Menopause: Alternative Choices
March 15, 2001 5pm PST, 7pm CST, 8pm EST
This program is made possible by an unrestricted educational grant from Remifen and GlaxoSmithKline.

Moderator
Susan Love, MD
President and Medical Director
Dr. Susan Love research Foundation

With Guests:
Mary Hardy, MD—Medical Director, Cedars-Sinai Integrative Medicine Medical Group, Los Angeles
Maida Taylor, MD—Associate Clinical Professor, Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Francisco

Dr. Susan Love: Welcome to “Powering Informed Choices,” a series of Internet chats on SusanLoveMD.com sponsored by an unrestricted educational grant from GlaxoSmithKline, US distributors of Remifemin Menopause. I am very excited to have as guests today Mary Hardy, Medical Director of the Cedars-Sinai Integrative Medicine Medical Group in Los Angeles, and Maida Taylor, an Associate Professor in the Department of Reproductive Sciences and Gynecology at the University of California, San Francisco.

We just got word that Mary Hardy is currently on a plane circling the airport in San Francisco and she will be with us as soon as possible. Maida and I will get started.

Dr. Maida Taylor: Hi, Susan.

Dr. Susan Love: Hi, Maida. Thank you for coming. I wanted to start our conversation today with an overview. Maida, how would you define menopause?

Dr. Maida Taylor: Well, how I would define it and how the profession defines it are two different things. But, for our purposes, the crude, operational definition of menopause is the cessation of menstrual periods for one year. So, it’s a retrospective diagnosis. And functionally, that may not be the most important issue for menopausal women.

Dr. Susan Love: So I wouldn’t know that I was in menopause until a year after I had stopped my period.
Dr. Maida Taylor: Exactly. Menopause is an endocrine event, but we have to wait. There are lots of women who probably have a lot of problems that we would call menopausal problems long before they’ve gone a year without periods.

Dr. Susan Love: I know I’ve heard of a lot of women who are having symptoms of hot flashes and are having periods who go to their doctor who says you’re not in menopause yet so we can’t do anything.

Dr. Maida Taylor: I think that’s really not fair to the women because, in fact, women can start having symptoms as much as 10 years before they actually cease menstruating. That’s a lot of time to go around complaining and have people telling you that there is nothing to do.

Dr. Susan Love: What is the cause of the symptoms then? If you’re still having periods, it’s not low estrogen.

Dr. Maida Taylor: We’ve made this assumption that low estrogen leads to hot flashes, when in fact it’s probably a dynamic process and the rates of fall are probably more important than absolute levels. The perimenopausal woman probably has higher estrogen levels than a younger woman. So when her estrogen levels fall at the end of her menstrual cycle, at the end of the second half of the menstrual cycle, the rate of decline of that estrogen may be steeper than when you’re younger, and that steepness or rapidity of fall is what sets off the symptoms.

Dr. Susan Love: Is that why sometimes postpartum you can have hot flashes and some menopausal symptoms like fuzzy thinking and mood swings?

Dr. Maida Taylor: Definitely. The postpartum is a state of very, very low estrogen levels, but they’re coming down from relatively high levels during the pregnancy itself. So you go from a relatively high estrogen state and then very rapidly into a very low estrogen state, which can leave you feeling awful.

Dr. Susan Love: So it’s really these variations rather than any specific level that is important.

Dr. Maida Taylor: We see women who’ve been treated for menopause but with very high levels of estrogen and, if it were just on the basis of absolute amounts of hormones, these women should never have a hot flash. Their estrogen levels may be 10, 20, 30 times normal, but they become symptomatic if they stop these very high doses. So it’s a dynamic system and not a static one.

Dr. Susan Love: Not surprising, since we women are always dynamic and not static! In the past, menopause has been termed an “estrogen deficiency” disease, but recent studies, as I’m sure you know, have indicated that postmenopausal women still make estrogen, although at lower levels, as well as testosterone and androstenedione. There
certainly is a shift in the level of hormones; but do we need to replace them back to premenopausal levels?

**Dr. Maida Taylor:** I think that’s a very controversial topic. That goes for a lot of different systems in the body, and not just estrogen. Androstenedione is lower; DHEA [dehydroepiandrosterone] is lower; but are we doing a service to try to replace to a level of a young adult? Maybe not. Maybe the levels appropriate for a 20-year-old aren’t appropriate for a 50-year-old and maybe we shouldn’t replace everything back to some youthful norm. The assumption that after menopause you’re somehow not “normal” is a very dangerous one.

**Dr. Susan Love:** Well, even using the word *replacement* makes it sound like you’re missing something and need to get it back again, rather than that you’re adding something additional which may or may not be useful.

