipulated the strains of wheat, right? So then if you eat the ancient varieties of wheat, like closer to the kamut and whatnot, you can be okay with that, but I hadn't taken into effect the actual modification to

include higher levels of gluten in the grain, which makes a lot of sense because how else can we get this really high lofty bread that squishes down to half a millimeter thick? I mean really.

Dr. Ellis: Right. I was standing in a bakery in Portland one day and I was looking through the glass window watching them make the bread and showing my daughter how they do all this and that, and I looked in, on the floor were all of these bags of flour and in big red letters it said high-gluten flour. And at that moment I was like, “Oh that’s why that bread tastes so good.” 😊

Yes, definitely people want their food to taste good. They want the crunchy on the outside and the chewy on the inside and they want their bread to stick together unlike rice bread or tapioca bread. It just doesn’t behave the same. It causes problems.

Jini: I want to go back to what you said before about a woman who’s got the belly fat due to estrogen because we have a question here from Steven in Fort Lauderdale, so this is a guy. He says: *I work out with a personal trainer five days a week. I eat a very healthy diet, Weston Price style organic home cooked raw foods, fermented foods. I can run 10 miles no problem and my muscle size and definition all over my body is excellent except for my belly. I have a good 3-inch fat roll around my belly that won’t seem to budge. My wife says my diet is fine but I just eat too much. I’m wondering if it could be anything to do with hormones. I’m 50 and I weigh 210 pounds.*

Dr. Ellis: So generally, we think belly fat around the middle, we all think about the CortiSlim Commercial so of course, cortisol definitely

plays a role in belly fat. Generally speaking, when it's the increased belly fat, you have an increased cardiovascular risk and so many of those people tend to have – you have to look at cholesterol and see if the triglycerides and the cholesterol and maybe the fasting glucose might be a little too high. If that's the case, then you look at insulin-resistance and carbohydrates restriction or very little carbohydrates, or using high-protein carbohydrates, like quinoa, are usually the thing that get rid of that belly fat.

So there's the carbohydrate component and it's interesting because if someone has insulin resistance, their receptors, they're making enough insulin but their receptors are not responding to it very well. And so what the body does is it says 'hey, I'm starving for fuel here in these cells, I need more glucose, I got to make more insulin.' And so the body makes more insulin and then a high-fasting insulin or high insulin throughout the day stimulates cortisol production, because if you have high insulin, it means that your body is starving and that's stressful. High cortisol in regards to the high insulin will definitely make for that high increased belly fat around the middle. Carbohydrates definitely drive that up. That's one.

The second thing is that as we age, our cortisol levels just naturally tend to rise and it has an inverse relationship with one of our major hormones, DHEA. DHEA is an adrenal hormone but peaks at the age of 25 to 30 and declines over time. So at 50, the DHEA levels are probably in their 30th percentile of what they were at the age of 25.

Basically, DHEA can be a really, really potent hormone for decreasing that waist, that belly fat around the waist but it also increases lean

muscle mass around the waist. The problem though and this is where – sometimes I wonder how much should we sell DHEA over the counter because it's a complicated hormone. It's an intermediate hormone that when taken orally can in a person with insulin-resistance, tend to convert to estrogen. So if you see men carry extra weight, they need the bro, they have man breasts. Those are the guys who should never, ever take DHEA alone without taking an aromatase inhibitor. Aromatase is the enzyme that converts DHEA to estrogen. Basically, using something to block that aromatase enzyme is very, very critical when giving or using DHEA.

The other thing is that DHEA has a very high conversion rate in the prostate to other hormones and so if there's any question of abnormal prostate health, you really need to be careful, because it can convert to testosterone within the prostate.

Jini: And so someone with belly fat, like this fellow, he doesn't necessarily have low testosterone. It could be just...

Dr. Ellis: Well, he could. You will have to test that too because at 50, his testosterone levels might be within normal limits but they might be on the very low end of normal.

