MENOPAUSE

CASE 1 PRESENTATION:
55 year old business woman, normal body weight, irregular exercise
LMP – 2 years ago; no HRT
No breast cancer history

KEY SYMPTOMS:
- hot flashes
- night sweats
- foggy thinking
- fatigue
- urinary incontinence
- vaginal dryness
- low libido

HORMONE TEST	IN RANGE	OUT OF RANGE	UNITS	RANGE
E2 (Estradiol)	1.0		pg/ml	1.0-1.5
Pg (Progesterone)		20 L	pg/ml	25-100
Pg/E2 Ratio		20 L		50-100
Testosterone		15 L	pg/ml	20-50
DHEA-s	4.5		ng/ml	3-10
AM Cortisol		10 H	ng/ml	3-8

ANALYSIS:
- Low normal estradiol contributes to hot flashes, night sweats, memory lapses, vaginal dryness and urinary incontinence
- Progesterone is low; it is needed for estrogen receptor response; helps stabilize vasomotor symptoms.
- Low testosterone, an anabolic hormone, contributes to vaginal dryness, memory loss and low libido.
- Low normal DHEA-s contributes to low testosterone. DHEA from adrenals often converts to T in women. [1]
- High AM cortisols, low testosterone and low E2 are contributing factors for bone loss.

CLINICAL PEARL:
High morning cortisol is an indication of adrenal dysregulation. During the menopause years, hormone replacement may or may not be sufficient to

restore balance if adrenal function is not in balance.

TREATMENT CONSIDERATIONS:

- Bio-identical estradiol; remember to start at low doses increasing only as required clinically.
- For uterine protection bio-identical progesterone in appropriate dosing for balance.
- BHRT can be dosed daily for a woman not cycling; a 2-3 day monthly hormone “holiday” if used, allows a resetting of cell receptors.
- Vaginal dryness is best corrected with estriol vaginal cream applied locally and massaged into tissues. The urogenital mucosa have numerous estrogen cell receptors, thereby the use of estriol locally can relieve urinary incontinence symptoms.