**Dr. Maida Taylor:** I think we have a lot of variation in the population and we should recognize that one size doesn’t fit all and that not all women react the same to a loss of their hormones. For some people it is, perhaps, catastrophic and for others it is relatively benign.

**Dr. Susan Love:** I think the fact that not everybody has symptoms at menopause is something that a lot of women don’t even realize.

**Dr. Maida Taylor:** You know, if we took out everybody on the planet’s thyroids, they’d ultimately get very sick and die. If we take out everyone’s adrenals, they’d get very sick and die. But if we take out everybody’s ovaries, some people don’t get sick or die. Some may develop some degenerative disorders that are estrogen-dependent. But, it doesn’t affect everyone. It doesn’t follow our model of a classic endocrine-deficient disease.

**Dr. Susan Love:** As I’m fond of saying, if estrogen deficiency is really a disease, then all men have it.

**Dr. Maida Taylor:** Oh, let’s not go there because men have a lot of testosterone and they can convert it to estrogen in their brains and that’s where it’s probably helping them.

**Dr. Susan Love:** Or not! Are there other alternatives besides estrogen that are reasonable for women to consider when they have menopausal symptoms?

**Dr. Maida Taylor:** I think there are lots of alternatives depending on the symptom. I think that no one alternative is a panacea for every menopausal complaint. We could go through them symptom by symptom. The most common complaint, and clearly the most recognizable one, is the hot flash. There are a number of interventions.

**Dr. Susan Love:** I know a lot of people suggest that we don’t have any data on alternatives. But in some cases we do have studies. What would you recommend?
Dr. Maida Taylor: I think the two classic products and, at this point, those with demonstrable benefits, are soy and black cohosh. We have data on both of those that suggest they can help with hot flashes. We have other herbals that have been recommended and some limited data showing less than satisfactory results. For example, ginseng doesn't appear to help hot flashes. Oil of evening primrose doesn't appear to be effective, and vitamin E is somewhat marginal.

Dr. Susan Love: Even the wild Mexican yam, which is touted a lot, has not really been shown to be of much use for hot flashes.

Dr. Maida Taylor: The chemical that’s in the yam is called diosgenin and it can be converted in a laboratory into progesterone and then to estrogen; but there’s no pathway for that bioconversion in the body. So yams are great in soup and I like them with peanut butter and tofu. It’s a different kind of yam than you can buy in the grocery store anyway.

Dr. Susan Love: I think this idea that if we eat all the right ingredients, our bodies will know how to put them all together and make them into the right thing, is a little simplistic.

Dr. Maida Taylor: I think diet is very, very important and I think exercise and lifestyle in general is a very important part of the equation. But, for people who are not feeling well I don’t think that food and food supplements are always a successful therapy.

Dr. Mary Hardy: Susan, hello. This is Mary Hardy.

Dr. Susan Love: We’re very happy to have you on the call and know you’re on the ground.

Dr. Mary Hardy: I made it! (laughs)

Dr. Susan Love: We actually have a question from the audience which I hope you can answer, Mary. It’s from Patty. “I’ve been treated for breast cancer and the chemo put me into menopause. I have fuzzy thinking and my legs ache terribly. What can I do?”

Dr. Mary Hardy: Well, this is a good question for us, because we’ve been treating a number of women in our complementary and alternative center in Los Angeles who are exactly in this situation. As you and Maida know, especially in young women whose tumors are estrogen-sensitive, it’s appropriate to block the bioavailability of estrogen. So women who may not even have come to their menopause yet may suddenly be right smack in the middle of it. We’ve tried a number of strategies, and they depend somewhat on severity and somewhat on what aspect of their menopausal symptoms are the worst for them. I heard Maida, as I came on, give a good discussion of the constituents and the complementary choices that would be good for hot flashes. I think soy is still a reasonable choice. A lot of people with estrogen-sensitive breast cancers worry about the safety, but I think at dietary levels, the equivalent of one serving a day, 45mg of isoflavones, maximum 80, no more than two servings, is a safe bet and a good place to start, even with estrogen-sensitive breast cancer.
Dr. Susan Love: I would agree with you. There actually is a study in rats where soy and tamoxifen are synergistic; so rather than counteracting each other, they work together.

Dr. Mary Hardy: Right. And, these isoflavones in soy are very weakly estrogenic, less than 100th of a percent. Tamoxifen is such a powerful antiestrogen, it just swamps the estrogen effect of these constituents.

Dr. Maida Taylor: And, there’s no evidence from Japan or China or any other country where they have a high soy intake that women do worse once they’re diagnosed.