So what he should ask his doctor to check and what even would be ideal is finding a doctor who actually uses 24-hour urine tests because not only will you get your estrogen levels as a man, you will get your testosterone levels and it's the free testosterone fraction. You'll get your metabolites of dihydrotestosterone so you'll know if you're

converting it to the most active testosterone and you'll get your cortisol-cortisone, all the metabolites.

And so that 24-hour urine test will tell you what you need to know along with a simple blood panel, because you can exercise, you can eat right, but unless you know what your physiology is doing, you're basically stabbing in the dark.

Jini: Here's another question also from a male. He says, "*I'm 49.*" Again, he's very fit. This guy does triathlons. He says, "*But I still get these periods of fatigue during the day and my sex drive has decreased in the last four years or so.*" So he's saying is this just normal aging or is there something he can or should do about it?

Dr. Ellis: So as we age, of course, we don't have the stamina that we used to but it's generally declining hormone levels. And so we're basically at 49, most people are living into their 80s and 90s these days and so if you're an active person, do you want to spend the next 30 years just watching the decline?

And so that's a really good reason for using a low-dose hormone replacement because your glands aren't going to up-regulate and start making more hormones and so supporting that decline with exogenous testosterone is a really good idea and or DHEA because as we discussed before, DHEA is an intermediate and it can go to testosterone as well, so guys who tend to have bald heads and hairy bodies, they tend to have a lot of conversion to dihydrotestosterone and so, those guys can usually take DHEA to increase their testosterone production.

Jini: Okay that's very interesting. Let's talk about Dr. Jonathan Wright's supplement that he developed called ThyroPlex, because he has ThyroPlex For Men, right? I've read his papers on why and how he developed that supplement. He basically said, "You know, the glands are like in a domino-linked chain, so you don't want to just treat one because then it can throw the others out of balance, so in ThyroPlex he has for the men, he has I believe – tell us what's in the one for the men just so I get it right the first time.

Dr. Ellis: Well actually, I have a bottle of the one for the women in front of me, so I'll tell you what's in that one, so this one has hypothalamus, adrenal gland, pituitary, ovary, and thyroid – I'm assuming that the men is very similar but obviously it doesn't have ovary, but probably has gonad...

Jini: Yeah, that's the only difference, is that the ovary is taken out and I think it's testicular, they call it, I'm not sure.

Dr. Ellis: Right, yeah.

Jini: So for these two cases we just talked about, would ThyroPlex for Men be something that would provide some sort of support or would it...?

Dr. Ellis: Because everyone is different, sometimes they work, sometimes they don't.

Glandulars tend to stimulate glandular production. I find that the ThyroPlex tends to work better for younger people rather than older people, but it's a very easy over the counter product to take and there's a long history of using hormone glandulars to increase hormone production, but it depends on the person and sometimes you just can't stimulate a gland to produce, that's at a certain... it's just basically a gland that – it's like an ovary that's past menopause; it seems like no matter how much black cohosh you give to try to stimulate the FSH, it's like trying to get blood from a turnip. If a gland is very, very deficient in hormones, you can't stimulate it to make more.

Jini: You have to give it the actual hormones because it just can't make anymore.

Dr. Ellis: Right, exactly.

Jini: Someone has sent this question in but I've had this question a lot and this woman says, *"I can't afford the full proper hormone testing, but my thyroid has tested in the low range of normal and I'm having some of the symptoms of tiredness, irritability, slow metabolism..."*

{call disconnects}

... people who say they can't afford to get the full hormone panel testing done and what we've found with a lot of my readers is that if you're in that position for females, often what can work is to take the ThyroPlex for Women and often along with the natural progesterone

cream and that sort of – it's unlikely to cause any harm - but in many cases, people can see a significant difference and as you said, depending on how far gone their glands are, it might be all they need, or it might not be enough.

Dr. Ellis: Right, exactly.

Jini: Would you say in your own opinion that for someone who can't afford to get the testing done that that would be a good way to proceed and if they were a guy, to try the ThyroPlex and if it doesn't help then they know that they need to go for this specific testing?