Dr. Mary Hardy: Sure. Absolutely. So, we’ve put a lot of fears to rest. Now, I don’t think ultra-high doses of isoflavones is a great idea, but the soy products that keep under 80mg of isoflavones are a reasonable bet. I also use black cohosh for these patients, and especially like it because it doesn’t appear to have a classic phytoestrogen, and has a good effect on hot flashes and on some of the thinking problems that some women get from a natural menopause or the menopause from chemotherapy. Again, for black cohosh, a couple of the test tube studies combining black cohosh with tamoxifen may improve the effects of tamoxifen, same as with soy. It’s very early data, but the trends are in the right direction. We also spend a lot of time helping patients think through mind-body interventions and lifestyle choices, like Maida said. But none of these things are the magic bullet; they all give 5, 10, 20 percent relief, and you need a whole program to get control of this. But, some patients have had terrible symptoms that have been resistant. And the court of last appeal, which has clinically been the best for our patients, is traditional Chinese medicine. When they’ve come and gone through all the conventional alternative therapies (if that’s not an oxymoron), we then usually use Chinese medicine. And we’re usually able to get them comfortable if not symptom free. We’ve also tried the herbs that help with mental alertness. We’ve had modest improvements with ginkgo, that helps with mental symptoms. And, for patients who are less alert because they’re depressed and overwhelmed because they’ve gone through a very tough time, we often will try things like SAM-e or St. John’s wort as long as there’s no herb/drug interactions. So that’s a quick overview of what we might do.

Dr. Susan Love: Now let me ask you, when I go into the health food store and look on the shelf, there are all these different products that say they have ginkgo or black cohosh. How do you tell which ones really have what they say they have, and are enough—that the dosages are correct?

Dr. Maida Taylor: There are two ways of ascertaining a reliable product. I think number one is a site on the Web called ConsumerLab [www.consumerlab.com] that rates products, that tests them to see if they really have what they say they have and in the amounts they say they have. There is also a group of herbal manufacturers who voluntarily subscribe to the production standards used in Germany that are set by the German government for production of botanicals. Also products that are generally made in Germany have been made to those standards.

Dr. Susan Love: So how can you tell?
Dr. Maida Taylor: Manufacturers in the US that subscribe to those standards will usually have a little seal on their packaging. It’s voluntary and I don’t know if anyone is checking up on them, but we hope they’re being honest and forthright on their testing standards and their quality controls.

Dr. Susan Love: Mary, do you have any recommendations in this regard?

Dr. Mary Hardy: Yes. I think Maida’s comment is a good one: You should be an educated consumer. The other thing I tell patients is that the products I look for are the ones that scientific studies have been done on, because I know those are the products that have been tested in a rigorous scientific fashion. So, you start with something that has a chance to be successful. Then there are some manufacturing standards you can look for. In essence, the real thing here is that if it’s too good to be true, it probably is. So, if you find a black cohosh product that’s $20, and right next to it is one that’s $10, be very careful, there might be a difference in those two products. Now price is not an absolute guarantee; but, a company that’s been in business a long time, that has a quality assurance program, all these boxes will have a consumer number on the back. Even if they answer the questions well, it’s not a guarantee, but certainly better if when you call them, they can’t answer anything about ensuring quality. So especially for women who are managing menopause, these are things you’re likely to take for a long time. So you want to find products you’re comfortable with.

Dr. Susan Love: So what’s the data we have on, for example, Remifemin? Are there any studies using that particular product?

Dr. Maida Taylor: There are about a dozen studies and there is a consistent trend within those studies showing significant improvement in vasomotor symptoms, in sleep disturbance, night sweats, and some changes in mood. In many instances the studies are small. Some studies are blinded and others aren’t and some didn’t have placebo controls. But the trend is there. There has also been some very good work by the manufacturer showing no evidence of toxicity and that’s also very reassuring that they’ve done that kind of testing. There’s no effect on liver or kidney function and that’s very helpful.

Dr. Mary Hardy: I agree that there’s a body of literature and I think the limitations that Maida stated are exactly right. Some of the observational studies, though, have included thousands of women, so the evidence for safety is pretty good and the efficacy is—the studies are getting more tightly controlled and so far, the trends have been maintained, which is again reassuring. This is a good example of what I was talking about, because this particular preparation of black cohosh is a very particular standardized extract. So we can say a lot about the effects of this particular extract. Then you start to make jumps. We assume that some of these would translate to other extracts or back to the basic herb, but the closer you are to the product that was used in the studies, the more assurance you have of getting the results that were seen in the trial.
Dr. Maida Taylor: In addition to what Mary just said, there is also the issue of, Is black cohosh estrogenic? And the research that’s been done has been very clear in demonstrating that there is no change in the vaginal tissue or vaginal lining or the uterine lining; no changes in estradiol or estrone or some of the other hormones that we would expect to see like FSH [follicle-stimulating hormone].

Dr. Mary Hardy: So it works, but not through the methods we’re used to.

Dr. Susan Love: Since we’re not totally sure what causes hot flashes and some of the menopausal symptoms, maybe that’s why we can’t quite figure out exactly how it works, even though it does.

Dr. Mary Hardy: Mm hmm. Good point.

Dr. Susan Love: Here’s another question from the audience, from Lucy. “I am 44 years old and have been taking 1 tablespoon of flaxseed per day. Is it safe and am I taking the right amount?”

Dr. Mary Hardy: Well, this is a great example, I get these questions all the time. The first thing I say is, for what? What are you trying to accomplish? It really depends. Flaxseed provides us with essential fatty acids; it is a very good food source, it’s good for bones, for skin, for anti-inflammatory work, etc.; but I don’t think it’s necessarily a specific treatment for menopause symptoms. If you take about a tablespoon—again, I’d have to ask: Is it fresh? Are you grinding it yourself? How are you using it? So, this is a good example of advising people to find someone local to them who can really advise them on the best way to use the product that they want to take to maintain health.

Dr. Susan Love: You do have to grind flaxseed, however. If you eat it whole, it will come out whole.

Dr. Mary Hardy: You can’t break down the husk, exactly.

Dr. Susan Love: You either have to do the oil or grind it before you eat it. It is a good source of omega-3 fatty acids, which might be good for your heart.

Dr. Maida Taylor: And, the seed casing is a source of lignans. But, how bioactive they are and how much you actually get from a tablespoon—it’s probably not enough to exert a major estrogenic effect.

Dr. Mary Hardy: No. I wouldn’t say. But, it will help keep your bowels regular, it may keep your cholesterol a little bit lower, help your skin be in a little better condition, and may be independently good for the heart as well.

Dr. Maida Taylor: My understanding with the essential fatty acids and the dermatitis literature is that a lot of the good effects of the essential fatty acids in the derm literature is with people with essential fatty acid metabolic defects.
Dr. Mary Hardy: Or very poor diets or drinking a lot of alcohol . . . but there have been a few studies, not with this essential fatty acid but the omega-3s from evening primrose oil, which show that people with atopic dermatitis and other conditions like that have seen the benefits.

Dr. Susan Love: We have another question from the audience. “What is the correlation between menopause and chronic long-term memory loss?” Maida, do you want to answer that?

Dr. Maida Taylor: Yes. Actually, I’ve just been reviewing some slides on that and there are some ongoing studies. One, in fact, was at UC and showed better cognitive persistence or better retention of cognitive function in women who took estrogen. I think the very long-term studies haven’t been done as yet and it’s not clear whether estrogen will prevent Alzheimer’s disease. There are two studies in the literature clearly demonstrating that estrogen provided no benefit in slowing the rate of progression of Alzheimer’s, unfortunately. One of the theories is that women who have severe hot flashes actually have abnormal blood flow pattern in their brain during the hot flash. They’ve shown this on PET scans and the blood flow pattern, the distribution of blood flow that results during the hot flash, is identical to the blood flow patterns that are seen in Alzheimer’s. So it may be a subset of people that are particularly susceptible and for whom estrogen may act ultimately as a preventative. But it is pretty well theoretical at this time.

Dr. Susan Love: But if that’s the case, then anything that helps hot flashes would be a preventive.

Dr. Maida Taylor: It would be nice to be able to demonstrate that if you took X and you didn’t have hot flashes and the blood flow in your brain stayed normal. That would be great. Especially if it was something that didn’t carry a long-term risk.

Dr. Susan Love: My concern with some of that data is that the studies tend to be done in women who’ve had hysterectomies and they tend to be done immediately after the hysterectomy. So they do the cognitive study; they do the hysterectomy. They give half the women estrogen and the other half none. Then they repeat the cognitive studies in four or six weeks. As we said earlier in this chat, the rebalancing from hormonal changes may take a little while. Nobody is actually repeating the cognitive studies at the end of a year or two years and I wonder whether the acute changes of the estrogen drop persist or whether the brain gets used to it.

Dr. Maida Taylor: From personal experience, I think the brain probably gets used to it. I tell people that your reproductive years are like a warm, tropical, lush coral reef system and that your menopausal years are perhaps a nice, warm, tropical beach. But, getting in from outside the reef onto the beach can be pretty rocky and you get pretty torn up along the way. It’s a California allusion. It’s a West Coast allusion. It’s those adjustment times where the shifts are so problematic. But, a lot of women persist in having symptoms for 10, 20, or 30 years.
Dr. Mary Hardy: I’ve also been struck by how durable some of these symptoms have been in some of my patients. In medical school that aspect of menopause is not highly emphasized, and for some women, that’s their primary complaint.

Dr. Maida Taylor: We’re all told within a couple of years, or a year or two, three years it will all go away and that’s not true for everyone.