Dr. Ellis: Exactly, and there is blood testing, but with blood testing definitely you're limited and there are some people that if they're just using progesterone-- it's really the ones where I'm using estrogen replacement therapy that I really sort of demand it. I don't think I have anyone who hasn't done the 24-hour urine test who I've put on estrogen because I don't feel comfortable giving them estrogen without knowing how they metabolize it.

If they're going to be on it long term, I want to know that information. But for someone who's having menopausal symptoms, there are many, many things you can use. You can use the progesterone like you mentioned. That's a great, great, great start for sure. The ThyroPlex because it covers the adrenals, the ovaries, the thyroid, the pituitary, that's a great thing to use. As far as other things for things like hot flashes, you can use vitamin E. You can limit your alcohol intake and your caffeine intake and your sugar intake, those really make hot flashes much worse. Exercise decreases hot flashes. DL-

phenylalanine can work very, very well, so can tryptophan. There are a lot of other things you can use without jumping into hormone replacement.

Again, I'm always very, very careful to not talk someone into it. Usually when people are getting on hormone replacement, they're in because they can't sleep, their bone loss is accelerating, they feel like they're not themselves and so aggressive symptoms usually lead to aggressive measures.

Jini: Here's another question. This is also from someone named Susan but she's in Kelowna. She says she's been on antidepressants. She started a raw food detox program about five weeks ago, *"And I've actually been doing everything I'm supposed to be doing. No cheating, but I've only lost 6 pounds and everyone else in the program has lost about 20. I had my thyroid tested and it tested normal but it tested in the low range. Because I'm on the antidepressants, a friend mentioned they can cause you to gain weight, so I'm wondering if that has something to do with it or could it be my hormones, because why is there the difference between me and everyone else?"* She says she's 42.

Dr. Ellis: Basically it could be any one of those things, so as far as the thyroid goes, oftentimes people get just the thyroid-stimulating hormone checked and that's a pituitary hormone. It's not a thyroid hormone, so getting the free T3 and the free T4 checked is really, really, really important. As far as hormones go, generally speaking if you're eating a restricted diet, I've read somewhere – I forget where I read it but something like six times more important is actually

exercising versus what you eat for weight loss and the type of exercise... sometimes people write they walk six days a week, but they're walking their Lhasa Apso, and so that doesn't count for exercise, because you're not sweating.

The type of exercise and the duration and really getting your heart rate up and doing more interval training is important for that and then sometimes actually, not eating enough calories can suspend weight loss because your body says 'I'm starving and so I'm not going to increase my metabolism because basically I need more caloric intake.'

The antidepressant: weight gain is one of the biggest side effects of antidepressants and so that could definitely be a factor. Not having enough estrogen gets in the way of losing weight. I don't know how many times I've heard patients say that they and their husband went on a diet. The husband loses 40 pounds a month and they lose 10 pounds and so definitely, estrogens and progesterones play a role in that weight loss.

The other thing is food allergies. Food allergies definitely increase weight and they also retain water and so checking food allergies, especially if with a detox you're eating things that you don't normally eat, usually that's a sign of food allergy; if you actually increase weight, or don't lose very much weight despite the fact that you're not eating very much.

Jini: Right, got you. So there's a number of things she's going to have to look at there. I guess the main thing that would stand out is why has everybody else in the program lost 20 pounds and she's lost

6? Because if they're on the same raw food detox... Like to me, the antidepressant is going to play a big role, because don't the antidepressants knock out your thyroid?

Dr. Ellis: I'm not sure what role antidepressants have on thyroid. I guess it would depend on the antidepressants.

Jini: On which one?