Dr. Mary Hardy: Right. I don’t think it’s all an estrogen issue, because I do have a small number of patients, even with adequate replacement, that part never quite gets back to normal. I think it challenges us to continue to be creative and look for solutions.

Dr. Maida Taylor: The cognitive part?

Dr. Mary Hardy: Yeah.

Dr. Susan Love: Or it challenges us to figure out . . . maybe the cause really isn’t an estrogenic one. Maybe it’s both true and unrelated.

Dr. Mary Hardy: I’m putting together something that Maida just now said with something I know . . . and this may be interesting. A handful of our patients who had a difficult menopause transition after cancer benefited from traditional Chinese medicine, both herbal and with acupuncture interventions, and there’s a growing body of data that acupuncture redistributes blood flow in the brain. So maybe that would be an interesting thing to look at, Maida.

Dr. Maida Taylor: It would be great to do it with PET scanning. That would be wonderful.

Dr. Mary Hardy: Wouldn’t that be a great study? To see if certain point selections would help to reestablish a more normal blood flow. This kind of marriage of western science with traditional experience, I think is what’s so exciting about integrative medicine.

Dr. Susan Love: And really getting away from the “and/or” approach. (It’s either one or the other—you either believe in traditional medicine or you don’t.) You really have to get away from that and into an integrative approach.

Dr. Mary Hardy: I’m definitely a “both/and” kind of person.

Dr. Susan Love: Here’s another question. “How long do the symptoms of menopause last? You said in some people they last for a long time, but what’s the average?”

Dr. Maida Taylor: I think on average that many women between one and five years will have a significant diminution in symptoms. I’m trying to recall the exact number, but that by age 58 or 60, something like that, there is a significant portion of women who are still symptomatic. I think 20 percent (and that may be a low estimate) have persistence of the
hot flashes. We haven’t necessarily done the longitudinal studies and we tend to look at newly menopausal women. As the baby boomers age, we’ll be surveyed up the wazoo and followed ad nauseam to see how our complaints shift. But the longitudinal data aren’t as good as the data on the 50-year-olds.

**Dr. Susan Love:** Interesting. One of the things that I’ve found in my own experience is that the worst part of menopause is its unpredictability. You might have symptoms for two months of one kind and they stop, or you’ll have heavy bleeding and then that stops, or hot flashes for six months and then they stop—how can treatment be studied in light of that variability? How can we tell what works when symptoms may stop on their own?

**Dr. Maida Taylor:** That’s a really magnificent question, Susan. Really the heart of the matter of doing good research in menopause is the fact that it is so unpredictable. I think that matching women—say if you have a study to do, what we end up doing is studying a subset of women who are very similar. And the outliers, the women who are not symptomatic, or who are erratic in their presentation, or who swing wildly, don’t get studied. For example, in an FDA-sanctioned hot flash study, everyone has to have more than 7 hot flashes a day, 14 days before entry, and be amenorrheic for more than a year, and have FSHs in the menopausal range, estradiols under 20 picograms. There’s a whole set of criteria, so we select out a group of women who all look like each other. And, if you don’t look like that, the research may not apply to you. Or, we extrapolate that it should and we’ll do the best we can for you.

**Dr. Susan Love:** Interesting. If that’s the case, then how should a woman decide what’s the best approach for her?

**Dr. Maida Taylor:** Mary, you do this a lot.

**Dr. Mary Hardy:** I do. I’m going to use another California allusion. You go to a restaurant and want to pick a wine; you kind of know what you want, but you talk to the wine concierge and tell him/her what you like. You say I know I want a red, or I like it really dry. So, I sit and ask people, what are you trying to accomplish? What are you most afraid of? What do you want to be sure to get a response to? And, then I’ll usually say to them, here are three or four or one, whatever are a few reasonable choices I think there are, and I tell them the pluses and minuses of each one. Alternately I remind them that none of these choices are life-and-death today; we can work our way up to a decision sequentially and make another choice as time goes by. I have a number of patients who will not take estrogen, so we start with natural treatments. But, if they’re not getting a good response or if I think they have a particular risk factor that makes estrogen a good choice for them, we stay in dialogue about that. So, it’s open communication, put the best choices on the table, and ultimately it’s up to the person or patient to pick the choice that works the best for them.

**Dr. Maida Taylor:** Mary, I wonder what it says about our personalities that you chose a wine analogy and I use the shoe analogy.
 Dr. Mary Hardy: (laughs) Well, I think it means I’m thinking about Napa Valley!

 Dr. Maida Taylor: I tell people that you’re also going to have to try them on. It’s like shoes. You have to walk in them and see how they feel. And sometimes you make a mistake and it’s not the right one for you; it’s too narrow or too wide and you go and try something else. And, to some degree it’s for somebody else. The studies are done for a 7.5 B and if you’re another size, then it may take us time to find something that’s comfortable and fits you, and some people like heels and some people don’t.

 Dr. Susan Love: It’s a good analogy, but I have a question that goes with that. How long should you be trying something to know if it’s working? For example, how long does it take for something like black cohosh or Remifemin to work?

 Dr. Mary Hardy: For herbal interventions, I’ll do that one because I might do that first. I say that you really can’t know for sure for three months. Because a lot of these remedies are milder and take a while to show an effect, but also, Susan, allow some of this natural variation to even itself out. So, you ought to be on a therapeutic dose of a good product for two months absolute minimum, and three months is the classic first time to reassess the decision point.

 Dr. Susan Love: So we shouldn’t be impatient and realize this is not a disease, but a long-term proposition.

 Dr. Mary Hardy: One of those character-building life experiences!

 Dr. Maida Taylor: The hormonal stuff has a shorter time course and in general one would expect it to be a matter of a week to two weeks or three weeks before we judge that a hormonal intervention wasn’t working properly.

 Dr. Mary Hardy: I can clarify that. People do get responses sooner than three months, it’s not like everyone will hang by their thumbs until the 11th week. Some people even have rapid responses. But, I wouldn’t say the treatment was a failure until we’ve gone a full dose for at least three months.

 Dr. Susan Love: That’s helpful, I think. This is something that Maida and I spoke about earlier and I think it’s appropriate to bring up now. “Do herbal approaches to menopause have the exact same results as estrogen?”

 Dr. Mary Hardy: Well, that’s interesting because it depends on what you’re talking about. The quick and simple answer is no. But, there’s a final common pathway if you want to see certain kinds of symptoms affected. There’s no one herb that will do all the things that estrogen likely will do. For example, we don’t really use black cohosh for bone health, but there are some early animal studies that say it can have positive effects on bone. Soy you use for hot flash relief, but there’s also some data there about bone health and also a modified derivative of soy called ipriflavone, pretty good data about the effects of ipriflavone on bone. It’s not a 1:1 correspondence, and there will be some
patients who, given the nature or the severity of their symptoms, will not be the best candidates for an herbal approach. For example, the patient we were talking about with very severe mental symptoms, she may need some pharmaceutical support, at least to get over the worst of things, and then think about the herbal approach to either minimize the amount of estrogen or, after a period of time, to transition off the estrogen if she desires to do that.

Dr. Maida Taylor: Mary made a wonderful point about the transitioning between things and that women have to be reminded that what we do right now, what we do today, that we have the capacity to change it and that you don’t need to get dispensation and you don’t need to get a divorce. We can modify the regimen and wean one thing down and increase another one and achieve a different balance at a later time. People may need more medicinals during the early symptomatic phases and then over time can be treated with less intense or lower doses or different products that carry lesser risks.

Dr. Susan Love: Menopause is a dynamic time of rebalancing. People get on something and are afraid that if they change things, all the symptoms will come back. But that’s often not the case.

Dr. Maida Taylor: It’s clearly not the case. Over time most women can be weaned, although it should be done slowly. A woman who may need high-dose estrogen may ultimately go to lower and lower doses and ultimately can change to a botanical product or a whole array of other choices.

Dr. Susan Love: I think one of the questions I hear a lot from women is whether they can combine some of these different products. How about taking kava, black cohosh, and valerian all together? Or even all of the products you’ve ever heard about menopause being combined into one pill? What do you think about that, Mary?

Dr. Mary Hardy: I make the point to people that even though my prescription pad is white and green, I make choices from both categories, I’m still a physician. And I tend to like to have a parsimony of interventions, maximize those before I go on. The combination products formulae can be useful, but the advantage of a formula is to tailor it to an individual. If you then give that formula to millions of women, I find that a paradox. You’ve taken a highly individual process and mass-marketed it. I find that less helpful. As a physician, I like to have relatively simple products, so as an advisor to the patient, I can help them put together one, two, three things to make the right treatment plan for them. Anytime you complicate things, your chance of having an interaction or intolerance, having too many pills to take, can go up. So, I start simple, where I’m likely to get a benefit and then escalate the program as I need to. You may start five things, the patient has a good response, and then you’re stuck—do they really need all five things? The process of taking that apart can be tedious.

Dr. Susan Love: Not only that. What if you take five things and you get a reaction? Which one is it? Or is it the interaction? I absolutely agree with you. We tend to think we can do these things on our own, but we need someone to help guide us; whether it’s an
integrative physician like yourself, or whether it’s an herbalist, someone who has some
training in the field.

**Dr. Mary Hardy:** If we send people away with one piece of advice, that would be it . . .
please get a support system. Make good decisions after having gotten good advice.
That’s what I’d say.