Dr. Ellis: But they're definitely known to increase weight, sometimes even up to 20 pounds, so that would be the most obvious thing, but of course, you can't just go off your antidepressant without having something in place to help you because that's a crutch for something that existed. So generally, when an antidepressant is needed, it's usually either after menopause and so using hormones can be very helpful for it because estrogen and serotonin sort of go hand in hand. When your estrogen is higher, your serotonin is higher. When your estrogen is falling at the end of the cycle, that's where most people have sort of PMS symptoms and so sometimes giving estrogen at the end of a cycle can improve someone's depression where they don't need antidepressants.

Jini: Oh, interesting.

Dr. Ellis: So there are other options outside of an antidepressant and actually estrogen decreases the activity of the monoamine oxidase inhibitor so it decreases the enzyme that gobbles up all of your serotonin when it's in the receptor site.

Jini: Okay, so it might be very worthwhile for her to get proper hormone testing done and get on a customized plan.

Dr. Ellis: Exactly and figure out, is the depression hormonal or is it nutraceutical? Is she missing some amino acids and cofactors and not able to make the right balance of GABA and dopamine and serotonin and norepinephrine.

Jini: You know, it's so funny like –I'm pretty knowledgeable in these things but even for me, hearing you talk, absolutely I'm thinking, "Oh my gosh, how can anybody be healthy? It is so complicated."

Dr. Ellis: It's very complicated.

Jini: And you take into account what we discussed before about the endocrine disruptors that are everywhere in our environment, in our water supply, in our food supply and you just kind of want to go crawl back under your covers for a bit, kind of feeling a little bit overwhelmed.

Dr. Ellis: I know and even when it comes to practicing medicine, you're like, "Okay, I know this much but how many things do we not know about?" If you start going in that direction, it's daunting, but for the most part, it's pretty rare that you find a patient that you really can't help a lot and a lot of our patients, they have an endocrinologist, they have a cardiologist, they have a general practitioner, they have an OB doctor, and so on but no one puts the pieces together and so our job as a holistic practitioner tends to basically say, "Collect all the lab work from all those other people and then we'll put it all together

and we'll connect the dots," and so we have fortunately many brains all considering the same person, but our job is to say, "Oh, well actually the medication you took for this may be affecting your depression," and so doctors, they get lists of what each other has given but they're not conversing with each other.

Jini: Exactly and they're not even knowing what each other is doing, so it's a very, very bizarre model for healthcare actually.

Dr. Ellis: It is and even when you go the Mayo Clinic. A friend of mine, she was in the Mayo Clinic and she had all these different teams but the teams didn't communicate with each other and that's a big problem.

Jini: Huge problem.

Dr. Ellis: And so yeah, even though your insurance covers you to see all these different doctors, another component of it is you don't even have enough time to tell them about everything that you're experiencing, so without that information, they can't make the right informed choices, because they're not informed and so we usually spend an hour with our new patients and usually, I see patients once, we follow up once and then I see them once a year and I try to channel as much as I can through their insurance so we can get things covered but it really – as we age, things become more complicated and it takes more time to figure out what those things are.

Jini: Exactly. Well, here's another question. This is from Nicki in LA. She says, "After the age of 40, I've noticed a few changes with my

period. I get spotting for a few days before the main flow begins. I'm more irritable than normal and I'm getting massive retention. What's going on and what can I do about it?"

Dr. Ellis: So if we look back into the work of John Lee, he's sort of the king of progesterone, he sort of has a rule that if you're still regularly menstruating, you don't need estrogen and I'd say that's true for the most part. It sounds to me like she needs more progesterone. Or a combination of progesterone and thyroid, because there are two different kinds of sort of peri-menopause which could be... at 40, she's probably not peri-menopausal but with the way things are going now, I'm seeing a lot of women in peri-menopause at 40.

But generally speaking, if the cycles are heavier and they're longer and there's a lot of water retention, progesterone is the key and basically, using progesterone for the second half of the menstrual cycle. If you do over the counter, it's usually 20 mg per quarter teaspoon and you put that on your inner arms and where the thin-skinned areas where you can see your blood vessels are, and you rotate the sites and using that sort of second half of the cycle usually fixes that problem. Progesterone is a diuretic so usually, puffy, bloated, swollen, breast tenderness, heavy cycles, those are your signs of progesterone deficiency. Also feeling super amped-up and cranky and irritable, anxious, those are signs of progesterone deficiency.