**Dr. Susan Love:** Maida, do you want to say anything about this?

**Dr. Maida Taylor:** I think there is a group of people who are drawing on the best of both
worlds, as Mary suggested. My biggest problem as a conventional physician is the
woman who comes in with a bag of stuff from the health food store and dumps it on my
desk and is already taking six, eight, ten different medications and doesn’t realize that
she’s taking potentially toxic doses of vitamin A, or B₆, and doesn’t realize there’s a
potential for toxicity from these things. I think we need to provide women with the idea
that if some is good, more isn’t necessarily better.

**Dr. Susan Love:** But that’s against the American way!

**Dr. Mary Hardy:** I would like to emphasize this point; I think Maida’s correct. People also
forget, if you ask a woman if she’s taking medicine, she says no, then you say what
about your birth control pill? (She thinks that’s not medicine; that’s contraception.) We
have a similar thing here, we’ll ask them what they’re taking for menopause and they’ll
drag out some bottle. Then I’ll ask if they’re taking a shake? Yeah, yeah. Well, that has
soy protein in it. And, then they say, well, that’s what I’m eating; that’s my diet. And I ask
to see the bars they’re eating. So by the time everything’s on the table, people may have
crossed the safe isoflavone line. When you’re talking to patients who are using
alternative therapies, it’s important to cover the gamut. We’re at the point now where
they’re practically putting things into potato chips! But, not enough. Not enough. But I’ve
seen drink formulations with a therapeutic dose; I’ve seen some formulations that have
had as much ginkgo in them as some of the pills.

**Dr. Maida Taylor:** Whoa! But, most of the time most of those things have barely
homeopathic doses and big price tags; small amounts of herbs and big price tags.

**Dr. Mary Hardy:** But, for the times that they don’t, we need to be sure that we’re
teaching patients how to look at the label and either find out if there is an issue, or know
that there might be one, or how to spot one.

**Dr. Susan Love:** Here’s another question from the audience. “I’m 30 years old. Should I
be on the birth control pill now to prevent symptoms of menopause later?”

**Dr. Maida Taylor:** Oh, it’s like should I put money in the stock market today to get rich
tomorrow? You don’t know. I think there is no evidence that taking the pill today will
stave off menopause later by keeping your ovaries fresh. For the woman in transition
who is already approaching menopause and has symptoms because her ovaries aren’t
functioning in a predictable way, the pill can be a real stabilizer and can even things out, but there is no evidence that taking it at age 30 will in any way be protective.

**Dr. Susan Love:** Here’s another good question from the audience. “I’ve heard it is safe to use black cohosh for six months. What happens after the six months, particularly if it is helping to relieve hot flashes? Is there any toxic effect on the liver from black cohosh?”

**Dr. Mary Hardy:** This is a good question and points out one of the limitations on how we do research. Maida will test me on this, but even estrogen is only indicated for six months, according to the official regulations. The reason for the six-month limit is that’s as long as the observational trials have ever gone. And clearly that’s not how women are using this product. Women stay on this product for years. We don’t have any studies that have looked at this before they start and then watch them as they go, and that’s the bad side. But the good side is that we don’t have any reports from the commercial data; people who take it don’t call the company and say, “I’m getting a liver transplant next week and it’s all your fault!” This is another case where we need to spend some time and effort and money to get a better sense of the natural history of menopause, and then do some observational studies on women long-term. My patients take it for years at a time without difficulty, but that’s one practitioner with one particular set of patients and we need to get a better look at that.

**Dr. Susan Love:** I do think if there were a lot of liver transplants, we would have heard about it!

**Dr. Mary Hardy:** Right! Right. That was a very sarcastic remark.

**Dr. Maida Taylor:** There was that slimming multiple that was used in Belgium, that was marketed as having *Stephania tetrandra* in it, but really had *Aristolochia fangchi*. People ended up with renal failure and ultimately with neoplasia and cancerous changes of the mucosa, the lining of the bladder ureter. Those kinds of things, disastrous clusters and experiences with herbals, do show up.

**Dr. Susan Love:** Certainly some of these herbals which seem new to us, like black cohosh, have been used in Europe for a long time. Lots and lots of women have taken it. So if there were significant safety things we would have heard about it.

**Dr. Maida Taylor:** Licorice is eaten in Europe in large quantities as a candy and in herbal therapies as a therapeutic. Yet there is a tremendous amount of licorice toxicity reported in the literature in Europe. It acts as a mineralocorticoid; it mimics one of the adrenal hormones and it can lead to hypertension and a whole other variety of vascular complications in a subset of susceptible people. We know it, it’s there, it’s widely reported and well recognized. Licorice may be hidden in things you don’t realize. Adriane [Fugh-]Berman likes to cite a case of a man who ate a large package of Twizzlers at the movies and went into congestive failure.
Dr. Mary Hardy: Right. And, just so our audience doesn’t get worried, virtually no licorice in the United States really has licorice in it [Twizzlers are an exception]. It’s sugar and anise flavoring, so it tastes like licorice because of the closely related herb, but it doesn’t have those properties. And, Maida is right, that’s one of the best-described toxicities of a common herb, and even at that it’s still uncommon. Not unheard of and anticipated, but it doesn’t happen every other minute. In general, if the herb is taken appropriately and if the product is what it says it is, it’s safe. That’s one of their advantages. They’re not quite as potent as pharmaceutical medications, but in general they’re easier to take with fewer side effects.