Jini: And when you say second half of the cycle, what does that mean?

Dr. Ellis: When we consider the menstrual cycle, we consider day 1 is when you first start menstruating, so when you start bleeding.

If you're spotting before, that doesn't really count, so unless it's heavy spotting. Really the first day of your flow of menstruation is day 1. Usually women start experiencing those symptoms somewhere after day 14 because day 14 is when your estrogen level peaks. Your progesterone level generally peaks at day 21, so as progesterone replacement, I usually have them start around day 14 and continue through day 28 and then discontinue when your menstrual cycle starts.

Jini: What happens if you continue to take progesterone during your menstrual cycle?

Dr. Ellis: There are studies that show that continual hormone stimulation can increase certain types of breast cancer.

I always recommend taking a break while menstruating because you want to give your body a break during that time just because breast cancer is kind of an ambiguous subject that people know lots of things about but no one really understands completely and so I just try to take all of the facts that I know and apply them as best as I can to reduce any breast cancer risks.

Jini: Right. You know what I found with the menstrual cycle and progesterone is, and this again, it started happening when I was about 41 or 42 and the day before the day of my period, I would get a really bad headache and I'm someone who never gets headaches, so I

immediately thought this has got to be related. I had some natural progesterone in my fridge and I put it on the soles of my feet just like a dime-sized amount and within half an hour, the headache goes away, and so I just use it until the headache goes – well, like I'll use it and the headache will go away and then if it's back the next day, I'll use it one more time and then that's usually it. I don't have to use it again. What is that?

Dr. Ellis: Very frequently if you give someone too much estrogen, they can get headaches.

Jini: Ah!

Dr. Ellis: Progesterone is – having headaches is a very big sign of progesterone deficiency.

Jini: Oh, interesting.

Dr. Ellis: So usually if people have headaches, especially before the cycle, that's the sign of progesterone deficiency as well.

Jini: So I should probably be taking it from the day 14 to 28 then?

Dr. Ellis: If you want to avoid the headaches, yes.

Jini: Right, so another question here from Laurie in Manchester. She says, "My family has a history of estrogen dominance with ovarian cysts and breast cysts, what can I do to be proactive against this estrogen dominance? I'm 34."

Dr. Ellis: Generally speaking, estrogen dominance is defined as someone who is a large breasted woman who has a lot of estrogen and in blood tests they tend to have very heavy cycles, or they have two cycles in a month. They just have a lot of estrogen and on the same side, as far as the dominance, that's often seen as progesterone deficiency. It just depends on what you want to name it.

Jini: Oh, very interesting.

Dr. Ellis: So using progesterone to offset that is usually what you do, and anyone who has a lot of cysts, usually it's iodine deficiency.

Jini: Right, so the potassium iodide...

Dr. Ellis: Iodine is what you use in the street. Well, the potassium iodide like the SSKI would be good but I tend to use Iodoral which is more of an iodine instead of the iodide but you don't want to use too much because then you'll suppress your thyroid.

So more than 14 mg a day has been shown to suppress thyroid function, so Iodoral is in the 12.5 mg tablet and I usually have people take half that, so that's 6.25 just because I don't want to suppress the thyroid.

Jini: Does potassium iodide, does that impact on the thyroid as much?

Dr. Ellis: It can absolutely and so anytime you're using – I use potassium iodide more specifically for urinary tract infections or when I'm traveling and you want to avoid getting sick, so you're using it for a short duration versus using it long term.

Jini: Right, because I know again in Dr. Wright's writings, he uses it for ovarian cysts and I believe he says you have to use it for a few months but after two weeks, you need to monitor your thyroid. Have you used it...?

Dr. Ellis: And that's the same for fibroids too and he'll use very large doses and he has found that in patients who have pretty severe ovarian cysts or fibroids that they can tolerate very high amounts of whether it would be potassium iodide or the Iodoral without suppressing the thyroid function, because they are so iodine deficient.

It really depends and so when you're using higher doses and he uses doses up first usually about six weeks I would say, and usually when you're doing that, you want to check the thyroid every three to four weeks.

Jini: Got you and just so we know, slightly off topic, but I've been doing some research on iodine used to break down scar tissue, because we have a lot of problems with people having intestinal strictures and rectal strictures where they get a build up of scar tissue.

Dr. Ellis: Right.

Jini: And so I found this – he’s an MD and PhD and he’s been doing a lot of experimentation and he’s been using the Lugol’s Iodine to regenerate scar tissue, so if we were to be using this, let’s say we’re using the potassium iodide rectally because I see on the bottle here, it says there’s 19 mg in one drop and I know per Dr. Wright’s protocol for I think the fibroids, does he recommends eight drops a day, does that sound right?

Dr. Ellis: Of the potassium iodide?

Jini: Yeah, the SSKI.

Dr. Ellis: I want to say yes but of course, the dose would be dependent on the person and how big those fibroids were but I want to say six to eight drops a day. Because in the inspection phases, he uses something like 15 drops a day for things like urinary tract infections.

Jini: Right, got you, so if you were using this rectally, you wouldn’t want to exceed that kind of dosage like let’s say if you did two drops a day rectally, how long could you go at that dosage before you’d really need to get your thyroid checked, or would that be okay?

Dr. Ellis: Well, yeah if we’re talking about the SSKI two drops a day, you could definitely use long term.

If you’re using the Lugol’s, two drops of Lugol’s equals one Iodoral tablet and so you could use that long term technically because it’s less than the 14 mg a day.

Jini: Right, got you, okay.

Dr. Ellis: But as actually in a meeting on Wednesday with him, we were having a discussion about this exact topic and he reported using high doses of iodine two to eight drops per day for fibrocystic breast disease and that was long term, even three to five months of that.

Jini: Oh okay, and that was fine? It wasn't...

Dr. Ellis: And that was fine.

Jini: ...unbalancing the thyroid? I think as you pointed out that the iodine deficiency is becoming a more widespread problem, so maybe whereas before when everybody was more balanced, taking iodine would have a bigger unbalancing effect, but now, if you say well, most people are going to be coming into it deficient anyway, you can take more and for a longer period of time before seeing any change in the thyroid.

Dr. Ellis: Right and David Brownstein, he's from Michigan. He has done a lot of work on iodine and he actually did the iodine loading test through Dr. Flechas, with something like 3,000 patients and found that the majority of them, something like 80% were iodine deficient.

Jini: 80%, wow! That's huge. I wanted to ask you, so for that caller Nicki from LA with the spotting and the water retention and you said that the natural progesterone would really benefit her, would this ThyroPlex for Women, be supportive for her as well?

Dr. Ellis: You know, because the spotting is occurring, there's probably a thyroid component as well.

Jini: Right.

Dr. Ellis: So a combination with – I found that usually the ThyroPlex works best in combination.

Jini: Ah! With the progesterone...

Dr. Ellis: Right, that a lot of people, so here's another issue too. I have been shying away from the glandulars a little bit recently because a lot of people who I'm seeing are autoimmune and giving them a glandular from another animal seems to work for a couple of weeks and then doesn't seem to work, or has negative side effects, so I'm wondering ha – is it that I'm introducing a bovine or a porcine gland into a human who's already got autoimmune tendencies and they tend to react and so that's something I've heard from a few other practitioners, that they're having the same problem and that's why using something like Armour for an autoimmune patient is a little more challenging at times.

Jini: Interesting.

Dr. Ellis: Again, it depends on the individual but for the spotting, I think a combination of ThyroPlex and progesterone would be a good idea.

Jini: You know what else I found with ThyroPlex, experimenting with it myself is I don't necessarily need it every day, like even if I just take one every three or four days, I've noticed that that gives me a bit more energy and just makes me feel a bit better, but it doesn't really make a difference if I take it every day.