Dr. Susan Love: I think one of the concerns people have and get confused about menopause (and we’ve been talking mostly about symptoms tonight) is the difference between the symptoms of menopause and the diseases that seem to increase as women get older. Do you want to comment on that, Maida?

Dr. Maida Taylor: I think there needs to be a great distinction made between symptoms and the processes we feel are estrogen-dependent. The profile of a woman who gets osteoporosis isn’t necessarily the same as the woman who gets hot flashes. I think that we know that for the immediate management of symptoms, estrogen provides tremendous relief. Some data we have on long-term disease prevention with estrogen (studies following a large population of women over time) are turning out to be not as good as we thought. Every algorithm and every kind of tree you use to promote estrogen for a certain type of woman relies heavily on the assumption that estrogen prevents or treats heart disease and we are now less enthusiastic about the benefits of estrogen as we use it. Estrogen in younger women plays some major role, but whether we are able to replace estrogen and provide coronary or cardiac benefits is very uncertain at this point in time.

Dr. Susan Love: It may not be that estrogen makes you healthy; it may be that healthy women take estrogen.

Dr. Maida Taylor: Yes, women with access to medical care and lots of money and upper-middle-class status and are well educated and do all the right things also are the people who go to the doctor and get estrogen because they’ve been told it’s good.

Dr. Susan Love: I have one last question here from the audience. And this one’s for you, Mary. “I’ve been on black cohosh. What is DGL—isn’t that licorice extract included in many black cohosh blends?”

Dr. Mary Hardy: Licorice is an herb that has a reputation as an estrogenic herb; some of its constituents do seem to have estrogenic effects. Licorice is also one of the herbs most commonly included in Chinese formulas as a governor or regulator herb. DGL is deglycyrrhizinated licorice. Glycyrrhizinic aci is a constituent in estrogen. It doesn’t provide the taste, but it does provide that hormone-like action that Maida was talking about. And that’s all the hormone action. So when you take out the glycyrrhizinic acid, you’ve lost the hormonal activity of licorice. So deglycyrrhizinated licorice is a great
soother; it can heal stomach and stomach ulcers, etc., but it probably will not have any estrogenic effects at that point.

**Dr. Susan Love:** And if it’s added to the black cohosh, it wouldn’t add much either.

**Dr. Mary Hardy:** It wouldn’t add much, but it also won’t hurt you. It might flavor a tea, for example, if you like the licorice flavoring. But it may be an example of someone knowing there’s a problem with that product but still wanting to have that word on the label for people who know it’s an estrogenic herb or has the reputation for that, though it’s not one of the ones we first go to. So it’s how to have it there but have it be safe, which is a marketing decision and not a clinical decision.

**Dr. Susan Love:** It goes back to our being safer with one product at a time and not mixing them together. If you’re going to do black cohosh, do it alone and don’t mix it in with a lot of other things.

**Dr. Mary Hardy:** There’s another way black cohosh is supplied. Remifemin also has a St. John’s/black cohosh mix which has been very nice for a lot of women with mood issues or thinking issues around their menopause, but again there are some cautions with St. John’s wort interactions, and that’s an example of a pretty standardized formula of a few things, not 12 things.

**Dr. Susan Love:** This has been a great chat. I want to point out to our audience that if you have any personal questions about breast cancer and menopause that we have not had time to answer, please submit them to “personal guidance” on the website and we will get back to you on a 1:1 basis. I also want to thank everybody very much for joining us today. Please tune in again next Thursday at the same time when we will have Part Two of our three-part series of webinars, “Powering Informed Choices.” I will be joined by Dr. Fredi Kronenberg, Director of the Rosenthal Center for Complementary & Alternative Medicine and Director of the Center for Complementary & Alternative Medicine Research in Aging & Women’s Health at Columbia University. We will talk a little more about herbal remedies and what is the science behind them. I welcome you to join us then with any further questions you might have. And we’ll have a third chat in two weeks. That will be about how to talk to your doctor about herbal remedies. I also want to give our thanks to GlaxoSmithKline, US distributors of Remifemin Menopause, for sponsoring this program today with an unrestricted educational grant. Thank you all very much and please come back and join us next week.