Dr. Ellis: Right, so I'm wondering if you're just up-regulating the gland and it's because people could take hormones and the action is much longer than you would expect if they should continue it.

Jini: Yeah, exactly. Yeah, I think with hormones too, it's just really listening to your own body and mapping out, okay if I do that, how does that make me feel? And if I experiment this way, like I'm saying for someone who can't afford to have testing done and the retesting done. Okay, I've got it.

Dr. Ellis: It's so many major glands that it's a great – it would be a great start for someone who either couldn't afford a doctor visit or couldn't afford doing a bunch of lab testing. It's a global approach to glandular deficiency.

Jini: Yeah, that's what we found for people using it with Crohn's and colitis where they've got the hormone imbalance as a result of their chronic illness. So it will be interesting though to see how many of those people have found any kind of autoimmune intolerance, because I haven't heard back from anybody yet, but then as well, I've been educating my people about natural progesterone as well, so a lot of people are taking the two together, so maybe that makes a big difference, I don't know.

Dr. Ellis: I see. Right.

Jini: Okay, I've got another question here from Teresa in Chicago. She says, *"Ever since my second child was born, I noticed my hair got a lot thinner. Also, the skin on my hands seems thinner and wrinkled easily when I push on it and I'm only 43. Is there anything I can do?"*

Dr. Ellis: So of course, we have to talk about sun exposure, because sun exposure definitely breaks down the tissue and then as far as the skin as we age, our estrogen levels fall and generally estrogen has a huge effect on the thickness of the skin. There's a book by Henry Lodge, he's a medical doctor, called *Younger Next Year* and it's interesting because he talks about all of the things that we can improve and sustain over a 30-year period, except our skin, and so usually you have to use a lot of essential fatty acids to maintain a lot of good fats in the skin. Oftentimes, women have really dry skin and that could be thyroid related, it could be estrogen deficiency, but using coconut oil physically on your body is extremely effective in improving how your skin looks. Drinking lots of water is very important. Smoking is one of the biggest things that decreases the integrity of the skin especially on the face, but you can use vitamin C on the face. There are some vitamin C crystals you can get in put-on-your-face lotion, but usually, it's things like water intake and hormones that cause the biggest effects in improvement in the skin.

Jini: Right. Yes, I found that the essential – the good fats make a huge difference in thickening the hair and keeping the skin wrinkle-free.

Dr. Ellis: Right and there are a couple of signs that you can look for, is if your ears are really itchy inside, that's a sign of essential fatty acid deficiency. If you have dry eyes, that's another sign, or they are kind of blurry in the morning, and then also just looking at your skin and seeing that it's dry.

Jini: And what do you find is - do you prefer flax oil or coconut oil or do you like a combination and then cod liver oil? I find cod liver oil, yeah...

Dr. Ellis: Yeah, I tend to recommend the cod liver oil because it's got - or any fish oil because it's got a high component of omega 3 fatty acids. We have a pretty large supply of omega 6 in our diets. Flax is good. If you're a vegetarian, you don't want to take fish; although, fish oil does have more omega 3 than flax and then on my skin, of course, I don't want to put fish oil on my skin, so I tend to use something like jojobo oil or calendula oil or coconut oil and for cooking, a lot of people tout the great things about coconut oil but you have to always remember 'everything in moderation'. I'm not a fan of these sort of 'I'm going to go eat six tablespoons of coconut oil a day because it's going to solve all my problems.' I just think that's too much oil for anyone and so I try to rotate the oils and use safflower oil instead of canola oil. I use olive oil on my food, but then when you cook it, it has different activity and so I do try to rotate the oils and just stay away from the peanut oils and the ones with very high saturated fatty acids.

Jini: The other thing with the high-dose coconut oil is, again it's one of those things that can work really well for the short term because maybe you are really deficient or you have an imbalance and then you get to a certain point and then you have to balance it out, and the other thing that I've heard from people, they just get sick of it. They're like, "Ah, I just can't face another tablespoon of coconut oil you know even though it's helped me lose you know, this amount of weight because it's very good for fat loss." They're like, "I just couldn't do it anymore because I just got so sick of it." Which I think is a good way of the body saying, "You know what? Enough, can you balance this out now?" You know?

Dr. Ellis: Right and I'm trying to find the perfect face cream because I'm 37 and my skin is changing and coconut oil works amazingly on my skin. It seems to work better than my \$60 tube of vitamin C cream and so what I'm trying to do now is work with a compounding pharmacist. We've got an ingredients' list in and we're trying to formulate a cream that has a coconut oil base. Coconut oil has a little bit of a smell too once you put it on, so everyone wants good skin and it's something that we all try to hold on to, but it's a complicated issue.

Jini: I've tried coconut oil on my body but I haven't used it on my face and what I've been using, and it was actually my integrated medical doctor who told me this, is olive oil and I put in a few drops of lavender essential oil and that's it and it is amazing, how well it works and then I saw this video of this fellow who's 108 and his skin on his cheeks was smooth and he said, "The only thing I've used on my skin my whole life is olive oil."

Dr. Ellis: Wow!

Jini: And of course, it's extra virgin organic first pressing. You know, you want the best olive oil.

Dr. Ellis: Right.

Jini: The one I get – mine is from Italy. Use the best olive oil and the lavender, it gives it a nice smell but it also gives it a little bit of astringency and what not and that's what I've been using and it's like you said, it is better than any of the expensive face creams for me anyway.

Dr. Ellis: Right and if we could get some minerals in there and some vitamin C, that would be even better.

Jini: Yes, exactly, to get in all those nutrients. Fabulous, okay well I am just going to check one more time if there are any more questions that have come in. No and we're done and there were some people on call that I think they just submitted their questions using the question box, so I think we have got-- Is there anything else you wanted to say? Like anything else that you commonly get asked or have we covered everything?

Dr. Ellis: Oh goodness. You know, as far as the weight loss is concerned, I think that yes, eating well and eating mostly whole foods and combining proteins when you eat carbohydrates is so important to feeling better, but fatigue is one of the biggest complaints that I get. Fatigue and weight gain and really I think that as Americans, we have

no idea how much we have forgotten that movement of our bodies and really getting some vigorous cardiovascular exercise plays such a role in overall health and so, I think that we need to really concentrate on telling people just what is exercise and how much do you need and that *Younger Next Year* book really focuses on saying, "In our 40s, 50s, 60s, you need to exercise five and six times a week if you want to maintain good cognitive function, good levels of energy, and sleep well and look the way you want to look and it's not just hormone replacement. It's not just checking for food allergies. It's a personal responsibility in trying to feel well and I think sometimes people forget that.

Jini: Yeah, it's very true the whole exercise thing, because it's almost like – well, it's so basic, but yet it requires the most amount of energy.

If faced with that or taking a pill, people are going to want to take the pill.

Dr. Ellis: They do and they'd say, "Oh, I just don't have time." I'm like, "Well, you have to schedule it in." It needs to be like sleep. It's as critical as sleep is, so whether you get up earlier-- but the economy is weird and people are having to do the jobs of two people and working too much and so I just think that if we can train ourselves to consider it one of the most important things, like sleep, I think we would be much better off.

Jini: Very, very good point. All right, so we're going to end with that and thank you so much for the call today. Again, massive amount of information and wonderful stuff and if anybody would like to reach Dr.

Wendy Ellis, you can reach her at www.TahomaClinicNorthSeattle.com and Wendy, is there a clinic number that they can phone?

Dr. Ellis: Sure, it's 206-402-4215.

Jini: Okay, perfect. Thanks so much for being on the call.

Dr. Ellis: Yeah, thanks for having me and have a good weekend.

Jini: You too. Bye-bye.

Dr. Ellis: Bye-bye.

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